Health Net®
MEDICARE PROGRAMS

January 1 – December 31, 2012

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of Health Net Seniority Plus Green (HMO)

This booklet gives you the details about your Medicare health care coverage from January 1 – December 31, 2012. It explains how to get the health care you need covered. This is an important legal document. Please keep it in a safe place.

This plan, Health Net Seniority Plus Green (HMO), is offered by Health Net of California, Inc. (When this *Evidence of Coverage* says "we," "us," or "our," it means Health Net of California, Inc. When it says "plan" or "our plan," it means Health Net Seniority Plus Green (HMO).)

A Medicare Advantage organization with a Medicare contract.

This information is available for free in other languages. Please contact our Member Services number at 1-800-275-4737 for additional information. (TTY/TDD users should call 1-800-929-9955). Hours are 8:00 a.m. to 8:00 p.m., seven days a week. Member Services also has free language interpreter services available for non-English speakers.

Esta información está disponible en forma gratuita en otros idiomas. Comuníquese con el número de nuestro Departamento de Servicios al Afiliado al 1-800-275-4737 para obtener información adicional. (Los usuarios de TTY/TDD deben llamar al 1-800-929-9955). El horario de atención es de 8:00 a.m. a 8:00 p.m., hora del Pacífico, los siete días de la semana. (Las llamadas a estos números son gratuitas). El Departamento de Servicios al Afiliado cuenta además con servicios de intérprete de idiomas gratuitos disponibles para las personas que no hablan inglés.

Thông tin này được cung cấp miễn phí qua nhiều ngôn ngữ khác. Xin quý vị liên lạc với Ban Phục vụ Hội viên tại số 1-800-275-4737 để biết thông tin chi tiết. (Người dùng TTY/TDD xin gọi 1-800-929-9955). Giờ làm việc từ 8 giờ sáng đến 8 giờ tối, giờ miền Tây, bảy ngày một tuần. (Các số điện thoại này được gọi miễn phí). Ngoài ra, Ban Phục vụ Hội viên cũng cung cấp dịch vụ thông dịch miễn phí cho những hội viên không biết tiếng Anh.

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

Benefits, formulary, pharmacy network, premium, deductible, and/or copayments/coinsurance may change on January 1, 2013.

2012 Evidence of Coverage

Table of Contents

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

Chapter 1. Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Health Net Seniority Plus Green (HMO), which is a Medicare HMO

You are covered by Medicare, and you have chosen to get your Medicare health care through our plan, Health Net Seniority Plus Green (HMO).

There are different types of Medicare health plans. Our plan is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization). Like all Medicare health plans, this Medicare HMO is approved by Medicare and run by a private company.

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

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

This plan, Health Net Seniority Plus Green (HMO), is offered by Health Net of California, Inc. (When this *Evidence of Coverage* says "we," "us," or "our," it means Health Net of California, Inc. When it says "plan" or "our plan," it means Health Net Seniority Plus Green (HMO).)

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

Section 1.3 What does this Chapter tell you?

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

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

Section 1.4 What if you are new to our plan?

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

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

Section 1.5 Legal information about the *Evidence of Coverage*

It's part of our contract with you

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

The contract is in effect for months in which you are enrolled in our plan between January 1, 2012 and December 31, 2012.

Medicare must approve our plan each year

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

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

Section 2.1 Your eligibility requirements

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

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

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

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally covers services furnished by institutional providers such as hospitals, skilled nursing facilities, or home health agencies.

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

Section 2.3 Here is the plan service area for our plan

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

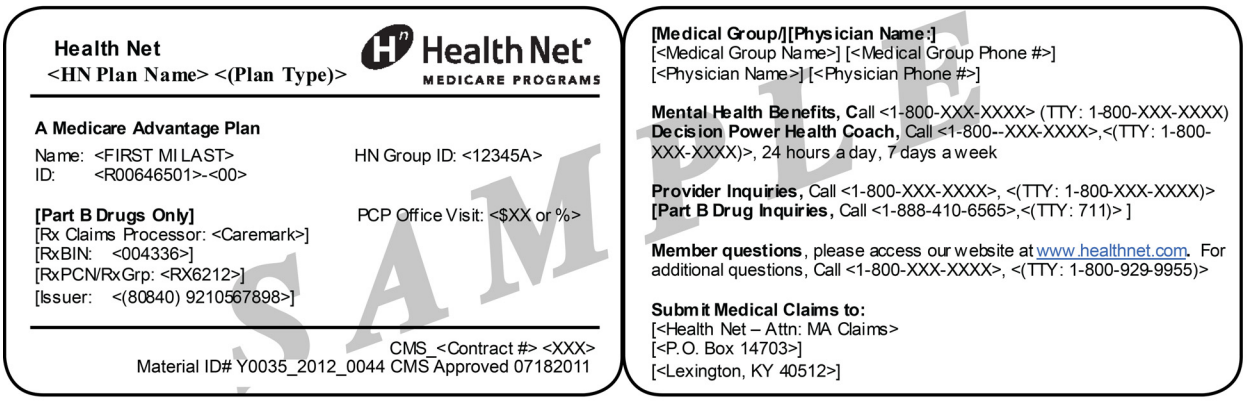
Our service area includes these counties in California: Kern, Los Angeles, Orange, Riverside, San Bernardino, and San Diego.

If you plan to move out of the service area, please contact Member Services. When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

SECTION 3 What other materials will you get from us?

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

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



As long as you are a member of our plan **you must <u>not</u> use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research

studies and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

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

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

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

Every year that you are a member of our plan, we will send you either a new *Provider Directory* or an update to your *Provider Directory.* This directory lists our network providers.

What are "network providers"?

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

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

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed care when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

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

SECTION 4 Your monthly premium for Health Net Seniority Plus Green (HMO)

Section 4.1 How much is your plan premium?

You do not pay a separate monthly plan premium for Health Net Seniority Plus Green (HMO). You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Many members are required to pay other Medicare premiums

As explained in Section 2 above, in order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members will be paying a premium for Medicare Part A and most plan members will be paying a premium for Medicare Part B. You must continue paying your Medicare Part B premium to remain a member of the plan.

- Your copy of *Medicare & You 2012* gives information about these premiums in the section called "2012 Medicare Costs." This explains how the Part B premium differs for people with different incomes.
- Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2012* from the Medicare website (http://www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.2 Can we change your monthly plan premium during the year?

No. We are not allowed to begin charging a monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

SECTION 5 Please keep your plan membership record up to date

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

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage including your Primary Care Provider/Medical Group.

The doctors, hospitals, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what**

services are covered for you. Because of this, it is very important that you help us keep your information up to date.

Let us know about these changes:

- Changes to your name, your address, or your phone number
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes
- If you are participating in a clinical research study

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

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

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

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

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

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

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

SECTION 7 How other insurance works with our plan

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

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

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

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

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

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

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

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are on the back cover of this booklet.) You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

Chapter 2. Important phone numbers and resources

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

How to contact our plan's Member Services

For assistance with claims, billing or member card questions, please call or write to our plan Member Services. We will be happy to help you.

Member Services	
CALL	1-800-275-4737 Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. During the annual enrollment period (between October 15 and December 7) through 45 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. Pacific time. During this time period, current and prospective members are able to speak with a Member Service representative. If you call outside these hours, when leaving a message, you should include your name, phone number and the time you called, and a representative will return your call no later than one business day after you leave a message. However, after February 14, 2012, your call will be handled by our automated phone system, Saturdays, Sundays, and holidays. When leaving a message, please include your name, phone number and the time that you called, and a representative will return your call no later than one business day after you leave a message. Member Services also has free language interpreter services available for non-English speakers.
TTY/TDD	1-800-929-9955 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	1-818-676-8100

WRITE	Health Net Medicare Programs P.O. Box 10198 Van Nuys, CA 91410-0198
WEBSITE	www.healthnet.com

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

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

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

Coverage Decisions for Medical Care	
CALL	1-800-275-4737 Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
TTY/TDD	1-800-929-9955 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	1-800-793-4473 (elective request) 1-800-672-2135 (urgent request, those that qualify for expedited organization determinations)
WRITE	Health Net Medical Management 21281 Burbank Blvd. Woodland Hills, CA 91367
WEBSITE	www.healthnet.com

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

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

Appeals for Medical Care	
CALL	1-800-275-4737 Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
TTY/TDD	1-800-929-9955 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	1-818-676-8179. Expedited Requests: 1-866-587-0544
WRITE	Health Net Seniority Plus Green (HMO) Appeals and Grievance Department P.O. Box 10344 Van Nuys, CA 91410-0344
WEBSITE	www.healthnet.com

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

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

Complaints about Medical Care

CALL	1-800-275-4737 Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
TTY/TDD	1-800-929-9955 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	1-818-676-8179
WRITE	Health Net Seniority Plus Green (HMO) Appeals and Grievance Department P.O. Box 10344 Van Nuys, CA 91410-0344

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

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

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

Payment Requests	
CALL	1-800-275-4737 Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.

