Your Medicare Health Benefits and Services as a Member of Health Net Pearl TX Option 2

This mailing gives you the details about your Medicare health coverage from January 1 – December 31, 2009, and explains how to get the health care you need. This is an important legal document. Please keep it in a safe place.

Health Net Member Services:
For help or information, please call Member Services or go to our Plan website at www.healthnet.com.

1-800-977-8221(Calls to these numbers are free)
TTY/TDD users call: 1-800-929-9955

Hours of Operation:
8:00 a.m. to 8:00 p.m., seven days a week

During the annual enrollment period (between November 15th and December 31st) through 60 days past the beginning of the following contract year, our Plan operates a toll-free call center for both current and prospective members that is staffed seven days a week from 8:00 a.m. to 8:00 p.m. During this time period, current and prospective members are able to speak with a Customer Service representative. If you call outside these hours, when leaving a message, you should include your name, number and the time you called, and a representative will return your call no later than one business day after you leave a message.) However, after March 2, 2009, your call will be handled by our automated phone system, Saturdays, Sundays, and holidays. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day after you leave a message.

This Plan is offered by Health Net Life Insurance Company, referred throughout the EOC as "we", "us" or "our." Health Net Pearl TX Option 2 is referred to as "Plan" or "our Plan." Our organization contracts with the Federal government.

This information may be available in a different format, including Spanish. Please call Member Services at the number listed above if you need plan information in another format or language.

Esta información puede estar disponible en un formato diferente, incluso en español. Si necesita información del plan en otro formato o idioma, llame al Departamento de Servicios al Afiliado al número indicado antes.

H5996_2009_051
10/2008

EOCID 220283
SAP# 6017752

This is Your 2009 Evidence of Coverage (EOC)

Table of Contents

1. Introduction

Thank you for being a member of our Plan!

This is your Evidence of Coverage, which explains how to get your Medicare health care coverage through our Plan, a Medicare Advantage Private Fee For Service (PFFS) Plan; you are still covered by Medicare, but you are getting your health care through our Plan.

This Evidence of Coverage, together with your enrollment form, riders (including optional supplemental benefit brochures), and amendments that we send to you, is our contract with you. The Evidence of Coverage explains your rights, benefits, and responsibilities as a member of our Plan and is in effect from January 1, 2009 - December 31, 2009. Our plan's contract with the Centers for Medicare & Medicaid Services (CMS) is renewed annually, and availability of coverage beyond the end of the current contract year is not guaranteed.

This Evidence of Coverage will explain to you:

- What is covered by our Plan and what isn't covered.
- How to get the care you need, including some rules you must follow.
- What you will have to pay for your health care.
- What to do if you are unhappy about something related to getting your covered services.
- How to leave our Plan, and other Medicare options that are available.

This Section of the EOC has important information about:

- Eligibility requirements
- The geographic service area of our Plan
- Keeping your membership record up-to-date
- Materials that you will receive from our Plan
- Paying your plan premiums
- Late enrollment penalty

Eligibility Requirements

To be a member of our Plan, you must live in our service area, be entitled to Medicare Part A, and enrolled in Medicare Part B. If you currently pay a premium for Medicare Part A and/or Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and remain a member of this plan.

The geographic service area for our Plan.

The counties in our service area are listed below.

Aransas, Bandera, Bazoria, Cass, Coke, Concho, Coryell, Crane, Denton, Dimmit, Duval, Ellis, Fort Bend, Franklin, Hartley, Jack, Jeff Davis, Kendall, King, Lampasas, Midland, Parker, Reagan, Rockwall, Tarrant, Titus, Tyler, Upton, Webb, Wise Counties, Texas

How do I keep my membership record up to date?

We have a membership record about you. Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific Plan coverage and other information. Doctors, hospitals, and other providers use your membership record to know what services are covered for you. Section 3 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up to date by telling Member Services if there are changes to your name, address, or phone number, or if you go into a nursing home. Also, tell Member Services about any changes in other health insurance coverage you have, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims from an automobile accident.

Materials that you will receive from our Plan

Plan membership card

While you are a member of our Plan, you must use our membership card for services covered by this plan. While you are a member of our Plan you must not use your red, white, and blue Medicare card to get covered services, items. Keep your red, white, and blue Medicare card in a safe place in case you need it later. If you get covered services using your red, white, and blue Medicare card instead of using our membership card while you are a plan member, the Medicare Program won't pay for these services and you may have to pay the full cost yourself.

Please carry your membership card that we gave you at all times and remember to show your card when you get covered services, items. If your membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card

Your monthly plan premium

As a member of our Plan, you pay:

1) Your monthly Medicare Part B premium. Most people will pay the standard premium amount, which is $96.40 in 2009. (Your Part B premium is typically deducted from your Social Security payment.) (If you receive benefits from your state Medicaid program, all or part of your Part B premium may be paid for you.)

   Your monthly premium will be higher if you are single (file an individual tax return) and your yearly income is more than $85,000, or if you are married (file a joint tax return) and your yearly income is more than $170,000.)

If your Yearly Income is*		**In 2009, you pay***
File individual tax return	File joint tax return	

$85,000 or below	$170,000 or below	$96.40
$85,001-$107,000	$171,001-$214,000	$134.90
$107,001-$160,000	$214,001-$320,000	$192.70
$160,001-$213,000	$320,001-$426,000	$250.50
Above $213,000	Above $426,000	$308.30

*The above income and Part B premium amounts are for 2009 and will change for 2010. If you pay a Part B late-enrollment penalty, the premium amount is higher.

2) Your monthly Medicare Part A premium, if necessary (most people don't have to pay this premium).

3) Your monthly premium for our Plan.

Your monthly premium for our Plan is listed in Section 10. (If you signed up for extra benefits, also called "optional supplemental benefits", then you pay an additional premium each month for these extra benefits.) If you have any questions about your Plan premiums or the payment programs, please call Member Services.

Monthly Plan Premium Payment Options

There are two ways to pay your monthly plan premium. You can choose your payment option when you enroll and make changes at anytime by calling Member Services at the phone number listed in Section 8. If you chose the additional Optional Supplemental Benefits, then the premium for these extra benefits can also be paid by the payment options mentioned below.

Option one: Pay your monthly plan premium directly to our Plan.
You may decide to pay your monthly plan premium directly to our Plan.
The monthly plan premium is due to us by the first of every month. You can make the payment by sending your check to:

Health Net Medicare Programs
P.O. Box 6000
Columbia, SC 29260-6000

Please note, a $15 fee will be assessed for all returned checks.

Instead of paying by check, you can have your monthly plan premium: automatically withdrawn from your bank account. If you are interested in this method, call Member Services at the phone number listed in Section 8 for the appropriate form. Once we have your approval to automatically withdraw the monthly premium, we will deduct the payment from your account on approximately the 1st of every month.

Option two: **You may have your monthly plan premium directly deducted from your monthly Social Security payment.**

Contact Member Services for more information on how to pay your monthly plan premium this way.

What is the Medicare Prescription Drug Plan late enrollment penalty?

If you don't join a Medicare drug plan when you are first eligible, and/or you go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a late enrollment penalty when you enroll in a plan later. The Medicare drug plan will let you know what the amount is and it will be added to your monthly premium. This penalty amount changes every year, and you have to pay it as long as you have Medicare prescription drug coverage. However, if you qualifY for extra help, you may not have to pay a penalty.

If you must pay a late enrollment penalty, your penalty is calculated when you first join a Medicare drug plan. To estimate your penalty, take 1% of the national base beneficiary premium for the year you join (in 2009, the national base beneficiary premium is $30.36. This amount may change in 2010). Multiply it by the number of full months you were eligible to join a Medicare drug plan but didn't, and then round that amount to the nearest ten cents. This is your estimated penalty amount, which is added each month to your Medicare drug plan's premium for as long as you are in that plan.

If you disagree with your late enrollment penalty, you may be eligible to have it reconsidered (reviewed). Call Member Services to find out more about the late enrollment penalty reconsideration process and how to ask for such a review.

If you have a late enrollment penalty, call Member Services for more information on your monthly plan premium payment options.

You won't have to pay a late enrollment penalty if:

- You had creditable coverage (coverage that expects to pay, on average, at least as much as Medicare's standard prescription drug coverage)
- You had prescription drug coverage but you were not adequately informed that the coverage was <u>not</u> creditable (as good as Medicare's drug coverage)
- Any period of time that you didn't have creditable prescription drug coverage was less than 63 continuous days
- You lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) AND you signed up for a Medicare prescription drug plan by December 31, 2006, AND you stay in a Medicare prescription drug plan
- You received or are receiving extra help.

What happens if you don't pay or are late with your monthly plan premiums?

If your monthly plan premiums are late, we will tell you in writing that if you don't pay your monthly plan premium by a certain date, which includes a grace period, we will end your membership in our Plan." Our plans grace period is 90 days. If we end your membership, you will have Original Medicare Plan coverage.

Should you decide later to re-enroll in our Plan, or to enroll in another plan that we offer, you will have to pay any late monthly plan premiums that you didn't pay from your previous enrollment in our Plan.

If you signed up for extra benefits ("optional supplemental benefits"), and you don't pay the additional monthly plan premium for these extra benefits on time, we will tell you in writing that if you don't pay the monthly plan premium for these extra benefits within 90 days we will end coverage for the extra benefits. If you want to terminate your extra benefits, you must notify us in advance or we will end your membership."

Important Information

We will send you Health Net Employer Status/Coordination of Benefits Survey so that we can know what other health coverage you have besides our Plan. Medicare requires us to collect this information from you, so when you get the survey, please fill it out and send it back. If you have additional health coverage, you must provide that information to our Plan. In addition, if you lose or gain additional health coverage, please call Member Services to update your membership records.

2. How You Get Care

How You Get Care

What are "providers"?

"Providers" is the term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed by the state and as appropriate eligible to receive payment from Medicare.

What are "covered services"?

"Covered services" is the term we use for all the medical care, health care services, supplies, and equipment that are covered by our Plan. Covered services are listed in the Benefits Chart in Section 10.

What do you pay for "covered services"?

The amount you pay for covered services is listed in Section 10.

Providers you can use to get services covered by our Plan

As a member of our Plan, you may get healthcare services from any provider, such as a doctor or hospital, in the United States who is eligible to be paid by Medicare and agrees to accept the plan's terms and conditions of payment prior to providing healthcare services to you. Not all providers may accept our plan's payment terms or agree to treat you. Therefore, you must show your plan membership ID card every time you visit a health care provider so that the provider is aware of your membership in a PFFS plan. There is a telephone number or website on the card for the provider to find out about our plan's terms and conditions of payment. This gives your provider the right to choose whether to accept our plan's terms and conditions of payment before treating you. The provider cannot change his/her mind about accepting the Plan's terms and conditions of payment after furnishing services. If you need emergency care, it is covered whether the provider agrees to accept the plan's payment terms or not.