TTY/TDD	1-800-929-9955 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	1-800-793-4473 (elective request) 1-800-672-2135 (urgent request)
WRITE	Health Net of California P.O. Box 14703 Lexington, KY 40512
WEBSITE	www.healthnet.com

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

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

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

Medicare	
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

WEBSITE	http://www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state by selecting "Help and Support" and then clicking on "Useful Phone Numbers and Websites." The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. Select "Find Out if You're Eligible." • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select "Health & Drug Plans" and then "Compare Drug and Health Plans" or "Compare Medigap Policies." These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. 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. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In California, the SHIP is called Health Insurance Counseling and Advocacy Program (HICAP).

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

HICAP counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or

treatment, and help you straighten out problems with your Medicare bills. HICAP counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

HICAP (California SHIP)	
CALL	1-800-434-0222
TTY	1-800-735-2929 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	HICAP 1300 National Drive, Suite 200 Sacramento, CA 95834-1992
WEBSITE	www.cahealthadvocates.org

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

There is a Quality Improvement Organization for each state. For California, the Quality Improvement Organization is called Health Services Advisory Group.

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

You should contact Health Services Advisory Group in any of these situations:

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

Health Services Advisory Group (California's Quality Improvement Organization)	
CALL	1-866-800-8749

TTY	711 (National Relay Service)
WRITE	Health Services Advisory Group 700 N. Brand Blvd., Suite 370 Glendale, CA 91203
WEBSITE	www.hsag.com

SECTION 5 Social Security

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

Social Security Administration	
CALL	1-800-772-1213 Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday. You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	1-800-325-0778 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 am to 7:00 pm, Monday through Friday.
WEBSITE	http://www.ssa.gov

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

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

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

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).
- **Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact Department of Health Care Services.

Department of Health Care Services (California's Medicaid program)	
CALL	1-916-552-9200 or 1-916-636-1980
TTY	711 (National Relay Service)
WRITE	Department of Health Care Services PO Box 997417 MS 4607 Sacramento, CA 95899-7417
WEBSITE	www.medi-cal.ca.gov

SECTION 7 How to contact the Railroad Retirement Board

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

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

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

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group, call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period.

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact **that group's benefits administrator.** The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

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

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

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

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

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

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

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

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

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

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

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary**. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
    - In most situations, your network PCP must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see Section 2.3 of this chapter.
    - Referrals from your PCP are not required for emergency care or urgently needed care. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).
- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Here are three exceptions:*
    - The plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.
    - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. Your PCP must give you approval in advance before you can use an out-of-network provider. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
    - Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area.

SECTION 2 Use providers in the plan's network to get your medical care

Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care

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

When you become a member of our plan, you must choose a plan provider to be your PCP. Your PCP is a health care professional who meets state requirements and is trained to give you basic medical care. Providers that can act as your PCP are those that provide a basic level of care. These include doctors providing general and/or family medical care, internists who provide internal medical care, and gynecologists who provide care for women. A nurse practitioner (NP),

a State licensed registered nurse with special training, providing a basic level of health care, can act as your PCP.

You will get most of your routine or basic care from your PCP. Your PCP will also help you arrange or coordinate the rest of the covered services you get as a member of our Plan. This includes:

- your x-rays,
- laboratory tests,
- therapies,
- care from doctors who are specialists,
- hospital admissions, and
- follow-up care.

"Coordinating" your covered services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your PCP (such as giving you a referral to see a specialist). For certain services, your PCP will need to get prior authorization (approval in advance). If the service you need requires prior authorization, your PCP will request the authorization from our plan or your Medical Group. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office.

As we explained above, you will usually see your PCP first for most of your routine health care needs. When your PCP thinks that you need specialized treatment, he or she will need to give you a referral (approval in advance) to see a plan specialist or certain other providers. There are only a few types of covered services you may get without getting approval from your PCP first, as we explain below. Please refer to Section 2.2 and 2.3 in this chapter for more information.

How do you choose your PCP?

When you enroll in our plan, you will choose a contracting Medical Group from our network. You will also choose a PCP from this contracting Medical Group. Medical Groups (and their affiliated PCPs and hospitals) can be found in the *Provider Directory* or you may visit our website at www.healthnet.com. To confirm the availability of a provider, or to ask about a specific PCP, please contact Member Services at the phone number on the back cover of this booklet.

If there is a particular plan specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist or uses that hospital. The name and office telephone number of your PCP is printed on your membership card.

For information on how to change your PCP, please see "Changing your PCP" below.

Changing your PCP

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

Your request will be effective on the first day of the month following the date our plan receives your request. To change your PCP, call Member Services or you may visit our website at www.healthnet.com.

When you contact us, be sure to let us know if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP, and tell you when the change to your new PCP will take effect.

They will also send you a new membership card that shows the name and phone number of your new PCP.

Section 2.2 What kinds of medical care can you get without getting approval in advance from your PCP?

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams as long as you get them from a network provider.
- Flu shots and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed care from in-network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, e.g., when you are temporarily outside of the plan's service area.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away).

Section 2.3 How to get care from specialists and other network providers

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

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

In order for you to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist). It is very important to get a referral (approval in advance) from your PCP before you see a plan specialist or certain other providers (there are a few exceptions, including routine women's health care as explained in Section 2.2). If you don't have a referral (approval in advance) before you get services from a specialist, you may have to pay for these services yourself.

If the specialist wants you to come back for more care, check first to be sure that the referral (approval in advance) you got from your PCP for the first visit covers more visits to the specialist.

Each plan PCP has certain plan specialists he or she uses for referrals and specific hospitals he or she uses to send members. This means that the PCP you select may determine the specialists you may see or the hospitals you may go to. If there are specific specialists or hospitals you want to use, find out whether your PCP sends patients to these specialists or hospitals. You may generally change your PCP at any time if you want to see a Plan specialist or go to a hospital that your current PCP can't refer you to. Earlier in this section, under "Changing your PCP," we tell you how to change your PCP.

Some types of services will require getting approval in advance from our plan or your Medical Group (this is called getting "prior authorization"). Prior authorization is an approval process that happens before you get certain services. If the service you need requires prior authorization, your PCP or other network provider will request the authorization from our plan or your Medical Group. The request will be reviewed and a decision (organization determination) will be sent to you and your provider. See the Medical Benefits Chart in Chapter 4, Section 2.1 of this booklet for the specific services that require prior authorization.

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

Sometimes a specialist, clinic, hospital or other network provider you are using might leave the plan. If this happens, and it is a provider you see on a regular basis, you will be sent notification at least 30 days prior to the provider's termination effective date. If you continue seeing the provider after the termination effective date, you may have to pay for these services yourself. If you decide to switch to another contracted plan provider, Member Services can assist you in finding and selecting a provider. Phone numbers are located on the back cover of this Evidence of Coverage.

Section 2.4 How to get care from out-of-network providers

If there is a certain type of service (e.g., when providers of specialized services are not available in network) that you need and that service is not available in our plan's network, you will need to get prior authorization (approval in advance) first. Your PCP will request prior authorization from our plan or your Medical Group.