If your provider agrees to accept our plan, then the provider must follow the plan's terms and conditions for payment, and bill the plan for the services they provide for you. You are only required to pay the copayment or coinsurance amount allowed by our plan at the time of the visit. A provider can decide at every visit whether or not to accept our plan's payment terms and agree to treat you.

As soon as you have told your provider that you are a member of our Plan (for example, by showing them your plan ID card) and they agree to treat you, your provider is bound by the terms and conditions of payment of the Plan even if they don't explicitly accept them. We call these providers "deemed providers".

If your provider doesn't agree to our plan's terms and conditions of payment, then the provider shouldn't provide services to you, except for emergencies. In this case, you will need to find another provider that will accept our plan's payment terms. If the provider chooses to treat you,

then they may not bill you. They must bill the plan for your covered health care services. You are only required to pay the copayment or coinsurance amount allowed by the plan and listed in Section 10 at the time of the service.

What should you do with your provider bills?

You should only pay the provider the cost-sharing allowed by our Plan and listed in Section 10. You should ask your provider to bill us for the rest of the fee and we will pay the provider according to our Plan's terms and conditions of payment. If the provider asks you to pay the full amount of the bill, and have you get paid back by the Plan, tell the provider that you only have to pay the cost-sharing amount. Your membership card in our Plan will indicate how the provider can contact us for information on our terms and conditions of payment. If the provider wants further information on payment for covered services, please have them contact us

Health Net Pearl Member Services
Post Office Box 1728,
Augusta, GA 30903-1728.
1-800-977-8221 (TTY/TDD 1-800-929-9955)

If you get a bill for the services, you may send the bill to us for payment. We will pay your provider for our share of the bill and will let you know if you must pay any cost-sharing. However, if you have already paid for the covered services we will reimburse you for our share of the cost.

If you have any questions about whether our plan will pay for a certain health care service, you can ask us for a written advance coverage decision before you get the service. We will let you know if our plan will pay for the service.

Getting care if you have a medical emergency or an urgent need for care

What is a "medical emergency"?

A "medical emergency" is when you believe that your health is in serious danger. A medical emergency includes severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting much worse.

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. You don't need to get approval or a referral first from your doctor or other network provider.
- As soon as possible, make sure that we know about your emergency, because we need to be involved in following up on your emergency care. This number is located on the back of the membership card).

What is covered if you have a medical emergency?

- You may get covered emergency medical care whenever you need it, anywhere in the United States.
- **Ambulance** services are covered in situations where other means of transportation in the United States would endanger your health. (See the benefits chart in Section 10 for more detailed information,)
- We offer covered emergency medical care outside of the United States (Worldwide coverage). Please refer to Section 10 for more information.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care—thinking that your health is in serious danger—and the doctor may say that it was not a medical emergency after all. If you decide to get follow-up care from the provider treating you, then you should advise them of your plan enrollment as soon as possible, for example by showing them your member ID card with your plan information. The plan will pay for all medically necessary plan covered services furnished by the provider and non-emergency care that you get from any provider in the United States to whom you have informed, by showing your member ID card, that you are a plan member, and who agrees to accept our plan's terms and conditions of payment.

What is urgently needed care?

Urgent care refers to non-emergency care received outside the service area of the Plan. However, as discussed in detail earlier in this section, a PFFS plan allows enrollees to access care from any Medicare-approved provider in the United States who agrees to accept our plan's terms and conditions of payment prior to treating you. Consequently, the concept of urgent care does not apply, since you may always obtain care outside of the service area.

What is your cost for services that aren't covered by our Plan?

Our Plan covers all of the medically-necessary services that are covered under Medicare Part A and Part B. Our Plan uses Medicare's coverage rules to decide what services are medically necessary. You are responsible for paying the full cost of services that aren't covered by our Plan. Other sections of this booklet describe the services that are covered under our Plan and the rules that apply to getting your care as a plan member. Our plan might not cover the costs of services that aren't medically necessary under Medicare, even if the service is listed as covered by our Plan.

If you need a service that our Plan decides isn't medically necessary based on Medicare's coverage rules, you may have to pay all of the costs of the service if you didn't ask for an advance coverage determination. However, you have the right to appeal the decision.

If you have any questions about whether our Plan will pay for a service or item, including inpatient hospital services, you have the right to have an organization determination made for the

service. You may call Member Services and tell us you would like a decision on whether the service will be covered before you get the service.

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

How can you participate in a clinical trial?

A "clinical trial" is a way of testing new types of medical care, like how well a new cancer drug works. A clinical trial is one of the final stages of a research process that helps doctors and researchers see if a new approach works and if it is safe.

The Original Medicare Plan pays for routine costs if you take part in a clinical trial that meets Medicare requirements (meaning it's a "qualified" clinical trial and Medicare-approved). Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if you weren't in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, the Original Medicare Plan (and not our Plan) pays the clinical trial doctors and other providers for the covered services you get that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in our Plan and continue to get the rest of your care, like diagnostic services, follow-up care, and care that is unrelated to the clinical trial through our Plan. Our Plan is still responsible for coverage of certain investigational devices exemptions (IDE), called Category B IDE devices, needed by our members.

You will have to pay the same coinsurance amounts charged under Original Medicare for the services you receive when participating in a qualifying clinical trial, but you do not have to pay the Original Medicare Part A or Part B deductibles because you are enrolled in our Plan.

You don't need to get a referral (approval in advance) from a network provider to join a clinical trial, and the clinical trial providers don't need to be network providers. However, please be sure to **tell us before you start participation in a clinical trial** so that we can keep track of your health care services. When you tell us about starting participation in a clinical trial, we can let you know whether the clinical trial is Medicare-approved, and what services you will get from clinical trial providers instead of from our plan.

You may view or download the publication "Medicare and Clinical Trials" at www.medicare.gov under "Search Tools" select "Find a Medicare Publication." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

How to access care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by our Plan under certain conditions. Covered services in an RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital or skilled nursing facility care. You may get services furnished in the home, but only items and services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "non-excepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state or local law. "Non-excepted" medical treatment is any other medical care or treatment.) **NOTE:** There is unlimited coverage for this benefit.

3. Your Rights and Responsibilities as a Member of our Plan

Introduction to your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this section, we explain your Medicare rights and protections as a member of our Plan and we explain what you can do if you think you are being treated unfairly or your rights are not being respected.

Your right to be treated with dignity, respect and fairness

You have the right to be treated with dignity, respect, and fairness at all times. Our Plan must obey laws that protect you from discrimination or unfair treatment. We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If you need help with communication, such as help from a language interpreter, please call Member Services. Member Services can also help if you need to file a complaint about access (such as wheel chair access). You may also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or your local Office for Civil Rights.

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people don't see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who isn't providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. You have the right to look at medical records held at the Plan, and to get a copy of your records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Member Services.

As explained in this booklet, you will get most or all of your care from licensed providers who have agreed to accept our plan's terms and conditions of payment and treat you. You have the right to seek care from any provider in the U.S. who is eligible to be paid by Medicare and agrees to accept our Plan's terms and conditions of payment. You have the right to timely access

to providers. “Timely access” means that you can get services within a reasonable amount of time.

Your right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our Plan. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a provider has denied care that you believe you were entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision called an organization determination. Organization determinations are discussed in Section 5.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of your refusing treatment.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called “advance directives.” There are different types of advance directives and different names for them. Documents called “living will” and “power of attorney for health care” are examples of advance directives.

If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. Section 8 of this booklet tells how to contact your SHIP, which stands for State Health Insurance Assistance Program. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with:

Office for Civil Rights
U.S. Department of Health & Human Services
1301 Young Street - Suite 1169
Dallas, TX 75202
1-214-767-4056
1-214-767-8940 (TDD)

Your right to get information about our Plan

You have the right to get information from us about our Plan. This includes information about our financial condition, and how our Plan compares to other health plans. To get any of this information, call Member Services.

Your right to get information in other formats

You have the right to get your questions answered. Our plan must have individuals and translation services available to answer questions from non-English speaking beneficiaries, and must provide information about our benefits that is accessible and appropriate for persons eligible for Medicare because of disability. If you have difficulty obtaining information from your plan based on language or a disability, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your right to get information about our network providers

You have the right to get information from us about our network providers and their qualifications and how we pay our doctors. To get this information, call Member Services.

Your right to get information about your Part C medical care or services and costs

You have the right to an explanation from us about any Part C medical care or service not covered by our Plan. We must tell you in writing why we will not pay for or approve a Part C medical care or service, and how you can file an appeal to ask us to change this decision. See Section 5 for more information about filing an appeal. You also have the right to this explanation

even if you obtain the Part C medical care or service from a provider not affiliated with our organization.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. See Section 4 and Section 5 for more information about complaints. If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against our Plan in the past. To get this information, call Member Services.

How to get more information about your rights

If you have questions or concerns about your rights and protections, you can

1. Call Member Services at the number on the cover of this booklet.
2. Get free help and information from your State Health Insurance Assistance Program (SHIP). Contact information for your SHIP is in Section 8 of this booklet.
3. Visit www.medicare.gov to view or download the publication "Your Medicare Rights & Protections."
4. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, you may call Member Services or:

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call your local Office for Civil Rights.
- If you have any other kind of concern or problem related to your Medicare rights and protections described in this section, you can also get help from your SHIP.

Your responsibilities as a member of our Plan include:

- Getting familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet to learn about your coverage, what you have to pay, and the rules you need to follow. Call Member Services if you have questions.
- Using all of your insurance coverage. If you have additional health insurance coverage besides our Plan, it is important that you use your other coverage in combination with your coverage as a member of our Plan to pay your health care expenses. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you.
- **You are required to tell our Plan if you have additional health insurance. Call Member Services.**
- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in our Plan and you must present your plan membership card to the provider.

- Giving your doctor and other providers the information they need to care for you, and following the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and have them explain your treatment in a way you can understand.
- Acting in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- Paying your plan premiums and coinsurance/co-payments for your covered services. You must pay for services that aren't covered.
- Notifying us if you move. If you move within our service area, we need to keep your membership record up-to-date. If you move outside of our plan service area, you cannot remain a member of our plan, but we can let you know if we have a plan in that area.
- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services.

4. How to File a Grievance

What is a Grievance?

A grievance is any complaint, other than one that involves a request for an initial determination or an appeal as described in Section 5 of this manual.

Grievances do not involve problems related to approving or paying for Part C medical care or services, problems about having to leave the hospital too soon, and problems about having Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending too soon.

If we will not pay for or give you the Part C medical care or services you want, you believe that you are being released from the hospital or SNF too soon, or your HHA or CORF services are ending too soon, you must follow the rules outlined in Section 5.

What types of problems might lead to your filing a grievance?

- Problems with the service you receive from Member Services.
- If you feel that you are being encouraged to leave (disenroll from) the Plan.
- If you disagree with our decision not to give you a "fast" decision or a "fast" appeal. We discuss these fast decisions and appeals in Section 5.
- We don't give you a decision within the required time frame.
- We don't give you required notices.
- You believe our notices and other written materials are hard to understand.
- Problems with the quality of the medical care or services you receive, including quality of care during a hospital stay.
- Problems with how long you have to wait on the phone, in the waiting room, or in the exam room.
- Problems getting appointments when you need them, or waiting too long for them.
- Rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance."

Who may file a grievance

You or someone you name may file a grievance. The person you name would be your "representative." You may name a relative, friend, lawyer, advocate, doctor, or anyone else to act for you. Other persons may already be authorized by the Court or in accordance with State law to act for you. If you want someone to act for you who is not already authorized by the Court or under State law, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may call Member Services.

Filing a grievance with our Plan

If you have a complaint, you or your representative may call the phone number for **Part C Grievances** (for complaints about Part C medical care or services) in Section 8. We will try to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or your complaint is related to quality of care, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this** the Grievance procedure. To make a complaint – or if you have questions about this procedure – please call the Member Services at the phone number in Section 8 of this booklet. Or you may send or fax us a written request to the address or fax number listed under Part C Grievances in Section 8 of this booklet.

You may also submit your complaint in writing or via facsimile to Health Net at:

Health Net
Appeal & Grievance Department
P.O. Box 10450
Van Nuys, CA 91410-0450
Fax 1-800-977-1959

How soon must you file your complaint?

You need to file your complaint within 60 calendar days after the event. We can give you more time if you have a good reason for missing the deadline.

Expedited Grievance Procedure

You are entitled to a quick review of your complaint if you disagree with our decision in the following circumstances:

- We deny your request for a fast review of a request for medical care**.**
- We deny your request for a fast review of an appeal of denied services.
- We decide additional time is needed to review your request for medical care.
- We decide additional time is needed to review your appeal of denial medical care.

Requests for Expedited Grievances may be submitted telephonically at the Member Services number shown in Section 8. You may also submit your complaint in writing or via facsimile to Health Net at:

Health Net
Appeal & Grievance Department
P.O. Box 10450
Van Nuys, CA 91410-0450
Fax 1-800-977-1959

Once the Expedited Grievance is received by Health Net, a Clinical Practitioner will review the case to determine the circumstances surrounding the denial of your request for expedited review or if the case extension was appropriate.

You will be notified of the outcome of the Expedited Grievance case verbally and in writing within 24 hours of initial receipt of the case.

Complaints about a decision regarding payment for, or provision of, Covered Services that you believe are covered by Original Medicare and should be provided or paid for by Health Net must be appealed through Health Net's Medicare Appeals procedure.

The grievance must be submitted within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have.

Fast Grievances

In certain cases, you have the right to ask for a "fast grievance," meaning we will answer your grievance within 24 hours. We discuss situations where you may request a fast grievance in Section 5.

For quality of care problems, you may also complain to the QIO

You may complain about the quality of care received under Medicare, including care during a hospital stay. You may complain to us using the grievance process, to the Quality Improvement Organization (QIO), or both. If you file with the QIO, we must help the QIO resolve the complaint. See Section 8 for more information about the QIO and for the name and phone number of the QIO in your state.

5. Complaints and Appeals about your Part C Medical Care and Service(s)

Introduction

This section explains how you ask for coverage of your Part C medical care or service(s) or payments in different situations. This section also explains how to make complaints when you think you are being asked to leave the hospital too soon, or you think your skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon. These types of requests and complaints are discussed below in Part 1, Part 2, or Part 3.

Other complaints that do not involve the types of requests or complaints discussed below in Part 1, Part 2, or Part 3 are considered **grievances**. You would file a grievance if you have any type of problem with us or one of our network providers that does not relate to coverage for Part C medical care or services. For more information about grievances, see Section 4.

Part 1. Requests for Part C medical care or services or payments.

Part 2. Complaints if you think you are asked to leave the hospital too soon.

Part 3. Complaints if you think your skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

PART 1. Requests for medical care or services or payment

This part explains what you can do if you have problems getting the Part C medical care or service you request, or payment (including the amount you paid) for a Part C medical care or service you already received.

If you have problems getting the Part C medical care or services you need, or payment for a Part C service you already received, you must request an initial determination with the plan.

Initial Determinations

The initial determination we make is the starting point for dealing with requests you may have about covering a Part C medical care or service you need, or paying for a Part C medical care or service you already received. Initial decisions about Part C medical care or services are called "**organization determinations**." With this decision, we explain whether we will provide the Part C medical care or service you are requesting, or pay for the Part C medical care or service you already received.

The following are examples of requests for initial determinations:

- You are not getting Part C medical care or services you want, and you believe that this care is covered by the Plan.

- We will not approve the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by the Plan.
- You are being told that a medical treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
- You have received Part C medical care or services that you believe should be covered by the Plan, but we have refused to pay for this care.

Who may ask for an initial determination?

You, your prescribing physician, or someone you name may ask us for an initial determination. The person you name would be your "appointed representative." You may name a relative, friend, advocate, doctor, or anyone else to act for you. Other persons may already be authorized under State law to act for you. If you want someone to act for you who is not already authorized under State law, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. If you are requesting Part C medical care or services, this statement must be sent to us at the address or fax number listed under "**Part C Organization Determinations**" in Section 8. To learn how to name your appointed representative, you may call Customer Service.

You also have the right to have a lawyer act for you. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

Asking for a "standard" or "fast" initial determination

A decision about whether we will give you, or pay for, the Part C medical care or service you are requesting can be a "standard" decision that is made within the standard time frame, or it can be a "fast" decision that is made more quickly. A fast decision is also called an "expedited" decision.

Asking for a standard decision

To ask for a standard decision for a Part C medical care or service you, your doctor, or your representative should fax, or write us at the numbers or address listed under **Part C Organization Determinations** (for appeals about Part C medical care or services) in Section 8.

Requests received after business hours are handled on the next business day.

Asking for a fast decision

You may ask for a fast decision **only** if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for benefits that you have not yet received. You cannot get a fast decision if you are asking us to pay you back for a benefit that you already received.)

If you are requesting a Part C medical care or service that you have not yet received, you, your doctor, or your representative may ask us to give you a fast decision by calling, faxing, or writing

us at the numbers or address listed under **Part C Organization Determinations** (for appeals about Part C medical care or services) in Section 8.

Requests received after business hours are handled on the next business day.

Be sure to ask for a "fast," or "expedited" review. If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "fast grievance." You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 4). If we deny your request for a fast initial determination, we will give you a standard decision.

What happens when you request an initial determination?

- For a decision about payment for Part C medical care or services you already received.

  If we do not need more information to make a decision, we have up to 30 days to make a decision after we receive your request, although a small number of decisions may take longer. However, if we need more information in order to make a decision, we have up to 60 days from the date of the receipt of your request to make a decision. You will be told in writing when we make a decision.

  If you have not received an answer from us within 60 days of your request, you have the right to appeal.

- For a standard decision about Part C medical care or services you have not yet received.

  We have 14 days to make a decision after we receive your request. However, we can take up to 14 more days if you ask for additional time, or if we need more information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a "fast grievance". For more information about fast grievances, see Section 4.

  If you have not received an answer from us within 14 days of your request (or by the end of any extended time period), you have the right to appeal.

- For a fast decision about Part C medical care or services you have not yet received.

If you receive a "fast" decision, we will give you our decision about your requested medical care or services within 72 hours after we receive the request. However, we can take up to 14 more days if we find that some information is missing that may benefit you, or if you need more time to prepare for this review. If we take additional days, we will notify you in writing. If you believe that we should not take any extra days, you can file a fast grievance. We will call you as soon as we make the decision.

If we do not tell you about our decision within 72 hours (or by the end of any extended time period), you have the right to appeal. If we deny your request for a fast decision, you may file a "fast grievance." For more information about fast grievances, see Section 4.

What happens if we decide completely in your favor?

- For a decision about payment for Part C medical care or services you already received.

  Generally, we must send payment no later than 30 days after we receive your request, although a small number of decisions may take up to 60 days. If we need more information in order to make a decision, we have up to 60 days from the date of the receipt of your request to make payment.

- For a standard decision about Part C medical care or services you have not yet received.

  We must authorize or provide your requested care within 14 days of receiving your request. If we extended the time needed to make our decision, we will authorize or provide your medical care before the extended time period expires.

- For a fast decision about Part C medical care or services you have not yet received.

  We must authorize or provide your requested care within 72 hours of receiving your request. If we extended the time needed to make our decision, we will authorize or provide your medical care before the extended time period expires.

What happens if we decide against you?

If we decide against you, we will send you a written decision explaining why we denied your request. If an initial determination does not give you all that you requested, you have the right to appeal the decision. (See **Appeal Level 1**.)

Appeal Level 1: Appeal to the Plan

You may ask us to review our initial determination, even if only part of our decision is not what you requested. An appeal to the plan about Part C medical care or services is also called a plan "**reconsideration**." When we receive your request to review the initial determination, we give the request to people at our organization who were not involved in making the initial determination. This helps ensure that we will give your request a fresh look.

Who may file your appeal of the initial determination?

If you are appealing an initial decision about Part C medical care or services, the rules about who may file an appeal are the same as the rules about who may ask for an organization determination. Follow the instructions under "Who may ask for an initial determination?" However, providers who do not have a contract with the Plan may also appeal a payment decision as long as the provider signs a "waiver of payment" statement saying it will not ask you to pay for the Part C medical care or service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

You must file the appeal request within 60 calendar days from the date included on the notice of our initial determination. We may give you more time if you have a good reason for missing the deadline.

How to file your appeal

1. Asking for a standard appeal

To ask for a standard appeal about a Part C medical care or service a signed, written appeal request must be sent to the address listed under **Part C Appeals** (for appeals about medical care or services) in Section 8.

2. Asking for a fast appeal

If you are appealing a decision we made about giving you a Part C medical care or service that you have not received yet, you and/or your doctor will need to decide if you need a fast appeal. The rules about asking for a fast appeal are the same as the rules about asking for a fast initial determination. You, your doctor, or your representative may ask us for a fast appeal by calling, faxing, or writing us at the numbers or address listed under **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.
Requests received after business hours are handled on the next business day.

Be sure to ask for a "fast" or "expedited" review. Remember, if your doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically give you a fast appeal. If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "fast grievance." You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 4). If we deny your request for a fast appeal, we will give you a standard appeal.

While the process for deciding on a standard or fast appeal is the same as the process at the initial determination level, the place where the appeal is sent is different. If you have any questions about this, please contact our Appeal & Grievance Department:

Appeal & Grievance Department
P.O. Box 10450
Van Nuys, CA 91410-0450

Telephone: 1-800-977-8221
Fax: 1-800-977-1959

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you or your representative. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information.