It is very important to get approval in advance before you see an out-of-network provider or receive services outside of our network (with the exception of emergency and urgently needed care, as explained in Section 3 below). If you don't get approval in advance, you may have to pay for these services yourself.

For information on coverage of out-of-network emergency and urgently needed care, please see Section 3 below.

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

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

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

What is covered if you have a medical emergency?

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

You may get covered emergency medical care outside the United States. This benefit is limited to $50,000. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. You are not covered for prescriptions purchased outside the United States. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet or call Member Services at the phone number listed on the back cover of this booklet.

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

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

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

However, after the doctor has said that it was *not* an emergency, we will cover additional care *only* if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- – *or* – the additional care you get is considered "urgently needed care" and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

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

What is "urgently needed care"?

"Urgently needed care" is a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have (for example, a flare-up of a chronic skin condition).

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

In most other situations, if you are in the plan's service area, we will cover urgently needed care *only* if you get this care from a network provider and follow the other rules described earlier in

this chapter. However, if the circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, we will cover urgently needed care that you get from an out-of-network provider.

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

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed care that you get from any provider.

Our plan provides Worldwide coverage of urgent/emergent and post-stabilization care for an annual limit of $50,000. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

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

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

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

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

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

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

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

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. The amount you pay for the

costs once a benefit limit has been reached will not count toward the out-of-pocket maximum. You can call Member Services when you want to know how much of your benefit limit you have already used.

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

Section 5.1 What is a "clinical research study"?

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

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

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

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

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

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

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

If you plan on participating in a clinical research study, contact Member Services (see Chapter 2, Section 1 of this *Evidence of Coverage*).

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

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

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

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

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

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

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

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

Do you want to know more?

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

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

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

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

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

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to *non-religious* aspects of care.
- If you get services from this institution that are provided to you in your home, our plan will cover these services only if your condition would ordinarily meet the conditions for coverage of services given by home health agencies that are not religious non-medical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
    - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
    - *– and –* you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Coverage limits for Inpatient Hospital Care apply. Please refer to Chapter 4: "*Medical benefits chart (what is covered and what you pay)*" for plan coverage information.

SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of durable medical equipment own the equipment after paying co-payments for the item for 13 months. As a member of our plan, however, you usually will not acquire ownership of rented durable medical equipment items no matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances we will transfer ownership of the durable medical equipment item. Call member services (phone numbers are on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

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

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

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

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

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

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

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

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

- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

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

Section 1.2 What is the most you will pay for covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered by our plan. (see the Medical Benefits Chart in Section 2, below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of our plan, the most you will have to pay out-of-pocket for in-network covered services in 2012 is $3,400. The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services

are marked with an asterisk in the Medical Benefits Chart.) If you reach the maximum out-of-pocket amount of $3,400, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 Our plan does not allow providers to "balance bill" you

As a member of Health Net Seniority Plus Green (HMO), an important protection for you is that, after you meet any deductibles, you only have to pay the plan's cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges such as "balance billing." This protection (that you never pay more than the plan cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges.

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you obtain covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
    - If you obtain covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get an authorization).
    - If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of -network providers only in certain situations, such as when you get an authorization).

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

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

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

- Your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart in italics.
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.

Medical Benefits Chart

Services that are covered for you	**What you must pay** when you get these services
Inpatient Care	
Inpatient hospital care You are covered for unlimited days per benefit period for Medicare-covered stays. 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 care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Inpatient substance abuse services • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. If Health Net Seniority Plus Green (HMO) provides transplant services at a distant location (farther away than the normal community patterns of care) and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood – including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* You pay: -$100 each day from days 1 through 4 per benefit period, for Medicare-covered inpatient hospital care; -$0 each day from days 5 and beyond per benefit period, for Medicare-covered inpatient hospital care. If you get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital.

Services that are covered for you		**What you must pay** when you get these services
with the first pint used. • Physician services **Note:** To be an inpatient, your provider must write an order to admit you to the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.		A benefit period begins the first day you go into a hospital or skilled nursing facility. The Benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Services that are covered for you	**What you must pay** when you get these services
Inpatient mental health care • Covered services include mental health care services that require a hospital stay. There is a 190-day lifetime limit in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. If you used part of the 190-day Medicare lifetime benefit prior to enrolling in our plan, then you are only entitled to receive the difference between the number of lifetime days already used in the Plan benefit.	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* You pay $900 per admission per benefit period for Medicare-covered inpatient mental health care. A benefit period begins the first day you go into a hospital or skilled nursing facility. The Benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods. Refer to "Additional Benefit Information " later in this chart for more information on mental health services.

Services that are covered for you	**What you must pay** when you get these services
Skilled nursing facility (SNF) care (For a definition of "skilled nursing facility care," see Chapter 10 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") You are covered for 100 days each Benefit period. No hospital stay required prior to admission. Covered services include: • 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. • 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 Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost sharing for a facility that isn't a plan provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital.	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* You pay: -$0 each day from days 1 through 20 per benefit period for Medicare-covered skilled nursing facility care; -$75 each day from days 21 through 100 per benefit period for Medicare-covered skilled nursing facility care . You pay for all costs for each day after day 100 in the benefit period. A benefit period begins the first day you go into a hospital or skilled nursing facility. The Benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a

Services that are covered for you		**What you must pay** when you get these services
		hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.
Inpatient services covered during a non-covered inpatient stay As described above, the plan covers up to 100 days per benefit period for skilled nursing facility (SNF) care. Once you have reached these coverage limits, the plan will no longer cover your stay in the SNF. However, we will cover certain types of services that you receive while you are still in the SNF. If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the skilled nursing facility (SNF) stay. Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • 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		The listed services will continue to be covered at the cost-sharing amounts shown in the benefits chart for the specific service. For Medicare-covered medical supplies including cast and splints, you pay the applicable cost-sharing amount where the specific service is provided. For example, if these medical supplies were used during a visit to an emergency room, then they would be included as part of the emergency room visit copayment.

Services that are covered for you		**What you must pay** when you get these services
patient's physical condition • Physical therapy, speech therapy, and occupational therapy		
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 fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies		*Requires prior authorization (approval in advance) to be covered, except in an emergency.* There is no copayment for Medicare-covered home health visits.
Hospice care You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out-of-network provider. Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. Covered services include: • Drugs for symptom control and pain relief • Short-term respite care • Home care You are still a member of our plan. If you need non-hospice care (care that is not related to your terminal condition), you have two options: • You can obtain your non-hospice care from plan providers. In this case, you only pay plan allowed cost sharing • --or-- You can get your care covered by Original Medicare. In		*Requires prior authorization (approval in advance) to be covered, except in an emergency.* You pay $10 for the one-time only hospice consultation. When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not our plan.

Services that are covered for you	**What you must pay** when you get these services
this case, you must pay the cost-sharing amounts under Original Medicare, except for emergency or urgently needed care. However, after payment, you can ask us to pay you back for the difference between the cost sharing in our plan and the cost sharing under Original Medicare. **Note:** If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
Outpatient Services	
Physician services, including doctor's office visits Covered services include: • Medically-necessary medical or surgical services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location • Consultation, diagnosis, and treatment by a specialist • Basic hearing and balance exams performed by your PCP or specialist, 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 by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	You pay $7 for each Medicare-covered primary care doctor office visit. You pay $10 for each visit to an in-network, in-area urgent care facility. *The following service requires prior authorization (approval in advance) to be covered, except in an emergency.* You pay $10 for each Medicare-covered specialist visit.

Services that are covered for you	**What you must pay** when you get these services
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include: • Services in an emergency department or outpatient clinic, including same-day surgery • Laboratory tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain screenings and preventive services • Certain drugs and biologicals that you can't give yourself **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	You pay the applicable cost sharing amounts shown in this Medical Benefits Chart for the specific service. For Medicare-covered medical supplies including cast and splints, you pay the applicable cost-sharing amount where the specific service is provided. For example, if these medical supplies were used during a visit to an emergency room, then they would be included as part of the emergency room visit copayment.