You may give us your additional information to support your appeal by calling, faxing, or writing us at the numbers or address listed under **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.

You may also deliver additional information in person to the address listed under **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.

You also have the right to ask us for a copy of information regarding your appeal. You may call or write us at the phone number or address listed under **Part C Appeals** (for appeals about Part C medical care or services) in Section 8.

How soon must we decide on your appeal?

- For a decision about payment for Part C medical care or services you already received.

  After we receive your appeal request, we have 60 days to decide. If we do not decide within 60 days, your appeal automatically goes to Appeal Level 2.

- For a standard decision about Part C medical care or services you have not yet received.

  After we receive your appeal, we have 30 days to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

- For a fast decision about Part C medical care or services you have not yet received.

  After we receive your appeal, we have 72 hours to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful

information is missing, we can take up to 14 more days to make our decision. If we do not decide within 72 hours (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

What happens if we decide completely in your favor?

- For a decision about payment for Part C medical care or services you already received.

  We must pay within 60 days of receiving your appeal request.

- For a standard decision about Part C medical care or services you have not yet received.

  We must authorize or provide your requested care within 30 days of receiving your appeal request. If we extended the time needed to decide your appeal, we will authorize or provide your requested care before the extended time period expires.

- For a fast decision about Part C medical care or services you have not yet received.

  We must authorize or provide your requested care within 72 hours of receiving your appeal request. If we extended the time needed to decide your appeal, we will authorize or provide your requested care before the extended time period expires.

Appeal Level 2: Independent Review Entity (IRE)

At the second level of appeal, your appeal is reviewed by an outside, Independent Review Entity (IRE) that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The IRE has no connection to us. You have the right to ask us for a copy of your case file that we sent to this entity.

How to file your appeal

If you asked for Part C medical care or services, or payment for Part C medical care or services, and we did not rule completely in your favor at Appeal Level 1, your appeal is automatically sent to the IRE.

How soon must the IRE decide?

The IRE has the same amount of time to make its decision as the plan had at **Appeal Level 1**.

If the IRE decides completely in your favor:

The IRE will tell you in writing about its decision and the reasons for it.

- For a decision about payment for Part C medical care or services you already received.

  We must pay within 30 days after we receive notice reversing our decision.

- For a standard decision about Part C medical care or services you have not yet received.

We must authorize your requested Part C medical care or service within 72 hours, or provide it to you within 14 days after we receive notice reversing our decision.

- For a fast decision about Part C medical care or services.

  We must authorize or provide your requested Part C medical care or services within 72 hours after we receive notice reversing our decision.

Appeal Level 3: Administrative Law Judge (ALJ)

If the IRE does not rule completely in your favor, you or your representative may ask for a review by an Administrative Law Judge (ALJ) if the dollar value of the Part C medical care or service you asked for meets the minimum requirement provided in the IRE's decision. During the ALJ review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel.

How to file your appeal

The request must be filed with an ALJ within 60 calendar days of the date you were notified of the decision made by the IRE (Appeal Level 2). The ALJ may give you more time if you have a good reason for missing the deadline. The decision you receive from the IRE will tell you how to file this appeal, including who can file it.

The ALJ will not review your appeal if the dollar value of the requested Part C medical care or service does not meet the minimum requirement specified in the IRE's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

How soon will the Judge make a decision?

The ALJ will hear your case, weigh all of the evidence, and make a decision as soon as possible.

If the Judge decides in your favor:

See the section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" below for information about what we must do if our decision denying what you asked for is reversed by an ALJ.

Appeal Level 4: Medicare Appeals Council (MAC)

If the ALJ does not rule completely in your favor, you or your representative may ask for a review by the Medicare Appeals Council (MAC).

How to file your appeal

The request must be filed with the MAC within 60 calendar days of the date you were notified of the decision made by the ALJ (Appeal Level 3). The MAC may give you more time if you have a good reason for missing the deadline. The decision you receive from the ALJ will tell you how to file this appeal, including who can file it.

How soon will the Council make a decision?

The MAC will first decide whether to review your case (it does not review every case it receives). If the MAC reviews your case, it will make a decision as soon as possible. If it decides not to review your case, you may request a review by a Federal Court Judge (see Appeal Level 5). The MAC will issue a written notice explaining any decision it makes. The notice will tell you how to request a review by a Federal Court Judge.

If the Council decides in your favor:

See the section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" below for information about what we must do if our decision denying what you asked for is reversed by the MAC.

Appeal Level 5: Federal Court

You have the right to continue your appeal by asking a Federal Court Judge to review your case if the amount involved meets the minimum requirement specified in the Medicare Appeals Council's decision, you received a decision from the Medicare Appeals Council (Appeal Level 4), and:

- The decision is not completely favorable to you, or
- The decision tells you that the MAC decided not to review your appeal request.

How to file your appeal

In order to request judicial review of your case, you must file a civil action in a United States district court within 60 calendar days after the date you were notified of the decision made by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Medicare Appeals Council will tell you how to request this review, including who can file the appeal.

Your appeal request will not be reviewed by a Federal Court if the dollar value of the requested Part C medical care or service does not meet the minimum requirement specified in the MAC's decision.

How soon will the Judge make a decision?

The Federal Court Judge will first decide whether to review your case. If it reviews your case, a decision will be made according to the rules established by the Federal judiciary.

If the Judge decides in your favor:

See the section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" below for information about what we must do if our decision denying what you asked for is reversed by a Federal Court Judge.

If the Judge decides against you:

You may have further appeal rights in the Federal Courts. Please refer to the Judge's decision for further information about your appeal rights.

Favorable Decisions by the ALJ, MAC, or a Federal Court Judge

This section explains what we must do if our initial decision denying what you asked for is reversed by the ALJ, MAC, or a Federal Court Judge.

- For a decision about Part C medical care or services, we must pay for, authorize, or provide the medical care or service you have asked for within 60 days of the date we receive the decision.

PART 2. Complaints (appeals) if you think you are being discharged from the hospital too soon

When you are admitted to the hospital, you have the right to get all the hospital care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your discharge date) is based on when your stay in the hospital is no longer medically necessary. This part explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

Within two days of admission as an inpatient or during pre-admission, someone at the hospital must give you a notice called the Important Message from Medicare (call Member Services or 1-800 MEDICARE (1-800-633-4227) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI). This notice explains:

- Your right to get all medically necessary hospital services paid for by the Plan (except for any applicable co-payments or deductibles).
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services and who will pay for them.
- Your right to get services you need after you leave the hospital.
- Your right to appeal a discharge decision and have your hospital services paid for by us during the appeal (except for any applicable co-payments or deductibles).

You (or your representative) will be asked to sign the Important Message from Medicare to show that you received and understood this notice. **Signing the notice does not mean that you agree that the coverage for your services should end – only that you received and understand the notice.** If the hospital gives you the Important Message from Medicare more than 2 days before your discharge day, it must give you a copy of your signed Important Message from Medicare before you are scheduled to be discharged.

Review of your hospital discharge by the Quality Improvement Organization

You have the right to request a review of your discharge. You may ask a Quality Improvement Organization to review whether you are being discharged too soon.

What is the "Quality Improvement Organization"?

"QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given

to Medicare patients. They are not part of the Plan or the hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. The QIO in Texas is TMF Health Quality Institute. The doctors and other health experts in TMF Health Quality Institute review certain types of complaints made by Medicare patients. These include complaints from Medicare patients who think their hospital stay is ending too soon.

Getting TMF Health Quality Institute to review your hospital discharge

You must quickly contact TMF Health Quality Institute. The Important Message from Medicare gives the name and telephone number of TMF Health Quality Institute and tells you what you must do.

- You must ask TMF Health Quality Institute for a **"fast review"** of your discharge. This "fast review" is also called an "immediate review."
- You must request a review from TMF Health Quality Institute no later than the day you are scheduled to be discharged from the hospital. **If you meet this deadline, you may stay in the hospital after your discharge date without paying for it while you wait to get the decision from TMF Health Quality Institute.**
- TMF Health Quality Institute will look at your medical information provided to the TMF Health Quality Institute by us and the hospital.
- During this process you will get a notice, called the Detailed Notice of Discharge, giving the reasons why we believe that your discharge date is medically appropriate. Call Member Services or 1-800-MEDICARE (1-800-633-4227 - TTY users should call 1-877-486-2048) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI/).
- TMF Health Quality Institute will decide, within one day after receiving the medical information it needs, whether it is medically appropriate for you to be discharged on the date that has been set for you.

What happens if TMF Health Quality Institute decides in your favor?

We will continue to cover your hospital stay (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

What happens if TMF Health Quality Institute agrees with the discharge?

You will not be responsible for paying the hospital charges until noon of the day after TMF Health Quality Institute gives you its decision. However, you could be financially liable for any inpatient hospital services provided after noon of the day after TMF Health Quality Institute gives you its decision. You may leave the hospital on or before that time and avoid any possible financial liability.

If you remain in the hospital, you may still ask TMF Health Quality Institute to review its first decision if you make the request within 60 days of receiving TMF Health Quality Institute's first denial of your request. However, you could be financially liable for any inpatient hospital services provided after noon of the day after TMF Health Quality Institute gave you its first decision.

What happens if you appeal TMF Health Quality Institute decision?

TMF Health Quality Institute has 14 days to decide whether to uphold its original decision or agree that you should continue to receive inpatient care. If TMF Health Quality Institute agrees that your care should continue, we must pay for or reimburse you for any care you have received since the discharge date on the Important Message from Medicare, and provide you with inpatient care (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

If TMF Health Quality Institute upholds its original decision, you may be able to appeal its decision to an Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds the decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal Court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date, and provide you with inpatient care (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

What if you do not ask TMF Health Quality Institute for a review by the deadline?

If you do not ask TMF Health Quality Institute for a fast review of your discharge by the deadline, you may ask us for a "fast appeal" of your discharge, which is discussed in Part 1 of this section. If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.
- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received after the discharge date.

If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the IRE appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal Court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

PART 3. Complaints (appeals) if you think coverage for your skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility services, is ending too soon

When you are a patient in a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF), you have the right to get all the SNF, HHA or CORF care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day we end coverage for your SNF, HHA or CORF services is based on when these services are no longer medically necessary. This part explains what to do if you believe that coverage for your services is ending too soon.

Information you will receive during your SNF, HHA or CORF stay

Your provider will give you written notice called the Notice of Medicare Non-Coverage at least 2 days before coverage for your services ends (call Member Services or 1-800 MEDICARE (1-800-633-4227) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI/). You (or your representative) will be asked to sign and date this notice to show that you received it. **Signing the notice does not mean that you agree that coverage for your services should end – only that you received and understood the notice.**

Getting TMF Health Quality Institute review of our decision to end coverage

You have the right to appeal our decision to end coverage for your services. As explained in the notice you get from your provider, you may ask the Quality Improvement Organization (the "QIO") to do an independent review of whether it is medically appropriate to end coverage for your services.