Services that are covered for you	**What you must pay** when you get these services
Chiropractic services Medicare-covered services include: • We cover only manual manipulation of the spine to correct subluxation • Routine (non-Medicare covered) chiropractic services* *The amounts you pay for these services do not count towards your maximum out-of pocket amount of $3,400.	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* You pay $10 for each Medicare-covered visit for the manual manipulation of the spine to correct subluxation. *No prior authorization (approval in advance) or referral is required for first time visits for routine chiropractic visits. Subsequent visits and treatment do require prior authorization.* You pay $10 for each non-Medicare covered (routine) chiropractic visit up to 30 visits every year (combined with acupuncture services).* Refer to "Additional Benefit Information " later in this chart for more information on routine chiropractic services.

Services that are covered for you	**What you must pay** when you get these services
Acupuncture *****The amounts you pay for these services do not count towards your maximum out-of pocket amount of $3,400.	*No prior authorization (approval in advance) or referral is required for first time visits for acupuncture visits. Subsequent visits and treatment do require prior authorization.* You pay $10 for each routine visit up to 30 visits every year (combined with chiropractic services).***** Refer to "Additional Benefit Information" later in this chart for more information on acupuncture benefits.
Podiatry services Medicare-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 Additional covered services include: • Routine (non-Medicare covered) foot care, limited to 12 visits per year. Additional visits must be approved by your PCP.	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* You pay $10 for each Medicare-covered visit (medically necessary foot care). You pay $10 for each routine (non-Medicare covered) visit.

Services that are covered for you	**What you must pay** when you get these services
Outpatient mental health care 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.	You pay $25 for each Medicare-covered individual or group therapy visit. Refer to "Additional Benefit Information " later in this chart for more information on outpatient mental health services, including the outpatient registration process.
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* There is no copayment for Medicare-covered partial hospitalization. Refer to "Additional Benefit Information " later in this chart for more information on mental health services.
Outpatient substance abuse services	You pay $25 for each Medicare-covered individual or group therapy visit. Refer to "Additional

Services that are covered for you		**What you must pay** when you get these services
		Benefit Information ” later in this chart for more information on outpatient substance abuse services, including the outpatient registration process.
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you are having surgery in a hospital, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”		*Requires prior authorization (approval in advance) to be covered, except in an emergency.* You pay $100 for each Medicare-covered visit in an outpatient hospital facility. You pay $50 for each Medicare-covered visit in an ambulatory surgical center. You pay $100 for Medicare-covered epidural injections performed in an outpatient hospital facility. You pay $50 for Medicare-covered epidural injections performed in an ambulatory surgical center.

Services that are covered for you	**What you must pay** when you get these services
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) or if authorized by the plan. 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.	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* You pay $125 for Medicare-covered ambulance services. Copayment applies per one-way trip. One copayment per day when there is more than one trip in a single day.
Emergency care Emergency care is care that is needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. • Coverage in the United States[1] • Worldwide coverage outside of the United States[1] [1]United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.	You pay $50 for each Medicare-covered emergency room visit. You do not pay this amount if you are immediately admitted to the hospital If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you

Services that are covered for you	**What you must pay** when you get these services
	would pay at a network hospital. There is no copayment for worldwide emergency care services received outside of the United States.[1] There is an annual limit of $50,000 for emergency services received outside of the United States.[1]
Urgently needed care Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition, that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible. • Coverage in the United States[1] • Worldwide coverage outside the United States[1] [1]United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.	You pay $10 for each Medicare-covered urgently needed care visit. You do not pay this amount if you are immediately admitted to the hospital. There is no copayment for worldwide emergency care services received outside of the United States.[1] There is an annual limit of $50,000 for emergency care services received outside of the United States.[1]

Services that are covered for you	**What you must pay** when you get these services
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, and speech language therapy, Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* There is no copayment for each Medicare-covered outpatient rehabilitation therapy visit.
Cardiac rehabilitation services Comprehensive programs that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* There is no copayment for each Medicare-covered cardiac rehabilitation services visit.
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* There is no copayment for each Medicare-covered pulmonary rehabilitation services visit.

Services that are covered for you	**What you must pay** when you get these services
Durable medical equipment and related supplies (For a definition of "durable medical equipment," see Chapter 10 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* You pay 20% coinsurance based on Health Net's contracted rate for Medicare-covered durable medical equipment and related supplies.
Prosthetic devices and related supplies Devices (other than dental) that replace a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* You pay 20% coinsurance based on Health Net's contracted rate for prosthetic devices and related supplies.
Diabetes self-management training, diabetic services 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 • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* There is no copayment for Medicare-covered diabetes supplies.

Services that are covered for you	**What you must pay** when you get these services
(including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions	You pay 20% coinsurance based on Health Net's contracted rate for Medicare-covered therapeutic shoes for people with diabetes who have severe diabetic foot disease. There is no copayment for Medicare-covered diabetes self-monitoring training.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory tests • Blood – including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests • Complex diagnostic radiology services (such as: CT Scans, MRAs, MRIs, PET Scans, stereotactic radiosurgery, and virtual colonoscopy)	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* There is no copayment for Medicare-covered x-ray services. There is no copayment for Medicare-covered laboratory tests and other Medicare-covered outpatient diagnostic tests. There is no copayment for Medicare-covered blood and blood

Services that are covered for you		**What you must pay** when you get these services
		services. You pay $60 for Medicare-covered radiation therapy and Medicare-covered diagnostic procedures and tests (complex diagnostic radiology services). For Medicare-covered medical supplies including cast and splints, you pay the applicable cost-sharing amount where the specific service is provided. For example, if these medical supplies were used during a visit to an emergency room, then they would be included as part of the emergency room visit copayment.
Vision care Medicare-covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and conditions of the eye. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year. • One pair of eyeglasses or contact lenses after each cataract		*Requires prior authorization (approval in advance) to be covered, except in an emergency.* You pay $10 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the

Services that are covered for you	**What you must pay** when you get these services
surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	eye).
Additional covered services include: • Routine eye exam (refraction), limited to one exam per year • *Choice of 1 routine eyewear purchase every 24 months*;*** o Limited to 1 set of frames and 1 pair of eyeglass lenses or contact lenses during a 24-month period*, **	There is no copayment for Medicare-covered glaucoma screening. There is no copayment for Medicare-covered eyewear. You pay $10 for each routine eye exam. You are covered up to $100 for routine eyewear every 24 months.*, ** There is a $100 frame allowance every 24 months.*, ** You pay 80% of the remaining balance. There is a $100 routine (non-medically necessary) contact lens allowance every 24 months.*, ** You pay 85% of the remaining balance for conventional contact lenses and 100% of the remaining balance for disposable contact
*Multi-year benefits may not be available in subsequent years. **Multi-year benefits may not be available in subsequent years. Refer to "Additional Benefit Information" later in this chart for more information on routine vision benefits.	

Services that are covered for you		**What you must pay** when you get these services
		lenses.* There is no copayment for medically necessary contact lenses once every 24 months.*, ** *The amounts you pay for these services do not count towards your maximum out-of-pocket amount of $3,400. **Multi-year benefits may not be available in subsequent years. Refer to "Additional Benefit Information " later in this chart for more information on routine vision benefits.
Preventive Services		
For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.		
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" physical exam.		There is no copayment for each Medicare-covered

Services that are covered for you	**What you must pay** when you get these services
	screening.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* There is no copayment for each Medicare-covered exam.
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* There is no copayment for Medicare-covered screenings.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover:	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* There is no

Services that are covered for you	**What you must pay** when you get these services
• Up to three screening exams during a pregnancy	copayment/ for Medicare-covered HIV screening.
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules	There is no copayment for the Medicare-covered Pneumonia vaccine. There is no copayment for the Medicare-covered Flu vaccine. *The following services requires prior authorization (approval in advance) to be covered, except in an emergency:* There is no copayment for the Medicare-covered Hepatitis B vaccine. There is no copayment for other Medicare-covered vaccines for those at risk (e.g., anti-rabies vaccine for those possibly exposed to rabies).
Breast cancer screening (mammograms) Covered services include:	There is no copayment for Medicare-covered breast cancer

Services that are covered for you	**What you must pay** when you get these services
• One baseline mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months**.**	screenings.
Cervical and vaginal cancer screening Medicare-covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months Additional covered services include: • Routine (non-Medicare covered) Pap tests and pelvic exams, limited to once per year	There is no copayment for Medicare-covered screenings. There is no copayment for routine (non-Medicare covered) Pap tests and pelvic exams.
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	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* There is no copayment for Medicare-covered prostate cancer screening exams.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* There is no

Services that are covered for you	**What you must pay** when you get these services
	copayment for Medicare-covered screening tests.
"Welcome to Medicare" physical exam The plan covers a one-time "Welcome to Medicare" physical exam, which includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** You must have the physical exam within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" physical exam.	There is no coinsurance, copayment, or deductible for the Welcome to Medicare exam.
Annual wellness visit • If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" exam. However, you don't need to have had a "Welcome to Medicare" exam to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* There is no copayment for Medicare-covered diabetes screening.

Services that are covered for you	**What you must pay** when you get these services
	There is no copayment for Medicare-covered fasting plasma glucose tests for persons at risk of diabetes.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a transplant when referred by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into another calendar year.	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* There is no copayment for each Medicare-covered medical nutrition therapy visit.
Smoking and tobacco use cessation (counseling to stop smoking) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: we cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: we cover cessation counseling services. We cover two counseling quit attempts within a 12-month period. Each counseling attempt includes up to four face-to-face visits, however, you will pay the applicable inpatient or outpatient cost sharing. Our plan also covers additional on-line and telephonic smoking cessation counseling. Please refer to "Additional Benefit Information"	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* If you haven't been diagnosed with an illness caused or complicated by tobacco use: There is no copayment for Medicare-covered smoking cessation counseling sessions.

Services that are covered for you		**What you must pay** when you get these services
later in this section.		If you have been diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that is affected by tobacco: There is no copayment for Medicare-covered smoking cessation counseling sessions. *The following service does not require prior authorization (approval in advance):* There is no copayment for additional non-Medicare covered smoking cessation counseling sessions.
Other Services		
Services to treat kidney disease and conditions Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.		*Requires prior authorization (approval in advance) to be covered, except in an emergency.* You pay $25 for Medicare-covered renal dialysis (kidney)

Services that are covered for you	**What you must pay** when you get these services
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section below, "Medicare Part B prescription drugs."	services. There is no copayment for Medicare-covered kidney disease education services, up to six sessions per lifetime.
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* You pay 20% coinsurance based on Health Net's contracted rate for Medicare-covered Part B drugs. You pay 20% coinsurance based on Health Net's contracted rate for Medicare-covered Part B chemotherapy drugs.

Services that are covered for you		**What you must pay** when you get these services
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 In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. Medicare-covered dental services include the following: • Otherwise non-covered procedures or services, such as tooth removal, when performed by a dentist incident to and as an integral part of an otherwise Medicare-covered procedure. • Extractions of teeth to prepare jaw for radiation treatment of neoplastic disease. • Dental exams prior to kidney transplantation. We cover: Preventive dental services*, limited to: • 2 oral exams per year* • 2 cleanings per year* • Dental x-rays up to 1 visit per year* *The amounts you pay for these services do not count towards your maximum out-of-pocket amount of $3,400.		*Requires prior authorization (approval in advance) to be covered, except in an emergency.* There is no copayment for Medicare-covered dental services. You are covered up to $500 for preventive dental services every year.* You pay a one time annual deductible of $35 for preventive dental services.* There is no copayment for covered preventive dental services after the $35 deductible, up to the $500 annual benefit maximum.* *The amounts you

Services that are covered for you	**What you must pay** when you get these services
	pay for these services do not count towards your maximum out-of-pocket amount of $3,400. Refer to "Additional Benefit Information" later in this chart for more information.
Hearing services Medicare covered services include: • Basic hearing evaluations performed by your provider are covered under physician office visits. Additional covered services include: • Routine (non Medicare-covered) hearing tests, limited to one test per year.	*Requires prior authorization (approval in advance) to be covered, except in an emergency.* You pay $10 for each Medicare-covered hearing test. You pay $10 for each routine (non-Medicare covered) hearing test. You pay 100% for hearing aids.
Health and wellness education programs Our plan covers the following services through Decision Power[SM]: • Written health education materials, including newsletters • Nutritional benefit • 24 hour / 7 days a week Nursing hotline • Smoking cessation	There is no copayment for health and wellness education programs. Refer to "Additional Benefit Information " later in this chart for more information on Decision Power benefits.

Services that are covered for you		**What you must pay** when you get these services
Additional Benefit Information		

Mental Health Care and Substance Abuse Benefits

Important Information: Please Read!

If you are a member of one of the following medical groups the information below describing how to obtain mental health services through MHN Services does not apply:

- **Camino Medical Group**
- **Palo Alto Medical Foundation**
- **Sutter Independent Physicians**
- **Sutter Medical Group (Sacramento/Placer Division)**
- **Sutter Medical Group (Yolo Division)**

If you are a member of one of these medical groups, you **must** obtain a referral from your primary care physician and use network hospitals and specialists associated with your Medical Group for all mental health services, except in an emergency or for urgent care when outside the Service Area. Mental health services should not be obtained from MHN Services as discussed below, but only through your medical group. Please refer to "Inpatient Mental Health Care," "Outpatient Mental Health Care" and "Outpatient Substance Abuse," in the Medical Benefits Chart for information on your mental health benefits and copayments. If you have any questions about this or any other plan benefit, please contact our Member Services Department by calling; **1-800-275-4737,** select option 4, (TTY/TDD **1-800-929-9955**) 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.

The Mental Health and Substance Abuse benefits are administered by MHN Services which contracts with Health Net to underwrite and administer these benefits.

Getting Services from MHN-Contracted Providers

Health Net Medicare Advantage members have the freedom to choose any Medicare eligible

contracted provider who provides mental health and substance abuse services to them as a Medicare patient.

Inpatient and Alternate Levels of Care (Partial Hospitalization, Intensive Outpatient)
MHN must authorize these services and supplies to be covered. To get authorization for these services, you must call MHN at **1-800-646-5610** (or TDD/TTY: **1-800-327-0801** for the hearing and speech impaired), 24 hours a day, seven days a week. MHN will refer you to a nearby Medicare eligible Contracted Mental Health Professional. That professional will evaluate you to determine if additional treatment is necessary. If you need treatment, the MHN-contracted mental health professional will develop a treatment plan and submit that plan to MHN for review. When authorized by MHN, the proposed services will be covered by this plan. If MHN Services does not approve the Treatment Plan, no further services or supplies will be covered for that condition. However, MHN Services may direct you to community resources where alternative forms of assistance are available.

For up-to-date provider information, please contact MHN at **1-800-646-5610** (or TDD/TTY: **1-800-327-0801** for the hearing and speech impaired), 24 hours a day, seven days a week. You may also contact Health Net's Member Services Department at the telephone number located on the back cover of this booklet, or visit our website at www.healthnet.com.

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

Medical necessity review may take place in the form of discussion with your provider about your treatment plan sometime during your course of treatment. MHN is available to answer any questions regarding your care 24 hours a day, 7 days a week. To contact MHN, call **1-800-646-5610** (or TDD/TTY: **1-800-327-0801** for the hearing and speech impaired), 24 hours a day, seven days a week.

What Mental Health and Substance Abuse Services are Covered?

The following services are covered under your plan. Please refer to the Medical Benefits Chart for copayment and coinsurance information.

Outpatient Services
Outpatient crisis intervention, short-term evaluation and therapy, longer-term specialized therapy and any rehabilitative care that is related to Substance Abuse may be covered with unlimited visits, subject to Medical Necessity review as determined by MHN Services. Medication management care is also covered when appropriate. Refer to "Outpatient Mental Health Care", "Outpatient Substance Abuse Services" and "Outpatient Substance Abuse" in the Medical Benefits Chart for your cost-sharing information.