How soon do you have to ask for TMF Health Quality Institute's review?

You must quickly contact TMF Health Quality Institute. The written notice you got from your provider gives the name and telephone number of your QIO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must contact TMF Health Quality Institute no later than noon of the day after you get the notice.
- If you get the notice more than 2 days before your coverage ends, you must make your request no later than noon of the day before the date that your Medicare coverage ends.

What will happen during TMF Health Quality Institute's review?

TMF Health Quality Institute will ask why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish. TMF Health Quality Institute will also look at your medical information, talk to your doctor, and review information that we have given to TMF Health Quality Institute. During this process, you will get a notice called the Detailed Explanation of Non-Coverage giving the reasons why we believe coverage for your services should end. Call Member Services or 1-800-MEDICARE (1-

800-633-4227 - TTY users should call 1-877-486-2048) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI/).

The QIO will make a decision within one full day after it receives all the information it needs.

What happens if TMF Health Quality Institute decides in your favor?

We will continue to cover your SNF, HHA or CORF services (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

What happens if TMF Health Quality Institute agrees that your coverage should end?

You will not be responsible for paying for any SNF, HHA, or CORF services provided before the termination date on the notice you get from your provider. You may stop getting services on or before the date given on the notice and avoid any possible financial liability. If you continue receiving services, you may still ask TMF Health Quality Institute to review its first decision if you make the request within 60 days of receiving TMF Health Quality Institute's first denial of your request.

What happens if you appeal TMF Health Quality Institute decision?

TMF Health Quality Institute has 14 days to decide whether to uphold its original decision or agree that you should continue to receive services. If TMF Health Quality Institute agrees that your services should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10

If TMF Health Quality Institute upholds its original decision, you may be able to appeal its decision to an Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds our decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal Court. If either the MAC or Federal Court agrees that your stay should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

What if you do not ask TMF Health Quality Institute for a review by the deadline?

If you do not ask TMF Health Quality Institute for a review by the deadline, you may ask us for a fast appeal, which is discussed in Part 1 of this section.

If you ask us for a fast appeal of your coverage ending and you continue getting services from the SNF, HHA, or CORF, you may have to pay for the care you get after your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that coverage for your services should continue, we will continue to cover your SNF, HHA, or CORF services (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.
- If we decide that you should not have continued getting services, we will not cover any services you received after the termination date.

If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the IRE appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable co-payments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in Section 10.

6. Ending your Membership

Ending your membership in our Plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our Plan because you have decided that you *want* to leave.
- There are also limited situations where we are required to end your membership. For example, if you move permanently out of our geographic service area.

Voluntarily ending your membership

There are only certain times during the year when you may voluntarily end your membership in our Plan. The key time to make changes is the Medicare fall open enrollment period (also known as the "Annual Election period"), which occurs every year from November 15 through December 31. This is the time to review your health care and drug coverage for the following year and make changes to your Medicare health or prescription drug coverage. Any changes you make during this time will be effective January 1. Certain individuals, such as those with Medicaid, those who get extra help, or who move, can make changes at other times. For more information on when you can make changes see the enrollment period table later in this section.

If you want to end your membership in our plan during this time, this is what you need to do:

- **If you are planning on enrolling in a new Medicare Advantage plan**: Simply join the new plan. You will be disenrolled from our plan when your new plan's coverage begins on January 1.
- **If you want to switch to Original Medicare Plan:** You must request to disenroll from our plan. For more information on how to request disenrollment contact Member Services, or call 1-800-MEDICARE (1-800-633-4227) to request disenrollment from our plan. TTY users should call 1-877-486-2048. Your enrollment in Original Medicare will be effective January 1.

  If you are already enrolled in a Medicare prescription drug plan, you will continue to be enrolled in your current plan -- disenrollment from our plan will not affect your enrollment. However, if you want to join a new Medicare prescription drug plan, you must request enrollment in the plan of your choice. Enrollment in the new drug plan will not automatically disenroll you from our plan. Your coverage will be effective January 1.

  If you do not have Medicare prescription drug coverage with another plan, you can join another Medicare Advantage plan that does not offer drug coverage or you can switch to the Original Medicare plan.

Enrollment Period	When?	Effective Date
Fall Open Enrollment (Annual Election Period) Time to review health and drug coverage and make changes.	Every year from November 15 to December 31	January 1
Medicare Advantage (MA) Open Enrollment MA-eligible beneficiaries can make one change to their health plan coverage. However, you cannot use this period to add, drop, or change your Medicare prescription drug coverage. Examples: If you are in a MA plan that does not have Medicare prescription drug coverage, you can switch to another Medicare Advantage plan that does not offer drug coverage or go to Original Medicare If you are in Original Medicare Plan and have a Medicare prescription drug plan, you can join a Medicare Advantage Plan that offers Medicare drug coverage If you are in an MA plan that offers Medicare drug coverage, you can leave and join Original Medicare Plan and a Medicare prescription drug plan	Every year from January 1 to March 31	First day of next month after plan receives your enrollment request
Special Enrollment Periods for limited special exceptions, such		

as: • You have a change in residence • You have Medicaid • You are eligible for extra help with Medicare prescriptions • You live in an institution (such as a nursing home)	Determined by exception.	Generally, first day of next month after plan receives your enrollment request

For more information about the options available to you during these enrollment periods, contact Medicare at 1-800-MEDICARE (1-800-633-4227.) TTY users should call 1-877-486-2048. Additional information can also be found in the *"Medicare & You"* handbook. This handbook is mailed to everyone with Medicare each fall. You may view or download a copy from www.medicare.gov - under "Search Tools," select "Find a Medicare Publication."

Until your membership ends, you must keep getting your Medicare services through our Plan

If you leave our Plan, it may take some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect earlier in this section). While you are waiting for your membership to end, you are still a member and must continue to get your care as usual through our Plan. If you happen to be hospitalized on the day your membership ends, generally you will be covered by our Plan until you are discharged. Call Member Services for more information and to help us coordinate with your new plan.

We cannot ask you to leave the Plan because of your health.

We cannot ask you to leave your health plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Involuntarily ending your membership

If any of the following situations occur, we will end your membership in our Plan.

- If you do not stay continuously enrolled in Medicare A and B.
- If you move out of the service area or are away from the service area for more than 6 months you cannot remain a member of our Plan. And we must end your membership ("disenroll" you)". If you plan to move or take a long trip, please call Member Services to find out if the place you are moving to or traveling to is in our Plan's service area.
- If you intentionally give us incorrect information on your enrollment request that would affect your eligibility to enroll in our Plan.

- If you behave in a way that is disruptive, to the extent that you continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of our Plan. We cannot make you leave our Plan for this reason unless we get permission first from Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.
- If you do not pay the Plan premiums, we will tell you in writing that you have a 90-day grace period during which you may pay the Plan premiums before your membership ends.

You have the right to make a complaint if we end your membership in our Plan

If we end your membership in our Plan we will tell you our reasons in writing and explain how you may file a complaint against us if you want to.

7. Definitions of Important Words Used in the EOC

Appeal – An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care services or payment for services you already received. You may also make a complaint if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our Plan doesn't pay for an item/service you think you should be able to receive. Section 5 explains appeals, including the process involved in making an appeal.

Benefit period – For both our Plan and the Original Medicare Plan, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

The type of care that is covered depends on whether you are considered an inpatient for hospital and SNF stays. You must be admitted to the hospital as an inpatient, not just under observation. You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 8 explains how to contact CMS.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed "co-payment" amounts that a plan may require be paid when specific services are received; or (3) any "coinsurance" amount that must be paid as a percentage of the total amount paid for a service.

Covered services – The general term we use in this EOC to mean all of the health care services and supplies that are covered by our Plan.

Creditable Prescription Drug Coverage – Coverage (for example, from an employer or union) that is at least as good as Medicare's prescription drug coverage.

Custodial care – Care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who don't have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Medicare does not cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

Deductible -- The amount you must pay for the health care services you receive before our Plan begins to pay its share of your covered services.

Disenroll or **Disenrollment** – The process of ending your membership in our Plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice). Section 6 discusses disenrollment.

Durable medical equipment – Certain medical equipment that is ordered by your doctor for use in the home. Examples are walkers, wheelchairs, or hospital beds.

Emergency care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our Plan.

Grievance – A type of complaint you make about us or one of our network providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 4 for more information about grievances.

Home health aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home health care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 10 under the heading "Home health care." If you need home health care services, our Plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice care – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit www.medicare.gov and under "Search Tools" choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call 1-800-MEDICARE (1-800-633-4227. TTY users should call 1-877-486-2048)

Inpatient Care – Health care that you get when you are admitted to a hospital.

Medically necessary – Services or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. A MA plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. Medicare Advantage Organizations can offer one or more Medicare Advantage plan in the same service area. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) Plan, or a Medicare Medical Savings Account (MSA) plan. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

"Medigap" (Medicare supplement insurance) policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in the Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan. (A Medicare Advantage plan is not a Medigap policy.)

Member (member of our Plan, or "plan member") – A person with Medicare who is eligible to get covered services, who has enrolled in our Plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 8 for information about how to contact Member Services.

Network providers – "Providers" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**network providers**" when they have an agreement with our Plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our Plan. Our Plan pays network

providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Optional supplemental benefits – Non-Medicare-covered benefits that can be purchased for an additional premium and are not included in your package of benefits. If you choose to have optional supplemental benefits, you may have to pay an additional premium. You must voluntarily elect Optional Supplemental Benefits in order to get them.

Organization Determination - The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about MA services or payment that you believe you should receive.

Original Medicare Plan – ("Traditional Medicare" or "Fee-for-service" Medicare) The Original Medicare Plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-network provider or out-of-network facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our Plan. Out-of-network providers are providers that are not employed, owned, or operated by our Plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this EOC in Section 2.

Out-of-Pocket Maximum – is the maximum dollar amount you must pay for covered health care services. After you reach that maximum, you will no longer have to pay for these health care services. Please see the benefit chart in Section 10 for more information on which services count toward the Out-of-Pocket Maximum.

Part C – see "Medicare Advantage (MA) Plan"

Prior authorization – Approval in advance to get services. In a PFFS plan you do not need prior authorization to obtain services. However, you may want to check with your plan before obtaining services to confirm that the service is covered by your plan and what your cost share responsibility is.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Section 8 for information about how to contact the QIO in your state and Section 5 for information about making complaints to the QIO.

Rehabilitation services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service area – "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan.

Skilled nursing facility (SNF) care - A level of care in a SNF ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services are physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to perform usual daily activities, such as eating and dressing by yourself.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently needed care – Section 2 explains about "urgently needed" services. These are different from emergency services.