Second Opinion
MHN Services may, as a condition of coverage, require that you obtain a second opinion from an appropriate Contracted Mental Health Professional to verify the Medical Necessity or appropriateness of a Covered Service. In addition, you as a Member, have the right to request a second opinion when:

- Your Contracted Mental Health Professional renders a diagnosis or recommends a Treatment Plan that you are not satisfied with;
- You are not satisfied with the result of the treatment rendered;
- You question the reasonableness or necessity of recommended surgical procedures;
- You are diagnosed with, or a Treatment Plan is recommended for, a condition that threatens loss of life, limb or bodily function or a substantial impairment, including but not limited to a Serious Chronic Condition; or
- Your Contracted Mental Health Professional is unable to diagnose your condition or test results are conflicting.
- The clinical indications are complex or confusing, a diagnosis is in doubt due to conflicting test results, or the Contracted Mental Health Professional is unable to diagnose the condition.
- The Treatment Plan in progress is not improving your medical condition within an appropriate period of time for the diagnosis and plan of care.
- If you have attempted to follow the plan of care or consulted with the initial Contracted Mental Health Professional due to serious concerns about the diagnosis or plan of care.

To request an authorization for a second opinion contact MHN Services at **1-800-646-5610** (or TDD/TTY **1-800-327-0801** for the hearing and speech impaired) 24 hours a day, seven days a week. MHN Services will review the request, and if a second opinion is considered Medically Necessary, MHN Services will authorize a referral to a Contracted Mental Health Professional. When you request a second opinion, you will be responsible for any applicable copayments.

Second opinions will only be authorized for Contracted Mental Health Professionals, unless it is demonstrated that an appropriately qualified Contracted Mental Health Professional is not available. MHN Services will ensure that the provider selected for the second opinion is appropriately licensed and has expertise in the specific clinical area in question.

If you face an imminent and serious threat to health, including, but not limited to, the potential loss of life, limb or other major bodily function, or lack of timeliness would be detrimental to the ability to regain maximum function, the second opinion will be rendered in a timely fashion appropriate to the nature of the condition not to exceed 72 hours of MHN Services receipt of the request, whenever possible. For a complete copy of this policy, contact MHN Services at **1-800-646-5610** (TDD/TTY **1-800-327-0801**), 24 hours a day, seven days a week.

Inpatient Services

If you think you require Inpatient services, you must obtain preauthorization from MHN Services. You must provide all necessary information concerning your problem before you begin treatment.

Inpatient treatment of a Mental Disorder or Substance Abuse is covered, subject to a combined lifetime maximum of 190 days per Member. The 190-day limit does not apply to Mental Health or Substance Abuse services provided in a psychiatric unit of a general hospital. Refer to "Inpatient Mental Health Care" in the Medical Benefits Chart for your cost-sharing information.

Covered inpatient services and supplies include:

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

Except in an emergency, services and supplies provided without preauthorization will not be covered by MHN Services – even if those services or supplies would have been covered had you requested preauthorization.

Detoxification
Inpatient services for acute detoxification and treatment of acute medical conditions relating to Substance Abuse are covered, except as stated below in "Mental Disorders and Substance Abuse Exclusions and Limitations."

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

MHN has a licensed clinician available 24 hours a day, seven days a week to address all requests for immediate admission to a facility if the patient poses a danger to self or others or is gravely disabled. MHN can be contacted at **1-800-646-5610** (TDD/TTY **1-800-327-0801** for the hearing and speech impaired) 24 hours a day, seven days a week.

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

woman or her unborn child; 2) serious impairment to bodily function; 3) serious dysfunction of any organ or part.

Transition of Care for New Enrollees
If you are receiving ongoing care for an Acute, serious, or chronic mental health condition from a non-Contracted Mental Health Professional at the time you enroll with Health Net, we may temporarily cover services from a provider not affiliated with MHN Services, subject to applicable copayments and any other exclusions and limitations of this Plan.

Your non-Contracted Mental Health Professional must be willing to accept MHN Services' standard mental health provider contract terms and conditions, including, but not limited to rates, credentialing, hospital privileging, utilization review, peer review and quality assurance requirements, and be located in the Plan's Service Area.

If you would like more information on how to request continued care, or request a copy of our continuity of care policy, please call MHN at **1-800-646-5610 (**TTY/TDD: **1-800-327-0801** for hearing and speech impaired) 24 hours a day, seven days a week.

Mental Disorders and Substance Abuse Exclusions and Limitations

Mental health care as a condition of parole, probation or court-ordered testing for Mental Disorders is limited to Medically Necessary services and subject to this Plan's visit limits described earlier in this section.

Services and supplies for treating Mental Disorders and Substance Abuse are covered only as specified in the Medical Benefits Chart under "Inpatient Mental Health Care," "Outpatient Mental Health Care" and "Outpatient Substance Abuse Services."

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

- Court-ordered testing and treatment, except when Medically Necessary and within the allowable visits under the plan contract.
- Private Hospital rooms and/or private duty nursing, unless determined to be a Medically Necessary Service and Authorization from MHN Services is obtained.
- Ancillary services such as:
  - Vocational rehabilitation and other rehabilitation services.
  - Behavioral training.
  - Speech or occupational therapy.
  - Sleep therapy and employment counseling.
  - Training or educational therapy or services.
  - Other education services.
  - Nutrition services.
- Treatment by providers other than those within licensing categories recognized by Medicare or MHN as providing medically necessary services in accordance with applicable

medical community standards.

- Services in excess of those with respect to which Authorization by MHN Services is obtained when authorization is required.
- Psychological testing except as conducted by a licensed psychologist for assistance in Treatment Planning, including medication management or diagnostic clarification and specifically excluding all educational, academic and achievement tests, psychological testing related to medical conditions or to determine surgical readiness and automated computer based reports.
- All prescription or non-prescription drugs and laboratory fees, except for drugs and laboratory fees prescribed by a practitioner in connection with Inpatient treatment.
- Inpatient services, treatment, or supplies rendered without Authorization, except in the event of Emergency Services.
- Healthcare services, treatment, or supplies rendered in a non-emergency by a provider who is not a Contracted Mental Health Professional, unless Authorization by MHN Services has been received or as otherwise provided by the Plan.
- Damage to a hospital or facility caused by you.
- Healthcare services, treatment or supplies determined to be Experimental by MHN Services in accordance with accepted mental health standards, except as otherwise required by law.
- Treatment for biofeedback, acupuncture or hypnotherapy.
- Healthcare services, treatment, or supplies rendered to you which are not Medically Necessary Services. This includes, but is not limited to, services, treatment, or supplies primarily for rest or convalescence, Custodial Care or Domiciliary Care as determined by MHN Services.
- Services received before your effective date or services received during an Inpatient stay that began before your effective date. Additionally, services received after your coverage ended are not covered, except for services received during an Inpatient stay that began before your termination date.
- Professional services received from a person who lives in your home or who is related to you by blood or marriage.
- Services performed in any emergency room which are not directly related to the treatment of a Mental Disorder.
- Services received out of your primary state of residence except in the event of Emergency Services and as otherwise authorized by MHN Services.
- Electro-Convulsive Therapy (ECT) except as authorized by MHN Services according to MHN Services policies and procedures.
- All other services, confinements, treatments or supplies not provided primarily for the treatment of specific covered benefits and/or specifically included as Covered Services elsewhere in this Plan.

How Do I File a Claim for Mental Health and Substance Abuse Services?

In most cases your mental health provider will submit your claims directly to MHN. If you receive a bill for the services, submit your claim to MHN. Claims forms can be found online at

www.mhn.com or call MHN's Claims Line for assistance at the toll-free number at **1-800-444-4281** (National Relay Service: 711, available for the hearing and speech impaired), Monday through Friday from 8:00 a.m. to 7:00 p.m., Central time.

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

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

You can also contact MHN Services at :**1-800-646-5610** (TDD/TTY **1-800-327-0801** for the hearing and speech impaired) 24 hours a day, seven days a week, to check the status of your claim. We will be able to provide a status within 72 hours of receipt of your claim. If a reimbursement is due to you, a check will be mailed no later than 60 days of receipt of your claim.