8. Helpful Phone Numbers and Resources

Contact Information for our Plan Member Services

If you have any questions or concerns, please call or write to our Plan Member Services. We will be happy to help you.

CALL 1-800-977-8221 Calls to this number are free.
Hours of Operation: 8:00 am to 8:00 p.m., 7 days a week.

During the annual enrollment period (between November 15th and December 31st) through 60 days past the beginning of the following contract year, our Plan operates a toll-free call center for both current and prospective members that is staffed seven days a week from 8:00 a.m. to 8:00 p.m. During this time period, current and prospective members are able to speak with a Customer Service representative. If you call outside these hours, when leaving a message, you should include your name, number and the time you called, and a representative will return your call no later than one business day after you leave a message.) However, after March 2, 2009, your call will be handled by our automated phone system, Saturdays, Sundays, and holidays. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day after you leave a message.

TTY/TDD 1-800-929-9955 This number requires special telephone equipment. Calls to this number are free.

FAX 1-888-557-7222

WRITE Health Net Medicare Programs
Post Office Box 1728
Augusta, GA 30903-1728

WEBSITE www.healthnet.com

Contact Information for Grievances, Organizations Determinations, and Appeals

Part C Organization Determinations (about your Medical Care and Services)

CALL 1-800-977-8221 Calls to this number are free.

TTY/TDD 1-800-929-9955 This number requires special telephone equipment. Calls to this number are free.

FAX 1-800-672-2135 (for urgent requests) and 1-800-793-4473 (for standard requests)

WRITE Health Net
Attn: Prior Authorizations, Advance Coverage Determination
21281 Burbank Boulevard
Woodland Hills, CA 91367

For information about Part C organization determinations, see Section 5.

Part C Grievances (about your Medical Care and Services)

CALL 1-800-977-8221 Calls to this number are free.

TTY/TDD 1-800-929-9955 This number requires special telephone equipment. Calls to this number are free.

FAX 1-800-977-1959

WRITE Appeal & Grievance Department
P.O. Box 10450
Van Nuys, CA 91410-0450

For information about Part C grievances, see Section 4.

Part C Appeals (about your Medical Care and Services)

CALL 1-800-977-8221. Calls to this number are free.

TTY/TDD 1-800-929-9955 This number requires special telephone equipment. Calls to this number are free.

FAX 1-800-977-1959

WRITE Appeal & Grievance Department
P.O. Box 10450
Van Nuys, CA 91410-0450

For information about Part C appeals, see Section 5.

Other important contacts

Below is a list of other important contacts. For the most up-to-date contact information, check your *Medicare & You* Handbook, visit www.medicare.gov and choose "Find Helpful Phone Numbers and Resources," or call 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048.

Texas Department of Aging and Disability Services (SHIP)

SHIPs is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Advantage Plans, Medicare Prescription Drug Plans, Medicare Cost Plans, and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in a Medicare Advantage Plan and special Medigap rights for people who have tried a Medicare Advantage Plan for the first time.

You may contact the SHIP in your state at

Texas Department of Aging and Disability Services
Health Information, Counseling & Advocacy Program
701 W. 51st Street, Mail Code: W350
Austin, TX 78751
1-800-252-9240

You may also find the website for your local SHIP at www.medicare.gov under "Search Tools" by selecting "Helpful Phone Numbers and Websites."

TMF Health Quality Institute

"QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and health professionals in your state that reviews medical care and handles certain types of complaints from patients with Medicare, and is paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and appeals filed by Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Sections 4 and 5 for more information about complaints, appeals and grievances.

You may contact TMF Health Quality Institute at

TMF Health Quality Institute
Bridgepoint I, Suite 300
5918 West Courtyard Drive
Austin, TX 78730-5036

1-800-725-9216

How to contact the Medicare program

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). Our organization contracts with the federal government.

- Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Customer service representatives are available 24 hours a day, including weekends.
- Visit www.medicare.gov for information. This is the official government website for Medicare**.** This website gives you up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare Prescription Drug Plans in your area. You can also search under "Search Tools" for Medicare contacts in your state. Select "Helpful Phone Numbers and Websites." If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer.

Medicaid

Medicaid is a state government program that helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact

Health & Human Services Commission of Texas
4900 N Lamar Blvd, 4th Floor
Austin, TX 78751-2316
1-800-252-8263

Social Security

Social Security programs include retirement benefits, disability benefits, family benefits, survivors' benefits, and benefits for the aged and blind. You may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You may also visit **www.socialsecurity.gov** on the Web.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you may call your local Railroad Retirement Board office or 1-800-808-0772. TTY users should call 312-751-4701. You may also visit www.rrb.gov on the Web.

Employer (or "Group") Coverage

If you get, or your spouse gets, benefits from your current or former employer or union, or from your spouse's current or former employer or union, call the employer/union benefits administrator or Member Services if you have any questions about your employer/union benefits,

plan premiums, or the open enrollment season. Important Note: You (or your spouse's) employer/union benefits may change, or you (or your spouse) may lose the benefits, if you enroll in Medicare Part D. Call your employer/union benefits administrator or Member Services to find out whether the benefits will change or be terminated if you or your spouse enrolls in Part D.

9. Legal Notices

Notice about governing law

Many laws apply to this Evidence of Coverage and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our Plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

Health care plan fraud

Health care plan fraud is defined as a deception or misrepresentation by a provider, Member, employer or any person acting on their behalf. It is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care plan by filing a claim that contains a false or deceptive statement is guilty of insurance fraud.

If you are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if you know of or suspect any illegal activity, call our Plan's toll-free Fraud Hotline at **1-800-977-3565**. The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

Circumstances beyond Health Net's control

Except as otherwise required by applicable law or regulation, to the extent that a natural disaster, war, riot, civil insurrection, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, disability of significant medical group personnel, or other similar events, not within the control of Health Net, results in the facilities, or personnel, of Health Net not being available to provide or arrange for services or benefits under this Evidence of Coverage, Health Net's obligation to provide such services or benefits shall be limited to the requirement that Health Net make a good faith effort to provide or arrange for the provision of such services or benefits within the resulting limitations on the availability of its facilities or personnel.

When a third party causes a member injuries

Except as otherwise required by applicable law or regulation, if you are ever injured through the actions of another person (a third party), Health Net will provide benefits for all covered services that you receive through this plan. However, if you receive money because of your injuries, you must reimburse Health Net or the medical providers for the value of any services provided to you through this plan.

Examples of how an injury could be caused by the actions of another person:

- You are in a car accident and the other driver is at fault.
- You slip and fall in a store because a wet spot was left on the floor.

Steps you must take

Health Net's legal right to reimbursement is called a lien.
If you are injured because of a third party, you must cooperate with Health Net's and the medical providers' efforts to obtain reimbursement, including:

- Telling Health Net and the medical providers the name and address of the third party, if you know it, the name and address of your lawyer, if you are using a lawyer, and describing how the injuries were caused.
- Completing any paperwork that Health Net or the medical providers may require to assist in enforcing the lien.
- Promptly responding to inquiries from the lienholders about the status of the case and any settlement discussions.
- Notifying the lienholders immediately upon you or your lawyer receiving any money from the third parties or their insurance companies.
- Holding any money that you or your lawyer receive from the third party or their insurance companies in trust, and reimbursing Health Net and the medical providers for the amount of the lien as soon as you are paid by the third party.

How the amount of your reimbursement is determined

Your reimbursement to Health Net or the medical provider under this lien is based on the value of the services you receive and the costs of perfecting this lien. For purposes of determining the lien amount, the value of the services depends on how the pharmacy was paid and will be determined as permitted by law. Unless the money that you receive came from a Workers' Compensation claim, the following applies:

- The amount of the reimbursement that you owe Health Net or the physician group will be reduced by the percentage that your recovery is reduced if a judge, jury or arbitrator determines that you were responsible for some portion of your injuries.
- The amount of the reimbursement that you owe Health Net or the physician group will also be reduced by a pro rata share for any legal fees or costs that you paid from the money you received.
- The amount that you will be required to reimburse Health Net or the physician group for services you receive under this plan will not exceed one-third of the money that you receive if you do engage a lawyer, or one-half of the money you receive if you do not engage a lawyer.
- Coordination of benefits protects you from higher plan premiums. The end result is more affordable health care.

Organ donation

In the event that a person or a person's family is in the position to make a decision regarding organ donation, it should be taken into consideration that advancements allow many patients to benefit from organ transplants, but the supply of organs has not kept pace with the number of eligible patients. The benefits of organ donation to patients awaiting a transplant include the chance to lead a happier, more productive life.

Notice of privacy practices

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

This Notice tells you about the ways in which Health Net (referred to as "we" or "the Plan") may collect, use and disclose your protected health information and your rights concerning your protected health information. "Protected health information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We are required by federal and state laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

How we may use and disclose your protected health information

We may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment.

- **Payment**. We use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment or premium billing.
- **Health Care Operations**. We use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or customer service.
- **Treatment**. We may use and disclose your protected health information to assist your health care providers (doctors, hospitals and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.
- **Plan Sponsor**. If you are enrolled through a group health plan, we may provide summaries of claims and expenses for enrollees in a group health plan to the plan sponsor, which is usually the employer.

If the plan sponsor provides plan administration services, we may also provide access to health information to support its performance of such services which may include but are not limited to claims audits or customer services functions. Health Net will only share health information upon a certification from the plan sponsor representing there are restrictions in place to ensure that only plan sponsor employees with a legitimate need to know will have access to health information in order to provide plan administration functions.

We may also disclose protected health information to a person, such as a family member, relative, or close personal friend, who's involved with your care or payment. We may disclose the relevant protected health information to these persons if you do not object or we can reasonably infer from the circumstances that you do not object to the disclosure; however, when you are not present or are incapacitated, we can make the disclosure if, in the exercise of professional judgment, we believe the disclosure is in your best interest.

Other permitted or required disclosures

- As Required by Law. We must disclose protected health information about you when required to do so by law.
- Public Health Activities. We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
- Victims of Abuse, Neglect or Domestic Violence. We may disclose protected health information to government agencies about abuse, neglect or domestic violence.
- Health Oversight Activities. We may disclose protected health information to government oversight agencies (e.g., California Department of Health Services) for activities authorized by law.
- Judicial and Administrative Proceedings. We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.
- Law Enforcement. We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- Coroners, Funeral Directors, Organ Donation. We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.
- Research. Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.
- To Avert a Serious Threat to Health or Safety. We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- Special Government Functions. We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.

- Workers' Compensation. We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

Other uses or disclosures with an authorization

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

Your rights regarding your protected health information

You have certain rights regarding protected health information that the Plan maintains about you.

- Right To Access Your Protected Health Information. You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.
- Right To Amend Your Protected Health Information. If you feel that protected health information maintained by the Plan is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by the Plan, as is often the case for health information in our records, or you ask to amend a record that is already accurate and complete.
- If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.
- Right to an Accounting of Disclosures by the Plan. You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes.
  Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.
- Right To Request Restrictions on the Use and Disclosure of Your Protected Health Information. You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. We may not agree to your request. If we do agree, we will comply with your request unless

the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

- Right To Receive Confidential Communications. You have the right to request that we use a certain method to communicate with you about the Plan or that we send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- Right to a Paper Copy of This Notice. You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.
- Contact Information for Exercising Your Rights. You may exercise any of the rights described above by contacting our privacy office. See the end of this Notice for the contact information.

Health information security

Health Net requires its employees to follow the Health Net security policies and procedures that limit access to health information about members to those employees who need it to perform their job responsibilities. In addition, Health Net maintains physical, administrative and technical security measures to safeguard your protected health information.

Changes to this notice

We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. We also post a copy of our current Notice on our website at www.healthnet.com. Any time we make a material change to this Notice, we will promptly revise and issue the new Notice with the new effective date.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with us and/or with the Secretary of the Department of Health and Human Services. All complaints to the Plan must be made in writing and sent to the privacy office listed at the end of this Notice. **We support your right to protect the privacy of your protected health information.** *We will not retaliate against you or penalize you for filing a complaint.*

Contact the plan

If you have any complaints or questions about this Notice or you want to submit a written request to the Plan as required in any of the previous sections of this Notice, please contact:

Health Net Privacy Office
Attention: Director, Information Privacy
Post Office Box 9103
Van Nuys, CA 91409

You may also contact us at:

Telephone: 1-800-522-0088
Fax: 1-818-676-8981
Email: Privacy@healthnet.com

10. How Much You Pay for Your Part C Medical Benefits

Our Plan is a Medicare Advantage Private-Fee-for-Service plan. A Medicare Advantage Private Fee-for-Service plan works differently than a Medicare supplement plan. Your doctor or hospital is not required to agree to accept the plan's terms and conditions, and thus may choose not to treat you, with the exception of emergencies. If your doctor or hospital does not agree to accept our payment terms and conditions, they may choose not to provide healthcare services to you, except in emergencies. Providers can find the plan's terms and conditions on our website at:. https://www.healthnet.com/pffs_terms.pdf

Your Monthly Premium for Our Plan

Your monthly premium for our Plan is $56.

If you signed up for extra benefits, also called "optional supplemental benefits", then you pay an additional premium each month for these extra benefits. If you have any questions about your Plan premiums or the payment programs, please call Member Services.

If you get your benefits from your current or former employer, or from your spouse's current or former employer, call the employer's benefits administrator for information about your Plan premium.

You can find more information about paying your plan premium in Section 1.

How Much You Pay for Part C Medical Benefits

This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. These are the benefits and coverage you get as a member of our Plan. Later in this section under "General Exclusions" you can find information about services that are not covered. It also tells about limitations on certain services. Further exclusions can be found in the Vendor Benefit Rider for members who have additional benefits or who have purchased Optional Supplemental benefits. Please refer to Section 10 for more information.

What do you pay for covered services?

"Deductibles," "co-payments," and "coinsurance"are the amounts you pay for covered services.

- The **"deductible"** is the amount you must pay for the health care services you receive before our Plan begins to pay its share of your covered services.
- A **"co-payment"** is a payment you make for your share of the cost of certain covered services you get. A co-payment is a set amount per service. You pay it when you get the service.
- **"Coinsurance"** is a payment you make for your share of the cost of certain covered services you receive. Coinsurance is a percentage of the cost of the service. You pay your coinsurance when you get the service.
- Depending on your Medicaid benefit, you may not have to pay out-of-pocket costs for

deductibles, co-payments and coinsurances. These costs may be covered by Medicaid, as long as you qualify for Medicaid benefits and the provider accepts Medicaid. The only exception is that you are responsible for your covered health care services "coinsurances or copayments" and your Medicaid copayments, if applicable.

What is the maximum amount you will pay for certain covered medical services?

There is a limit to how much you have to pay Out-of-Pocket for certain covered health care services each year.

The Annual Out-of-Pocket Maximum for this plan is $3,350 and applies to the benefits indicated below. Once the total costs, including your copayments, and coinsurance reaches $3,350, then you won't have to continue paying for these expenses for the remainder of the year.

The following benefits will count toward your annual Out-of-Pocket Maximum:

Inpatient Hospital Care, Inpatient Mental Health Care, Skilled Nursing Facility, Home Health Care, Physician Services including Doctor Office Visits, Medicare-covered Chiropractic Services, Medicare-covered Podiatry Services, Other Health Care Professional Services, Outpatient Mental Health Care. Partial Hospitalization (Psychiatric Care), Outpatient Substance Abuse Care, Ambulatory Surgical Center Services, Outpatient Hospital Services, Ambulance Services, Medicare-covered Emergency Care, Urgently Needed Care, Outpatient Rehabilitation Services; Cardiac Rehabilitation Services; Comprehensive Outpatient Rehabilitation Facility (CORF); Durable Medical Equipment; Prosthetic Devices and Related Supplies. Diabetes Self-Monitoring Training and Supplies, Medical Nutrition Therapy, Diagnostic Tests, X-rays, and Lab Services, Blood - Storage and Administration, Bone Mass Measurement, Colorectal Screening Exams, Immunizations, Mammograms, Pap Smears and Pelvic Exams, Prostate Cancer Screening Exams, Cardiovascular Disease Testing, Dialysis (Kidney), Medicare-covered Part B Prescription Drugs, Medicare-covered Dental Services, Medicare-covered Hearing Services, Medicare-covered Vision Services, Medicare-covered Physical Exams, Medicare-covered Smoking Cessation.

Benefits Chart

The benefits chart on the following pages lists the services our Plan covers and what you pay for each service. The covered services listed in the Benefits Chart in this section are covered only when all requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare Program.
- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered.
- Prior notification, or letting Health Net know in advance that you are receiving certain medical services, is not required, but helps us know if there is any additional assistance we can provide to improve your care before you receive the service. The benefit chart in this section will tell you the services recommended for prior notification.

See Section 2 for information on requirements for using network providers.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Inpatient Services	
Inpatient hospital care* You are covered for unlimited days each benefit period. Covered services include: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. All other components of blood are covered beginning with the first pint used • Physician Services *Prior notification is recommended for this benefit	You pay: $225 each day for days 1 - 10 $0 each day for days 11 and beyond

Benefits chart – your covered services	**What you must pay** when you get these covered services
Inpatient mental health care* Covered services include mental health care services that require a hospital stay. Medicare beneficiaries may only receive 190 days in a Psychiatric Hospital in a lifetime. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. *Prior notification is recommended for this benefit	You pay: $1,024 copayment for each Medicare-covered hospital stay
Skilled nursing facility (SNF) care* 3-Days prior hospital stay is required. You are covered for 100 days each benefit period. Covered services include: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician services *Prior notification is recommended for this benefit	You pay: - $0 each day for days 1 – 17 - $120 each day for days 18 – 100 each benefit period. A benefit period begins on the first day you go to a Medicare-covered skilled nursing facility. The benefit period ends when you haven't been an inpatient at any SNF for 60 days in a row. If you go to the SNF after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. The type of care you actually get during the stay determines whether you are considered an inpatient for SNF stays.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Inpatient services covered when the hospital or SNF days aren't, or are no longer, covered Covered services include: • Physician services • Tests (like X-ray or lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and Orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	The listed services will continue to be covered at the co-payment amounts shown in the benefits chart for the specific service.
Home health agency care* Covered services include: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total less than eight hours per day and 35 or fewer hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical social services • Medical equipment and supplies *Prior notification is recommended for this benefit	There is no copayment for Medicare-covered home health visits.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Hospice care You may receive care from any Medicare-certified hospice program. The Original Medicare Plan (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. Covered services include: • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by the Original Medicare Plan • Home care Our Plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	When you enroll in a Medicare-certified Hospice program, your hospice services are paid for by the Original Medicare Plan, not your Medicare Advantage plan (see Section 2 for more information about hospice services). You pay $40 copayment for the "one time only" hospice consultation..
Outpatient Services	
Physician services, including doctor office visits Covered services include: • Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center • Consultation, diagnosis, and treatment by a specialist • Hearing and balance exams, if your doctor orders it to see if you need medical treatment. • Telehealth office visits including consultation, diagnosis and treatment by a specialist • Second opinion prior to surgery • Outpatient hospital services • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor)	You pay $15 for each primary care doctor office visit for Medicare-covered services. You pay $40 for each specialist visit for Medicare-covered services. You may go to any doctor, specialist, or hospital that accepts the plan's payment.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation	You pay $40 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation). Routine (non-Medicare covered) chiropractic services not covered. However, this plan covers routine chiropractic benefits for an extra cost (refer to "Optional Supplemental Benefits" later in this section).
Podiatry services Covered services include: • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	You pay $40 for each Medicare-covered visit (medically necessary foot care). Routine (non-Medicare covered) foot care not covered.
Outpatient mental health care (including Partial Hospitalization Services) Covered services include: • Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	You pay $40 for each individual/group therapy visit for Medicare-covered outpatient Mental Health and Partial hospitalization services.
Outpatient substance abuse services	You pay $40 for each individual/group visit for Medicare-covered services.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Outpatient surgery (including services provided at ambulatory surgical centers)	You pay: $150 for each Medicare-covered visit to an ambulatory surgical center. $150 for each Medicare-covered visit to an outpatient hospital facility.
Ambulance services Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health). The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required.	You pay $175 for Medicare-covered ambulance services.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Emergency care	
• Coverage in the United States* * United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.	**Coverage in the United States*** You pay $50 for each Medicare-covered emergency room visit.
• Worldwide Coverage	**Worldwide Coverage Outside the United States*** There is an annual limit of $50,000 for Emergency Services outside of the United States. There is no copayment or deductible for worldwide Emergency Care services outside the United States.
Urgently needed care • Coverage in the United States* * United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.	You pay $50 for each Medicare-covered urgently needed care visit.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, speech language therapy, and cardiac rehabilitative therapy	You pay $40 for each Medicare-covered Occupational Therapy visit. You pay $40 for each Medicare-covered Physical Therapy and/or Speech/Language Therapy visit. You pay $40 for each Medicare-covered Cardiac Rehabilitative Therapy visit.
Durable medical equipment and related supplies* Covered items include: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of "durable medical equipment" in Section 7.) *Prior notification is recommended for this benefit	You pay 30% of the cost for each Medicare-covered item.
Prosthetic devices and related supplies* – (other than dental) that replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail. *Prior notification is recommended for this benefit	You pay 30% of the cost for each Medicare-covered item