When You Receive Emergency/Urgent Services from a Non-Contracting MHN Services Provider/Facility

You may be hospitalized at a non-MHN Services facility due to an immediate medical emergency. You may be transferred to an MHN Services facility as soon as your medical condition is stable enough for such a move. If MHN Services arranges a transfer, MHN Services will be financially responsible for the cost of the transportation to an MHN Services facility. When receiving Emergency Care from a non-MHN Services provider, you should request that the provider bill MHN Services directly for services. If the provider bills you directly, MHN Services will reimburse you charges paid for emergency services and out-of-area urgent care services less any applicable copayments. In order to receive reimbursement, you should submit an itemized bill and completed claim form to MHN Services. A claim form can be obtained online at www.mhn.com or by contacting MHN's Claims Line for assistance at the toll-free number **1-800-444-4281** (National Relay Service: 711, available for the hearing and speech impaired) Monday through Friday from 8:00 a.m. to 7:00 p.m., Central time.

Completed claim forms should be submitted to:

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

QUESTIONS?

For up-to-date provider information or to obtain authorization to receive services, please contact MHN Services at **1-800-646-5610** (TDD/TTY **1-800-327-0801** for the hearing and speech impaired) 24 hours a day, seven days a week. Calls to these numbers are free. Or visit MHN Services' web site at www.mhn.com for a list of MHN Services Contracted Mental Health Professionals in your area.

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

Dental Services

As a Member of our plan, you have Medicare-covered Dental benefits. As a Member of our plan, you also have non-Medicare covered preventive Dental benefits described below.

Dental services are administered by Health Net Dental. Dental services are covered as shown under "Dental services" in the Medical Benefits Chart. You can see any licensed dentist to receive covered dental services. Please contact Health Net Dental Member Services at the toll-free number **1-866-249-2382** (or TTY **1-800-855-2880**), Monday through Friday, 5:00 a.m. to 8:00 p.m. Pacific time, except holidays.

What Health Net Dental services are covered?

Preventive services listed below are covered. See "Dental services" in the Medical Benefits Chart for deductible, copayment, coinsurance and benefit maximums information.

- Oral examinations (covered as a separate benefit only if no other service was done during the visit other than x-rays)
- Bitewing x-rays
- Panoramic and full mouth x-rays
- Dental prophylaxis (cleanings)
- Extraoral x-rays

What Health Net Dental services are not covered by our plan?

In addition to any exclusions or limitations described in Section 3 of this chapter, "What types of benefits are not covered by the plan?," the following items and services are not covered by our plan as part of the routine dental benefits provided by Health Net Dental.

General Dental Limitations:

1. Oral examinations covered as a separate benefit only if no other service was done during the visit other than x-rays. Limited to 2 times per 12 months.
2. Complete series or panorex radiographs limited to one time per 36 months (multi-year benefits may not be available in subsequent years).
3. Bitewing radiographs limited to 1 series of films every 12 months.
4. Extraoral radiographs limited to 2 films every 12 months.
5. Dental prophylaxis (cleaning) limited to 2 times per 12 months.
6. Health Net Dental has a $35 calendar year deductible for preventive dental services.

7. Health Net Dental has a $500 Plan Maximum per year combined for preventive dental services.

General Dental Exclusions:

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

How do I file a Health Net Dental claim?

Health Net Dental has a $35 calendar year deductible and $500 Plan Maximum per year for Preventive Services.

When you see a dentist, you may have to file a claim with Health Net Dental. Health Net Dental will pay your provider its share of the bill for any covered services that are determined to have been Medically Necessary and let you know what, if anything, you must pay your provider. Please call or write to the Health Net Dental Member Services department for a claim form and claim filing instructions at the toll-free number **1-866-249-2382** (or TTY **1-800-855-2880**), Monday through Friday, 5:00 a.m. to 8:00 p.m., Pacific time, except holidays. You can also get a claim form at Health Net Dental's website at www.hndental.com. The bill should be submitted to the following address:

Health Net Dental Claims Department
P.O. Box 30567
Salt Lake City, UT 84130

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

Chiropractic Care

As a Member of our plan, you have Medicare-covered Chiropractic benefits (manual manipulation to correct subluxation). Please see the Medical Benefits Chart earlier in this chapter for copayment and benefit information. As a member of our plan, you also have non-Medicare covered chiropractic benefits described below.

American Specialty Health Plans of California, Inc. (ASH Plans) will provide access to covered Chiropractic Services for you. You may access any ASH Plans Contracted Chiropractor without a physician referral, including without a referral from your Primary Care Physician ("PCP"). All covered Chiropractic Services must be Medically Necessary and may require verification of Medical Necessity through an authorization process by ASH Plans, except as listed below. The ASH Plans Contracted Chiropractor you select will provide the initial examination and will contact ASH Plans for any required authorization of the treatment plan he/she develops for you. For a list of ASH Plans Contracted Chiropractors, please call ASH Plans at **1-800-678-9133** (TDD/TTY **1-877-710-2746**), Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays, Pacific Time.

Chiropractic Services are covered up to the maximum of 30 visits (combined with Acupuncture Services) per calendar year. You may receive covered Chiropractic Services from any ASH Plans Contracted Chiropractor at any time, and you are not required to pre-designate the ASH Plans Contracted Chiropractor from whom you will receive covered Chiropractic Services. You must receive covered Chiropractic Services from an ASH Plans Contracted Chiropractor, except that:

- You may receive Emergency Chiropractic Services from a non-Contracted Provider; and
- If covered Chiropractic Services are not available and accessible, you may obtain covered Chiropractic Services from a non-Contracted Provider who is available and accessible to you upon referral by ASH Plans.

The following Chiropractic Services do not require authorization by ASH Plans:

- An initial examination by an ASH Plans Contracted Chiropractor to the extent consistent with professionally recognized standards of practice;

- Urgent Services; and
- Emergency Chiropractic Services.

Chiropractic Covered Services:

- You are required to pay a copayment for each office visit to an ASH Plans Contracted Chiropractor, as described below. A maximum number of visits per calendar year will apply to each Member**.** All Chiropractic Services except for the initial evaluation may require verification of Medical Necessity.
- A new patient exam or an established patient exam for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of Chiropractic Services. A new patient is one who has not received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years.
- Established patient exams to assess the need to initiate, continue, extend, or change a Course of Treatment. The established patient exam may require verification of Medical Necessity.
- Adjunctive modalities and procedures such as rehabilitative exercise, traction, ultrasound, electrical muscle stimulation, and other therapies are covered only when provided during the same Course of Treatment and in support of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.
- Follow-up office visits may include manipulation of the spine, joints and/or musculoskeletal soft tissue, a re-evaluation, and/or other services, in various combinations.
- X-rays and clinical laboratory tests are payable in full when provided by or referred by ASH Plans Contracted Chiropractor and approved by ASH Plans as Medically Necessary. Radiological consultations are a covered benefit when approved by ASH Plans as Medically Necessary Services and when provided by a licensed chiropractic radiologist, medical radiologist, radiology group, or hospital that has contracted with ASH Plans to provide those services.
- Chiropractic Supports and Appliances are covered up to a maximum of $50 per year when approved by ASH Plans as Medically Necessary for the treatment of either Neuromusculoskeletal Disorders or Pain Syndromes or both.
- Urgent Services.
- Emergency Services.

Second Opinion

You have direct access to any other ASH Plans Contracted Chiropractor. Your visit to another ASH Plans Contracted Chiropractor for purposes of obtaining a second opinion generally will count as one visit, for purposes of any Maximum Benefit, and you must pay any Copayment that

applies for that visit on the same terms and conditions as a visit to any other ASH Plans Contracted Chiropractor.