Benefits chart – your covered services	**What you must pay** when you get these covered services
Diabetes self-monitoring, training and supplies – for all people who have diabetes (insulin and non-insulin users). Covered services include: • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts • Self-management training is covered under certain conditions • For persons at risk of diabetes: Fasting plasma glucose tests. Please call Member Services at the number in Section 8 for more information on how often we will cover these tests.	There is no copayment for Diabetes self-monitoring training. You pay 30% of the cost for each Medicare-covered Diabetes Supply item. You pay 30% of the cost for Medicare-covered therapeutic shoes.
Medical nutrition therapy – for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.	There is no copayment for Medicare-covered Medical Nutrition Therapy visits. Office visit copayment may apply.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Outpatient diagnostic tests and therapeutic services and supplies Covered services include: • X-rays • Radiation therapy • Complex diagnostic radiology (PET Scan, CT Scan, MRI) • Surgical supplies, such as dressings • Supplies, such as splints and casts • Laboratory tests • Blood - Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests	You pay: $25 for each Medicare-covered X-ray visit. 30% of the cost for each Medicare-covered radiation therapy service. 30% of the cost for each Medicare-covered complex diagnostic radiology service. $0 for each Medicare-covered clinical/diagnostic lab service. Office visit copayment may apply. Copayments are applied as appropriate depending on the place where services are rendered.
Vision care Covered services include: • Outpatient physician services for eye care. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	You pay: $40 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye) $40 for Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery) Routine (non-Medicare covered) eye exams and glasses not covered. However, this plan covers routine vision care for an extra cost (refer to "Optional Supplemental Benefits" later in this section)

Benefits chart – your covered services	**What you must pay** when you get these covered services
Preventive Care and Screening Tests	
Abdominal Aortic Aneurysm Screening A one-time screening ultrasound for people at risk. Medicare only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" physical exam.	There is no copayment for Medicare-covered Abdominal Aortic Aneurysm Exams. Office visit copayment may apply. Copayments are applied as appropriate depending on the place where services are rendered.
Bone-mass measurements For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no copayment for each Medicare-covered Bone Mass Measurement. Office visit copayment may apply. Copayments are applied as appropriate depending on the place where services are rendered.
Colorectal screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy	There is no copayment for Medicare-covered Colectoral Screening Exams. Office visit copayment may apply. Copayments are applied as appropriate depending on the place where services are rendered An additional facility charge may apply.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Immunizations Covered services include: • Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk	There is no copayment for the Pneumonia and Flu vaccines. There is no copayment for the Hepatitis B vaccine. Office visit copayment may apply. Copayments are applied as appropriate depending on the place where services are rendered.
Mammography screening Covered services include: • One baseline exam between the ages of 35 and 39 • One screening every 12 months for women age 40 and older	There is no copayment for Medicare-covered Screening Mammograms. Office visit copayment may apply. Copayments are applied as appropriate depending on the place where services are rendered.
Pap tests, pelvic exams, and clinical breast exam Covered services include: • For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months. • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months.	There is no copayment for Medicare-covered Pap Smears and Pelvic Exams. Office visit copayment may apply. Copayments are applied as appropriate depending on the place where services are rendered.
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no copayment for Medicare-covered Prostate Cancer Screening exams. Office visit copayment may apply. Copayments are applied as appropriate depending on the place where services are rendered.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). Please call Member Services at the number in Section 8 for more information on how often we will cover these tests.	There is no copayment for Medicare-covered cardiovascular screening blood tests. Office visit copayment may apply.
Physical exams	You pay $0 for Medicare covered physical exams. You pay $0 for each routine physical exam, (limited to one exam each year).
Other Services	
Dialysis (Kidney) Covered services include: • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Section 2) • Inpatient dialysis treatments (if you are admitted to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	You pay 20% for each outpatient dialysis treatment. You pay 20% for home dialysis treatment.
Medicare Part B Prescription Drugs These drugs are covered under Part B of the Original Medicare Plan. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected while you are getting physician services • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan	You pay 20% of the cost for Part B drugs. Part D Prescription drugs are not covered.

Benefits chart – your covered services	**What you must pay** when you get these covered services
• Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoisis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases	
Additional Benefits	
Dental Services	You pay $40 for Medicare-covered dental benefits. Routine (non-Medicare covered) dental services not covered. However, this plan covers routine dental services for an extra cost (refer to "Optional Supplemental Benefits" later in this section)
Hearing Services	You pay $40 for Medicare-covered hearing exams. Hearing aids and routine (non-Medicare covered) hearing exams not covered.

Benefits chart – your covered services	**What you must pay** when you get these covered services
Health and wellness education programs These are programs focused on clinical health conditions such as hypertension, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, smoking cessation, fitness, and stress management. • Written health education materials, including newsletter • Nutritional Training • Smoking Cessation • Nursing hotline (Decision Power)	There is no copayment for health and wellness education programs.

Extra "optional supplemental" benefits you can buy

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

Optional Supplemental Benefits Premium, Monthly Plan Premium and Other Important Information	
Premium	You pay $23 each month, in addition to your monthly plan premium and the Medicare Part B premium, for these optional benefits: • Chiropractic Services • Dental Services • Vision Services
Chiropractic Care	$10 per office visit for up to 20 routine visit(s) per year. $60 maximum payable amount per visit. Medicare-covered chiropractic services (manual manipulation of the spine to correct a displacement or misalignment of a joint or body part) are not included as part of the "Optional Supplemental Benefit Buy-up" for

	Chiropractic Services.
Dental Services	You pay an annual deductible of $35. There is a $750 Annual Maximum. You are covered for the following preventive and diagnostic services: -Oral exams up to 2 visit every 12 months -Cleanings up to 2 visit every 12 months -Dental x-rays up to 1 visit every 12 months You pay 20% coinsurance for restorative services. You are covered for the following restorative services: -Amalgam fillings, one per restoration per surface every 36 months* -Resin composite fillings, one per restoration per surface every 36 months* *multi-year benefits may not be available in subsequent years. Services are available in or out of network. Refer to the Vendor Benefits Rider for more information regarding optional supplemental dental services.
Vision Services	You pay $15 copayment for routine (non-Medicare covered) annual eye exams.

	There is no copayment for routine (non-Medicare covered) eyewear. There is a $100 maximum coverage amount for routine (non-Medicare covered) eyewear every two years for frames, lenses or contact lenses combined* *multi-year benefits may not be available in subsequent years. Services are available in or out of network Refer to the Vendor Benefits Rider for more information regarding optional supplemental vision services.

Deductibles, copayments, and co-insurance for optional supplemental benefits do not apply to the health care service out-of-pocket maximum. Refer to the health care service out of pocket maximum earlier in this section for more information.

Members may choose a supplemental buy-up package to add to their existing plan. If you want these Optional Supplemental Benefits you must sign up of them and pay an additional premium. You may only enroll n these benefits during the Optional Supplemental Benefits election periods. The election periods for these benefits are:
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Election Period	***Effective Date***
November 15, 2008 through December 31, 2008	January 1, 2009
The first 30-days in January	February 1, 2009
May 15, 2009 through June 30, 2009	July 1, 2009

Members may disenroll from these Optional Supplemental Benefits at anytime and revert back to the basic Health Net Pearl plan. You may disenroll from the Optional Supplemental Benefits by sending a letter to Health Net requesting to be disenrolled. It is important that you state your

request is for Disenrollment from the Optional Supplemental Benefits only and the letter must be signed. We will then send you a letter that tells you when your Optional Supplemental Benefits will end. This is your Optional Supplemental Benefits **Disenrollment date**. In most cases, your Disenrollment date will be the first day of the month after the month we receive your request to discontinue these benefits.

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

Members who disenroll may not re-enroll until the next election period. The available election periods for the Optional Supplemental Benefits are from November 15, 2008 through December 31, 2008 for a January 1, 2009 effective date, the first 30 days in January for a February 1, 2009 effective date, or from May 15, 2009 through June 30, 2009 for a July 1, 2009 effective date.

Members who fail to pay the monthly premium for the Optional Supplemental Benefits will lose the benefits but will remain enrolled in the basic Pearl plan. The Optional Supplemental Benefits included in this section are subject to the same appeals process as any other benefits. See Sections 9 and 10 for information about making complaints. For a detailed explanation of these benefits, including limitations and restrictions, please see the Vendor Benefit Rider for more information.

The optional supplemental benefits included in this section are subject to the same appeals process as any other benefits.

General Exclusions

Introduction

The purpose of this part of Section 10 is to tell you about medical care and services, items, that aren't covered ("are excluded") or are limited by our Plan. The list below tells about these exclusions and limitations. The list describes services, items, that aren't covered under any conditions, and some services that are covered only under specific conditions. (The Benefits Chart earlier also explains about some restrictions or limitations that apply to certain services).

If you get services/items that are not covered, you must pay for them yourself

We won't pay for the exclusions that are listed in this section (or elsewhere in this EOC), and neither will the Original Medicare Plan, unless they are found upon appeal to be services/items that we should have paid or covered (appeals are discussed in Section 5).

What services are not covered or are limited by our Plan?

In addition to any exclusions or limitations described in the Benefits Chart, in the Vendor Benefit Rider, or anywhere else in this EOC, **the following items and services aren't covered under the Original Medicare Plan or by our plan:**

1. Services that aren't reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by our Plan as a covered service.
2. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. The Centers for Medicare and Medicaid Services (CMS) will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to plan members. Experimental procedures and items are those items and procedures determined by our Plan and the Original Medicare Plan to not be generally accepted by the medical community.
3. Surgical treatment of morbid obesity unless medically necessary and covered under the Original Medicare plan.
4. Private room in a hospital, unless medically necessary.
5. Private duty nurses.
6. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
7. Nursing care on a full-time basis in your home.
8. Custodial care unless it is provided in conjunction with covered skilled nursing care and/or skilled rehabilitation services. This includes care that helps people with activities of daily living like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
9. Homemaker services.
10. Charges imposed by immediate relatives or members of your household.
11. Meals delivered to your home.
12. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: Weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.
13. Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. All stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.

14. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. However, non-routine dental services received at a hospital may be covered. However, these items are available under optional supplemental benefits.
15. Chiropractic care is generally not covered under the Plan, (with the exception of manual manipulation of the spine,) and is limited according to Medicare guidelines. However, these items are available under optional supplemental benefits.
16. Routine foot care is generally not covered under the Plan and is limited according to Medicare guidelines.
17. Orthopedic shoes unless they are part of a leg brace and are included in the cost of the brace. Exception: Therapeutic shoes are covered for people with diabetic foot disease.
18. Supportive devices for the feet. Exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
19. Hearing aids and routine hearing examinations.
20. Eyeglasses (except after cataract surgery), radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services. However, these items are available under optional supplemental benefits.
21. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
22. Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices.
23. Acupuncture.
24. Naturopath services.
25. Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under our Plan, we will reimburse veterans for the difference. Members are still responsible for our Plan cost-sharing amount.
26. Any of the services listed above that aren't covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

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