X-ray and Laboratory Tests

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

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

Chiropractic Services Exclusions and Limitations

The following items and services are limited or excluded under Chiropractic Services:

- Services rendered in excess of visit limits or benefit maximums.
- Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order.
- Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; and all support appliances or durable medical equipment **except those specifically noted as covered above under "Chiropractic Covered Services."**
- Education programs, non-medical lifestyle or self-help, or any self-help physical exercise training or any related diagnostic testing.
- Hypnotherapy, behavior training, sleep therapy and weight programs.
- Services or treatments delivered by a Non- Contracted Provider, except for (a) Emergency Services; (b) Urgent Services; (c) services that are provided pursuant to a continuity of care plan approved by ASH Plans; or (d) services that are provided upon referral by ASH Plans in situations where such services are not available and accessible to a Member from a Contracted Chiropractor within the Service Area.
- Adjunctive physiotherapy modalities and procedures unless provided during the same Course of Treatment and in conjunction with chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.
- Services, exams, (other than an initial examination to determine the appropriateness of Chiropractic Services), and/or treatments for conditions other than Neuromusculo-skeletal Disorders or Pain Syndromes.
- Services provided by a chiropractor practicing outside California, except for Emergency Chiropractic Services or Urgent Services.
- Any service or supply that is not permitted by state law with respect to the provider's scope of practice.

- Thermography; magnets used for diagnostic or therapeutic use; nerve conduction studies (e.g., EEG, EMG, SEMG, SSEP, and NCV); or electrocardiogram (EKG) studies.
- Transportation costs, including local ambulance charges.
- Dietary and nutritional supplements, including vitamins, minerals, herbs, herbals and herbal products, injectable supplements and injection services, or other similar products.
- Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, therapeutic radiology, and any diagnostic radiology other than covered plain film studies.
- Services or treatments for pre-employment physicals or vocational rehabilitation.
- Any services or treatments for conditions caused by or arising out of the course of employment or covered under workers' compensation or similar laws.
- Auxiliary aids and services, including, but not limited, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids
- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services under anesthesia, or other related services.

How to File a Claim for Chiropractic Services

In most cases your Chiropractic service provider will submit your claims to ASH Plans. To file a claim you may have, please send us a letter or complete an ASH Plans claim form. If you need a claim form, go online to www.ashcompanies.com or contact ASH Plans at **1-800-678-9133** (TDD/TTY **1-877-710-2746**), Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays, Pacific Time.

Attach your itemized bill to the claim form or letter. Mail the itemized bill, completed claim form or letter to:

American Specialty Health Plans
P.O. Box 509002
San Diego, CA 92150-9002

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

When You Receive Emergency/Urgent Services from a Non-Contracted ASH Plans Provider/Facility

When receiving Emergency Care or Urgent Care from a non-Contracted Provider, you should request that the provider bill ASH Plans directly for services. If the provider bills you directly, ASH Plans will reimburse you charges paid for emergency services and out-of-area urgent care services less any applicable copayments. In order to receive reimbursement, you should submit an itemized bill and completed claim form to ASH Plans. A claim form can be obtained online at www.ashcompanies.com or by contacting ASH Plans at **1-800-678-9133** (TDD/TTY **1-877-710-2746**), Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays, Pacific Time.

Completed claim forms should be submitted to:

American Specialty Health Plans
P.O. Box 509002
San Diego, CA 92150-9002

QUESTIONS?

For up-to-date provider information, please contact ASH Plans at **1-800-678-9133** (TDD/TTY **1-877-710-2746**), Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays, Pacific Time. Or visit ASH Plans' web site at www.ashcompanies.com for a list of ASH Plans Contracted Chiropractors in your area.

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

Acupuncture Services

As a Member of our plan, you have non-Medicare covered Acupuncture benefits described below.

American Specialty Health Plans of California, Inc. (ASH Plans) will provide access to covered Acupuncture Services for you. You may access any ASH Plans Contracted Acupuncturist without a Physician referral, including without a referral from your Primary Care Physician ("PCP"). All covered Acupuncture Services must be Medically Necessary and may require verification of Medical Necessity through an authorization process by ASH Plans, except as listed below. The ASH Plans Contracted Acupuncturist you select will conduct the initial examination and will contact ASH Plans for any required authorization of the treatment plan he/she develops for you.

Acupuncture Services are covered up to the maximum of 30 visits (combined with Chiropractic Services) per Calendar Year. You may receive covered Acupuncture Services from any ASH Plans Contracted Acupuncturist at any time, and you are not required to pre-designate, at any time, the ASH Plans Contracted Acupuncturist from whom you will receive covered Acupuncture Services. You must receive covered Acupuncture Services from an ASH Plans Contracted Acupuncturist except that:

- You may receive Emergency Acupuncture Services from a non-Contracted Provider; and
- If covered Acupuncture Services are not available and accessible, you may obtain covered Acupuncture Services from a non-Contracted Provider who is available and accessible to you upon referral by ASH Plans.

The following Acupuncture Services do not require authorization by ASH Plans:

- An initial examination by an ASH Plans Contracted Acupuncturist to the extent consistent with professionally recognized standards of practice;
- Urgent Services; and
- Emergency Acupuncture Services.

Acupuncture Covered Services

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

- Emergency Services.

Second Opinion

You have direct access to any other ASH Plans Contracted Acupuncturist. Your visit to another ASH Plans Contracted Acupuncturist for purposes of obtaining a second opinion generally will count as one visit, for purposes of any Maximum Benefit, and you must pay any Copayment that applies for that visit on the same terms and conditions as a visit to any other ASH Plans Contracted Acupuncturist.

Acupuncture Services Exclusions and Limitations

The following items and services are limited or excluded under the Acupuncture Services:

- Services rendered in excess of visit or benefit maximums.
- Auxiliary aids and services, including, but not limited, to interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids.
- Services, exams (other than an initial examination to determine the appropriateness of Acupuncture Services) and/or treatments for conditions other than Neuromusculoskeletal Disorders, Nausea, Pain or pain syndromes.
- Services or treatments delivered by a Non-Contracted Provider, except for (a) Emergency Services; (b) Urgent Services; (c) services that are provided pursuant to a continuity of care plan approved by ASH Plans; or (d) services that are provided upon referral by ASH Plans in situations where such services are not available and accessible to you from a Contracted Acupuncturist within the Service Area.
- Services and other treatments that are classified as Experimental or Investigational.
- Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order.
- Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances or durable medical equipment.
- Educational programs, non-medical lifestyle or self-help, or self-help physical exercise training or any related diagnostic testing.
- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services or other related services.
- Services or treatments for pre-employment physicals or vocational rehabilitation.
- Hypnotherapy, sleep therapy, behavior training, and weight programs are not covered.
- Services provided by an acupuncturist practicing outside California, except for Urgent Services or Emergency Services.
- Services, examination (other than an initial examination to determine the appropriateness of Acupuncture Services) and/or treatments for conditions other than Neuromusculoskeletal Disorders, Nausea, Pain Syndromes or Pain.
- Transportation costs, including local ambulance charges.
- Any services or treatments for conditions caused by or arising out of the course of employment or covered under workers' compensation or similar laws.
- Adjunctive therapy not associated with acupuncture.

- Dietary and nutritional supplements, including vitamins, minerals, herbs, herbals and herbal products, injectable supplements and injection services, or other similar products.
- Thermography, magnets used for diagnostic or therapeutic use, ion cord devices, manipulation or adjustments of the joints, physical therapy services, iridology, hormone replacement products, acupuncture point or trigger-point injections (including injectable substances), laser/laser biostim, colorpuncture, NAET diagnosis and/or treatment, and direct moxibustion. Any service or supply that is not permitted by state law with respect to the provider's scope of practice.

How to File a Claim for Acupuncture Services

In most cases your Acupuncture service provider will submit your claims to ASH Plans. To file a claim you may have, please send us a letter or complete an ASH Plans claim form. If you need a claim form, go online to www.ashcompanies.com or contact ASH Plans at **1-800-678-9133** (TDD/TTY **1-877-710-2746**), Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays, Pacific Time.

Attach your itemized bill to the claim form or letter. Mail the itemized bill, completed claim form or letter to:

American Specialty Health Plans
P.O. Box 509002
San Diego, CA 92150-9002

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

When You Receive Emergency/Urgent Services from a Non-Contracting ASH Plans Provider/Facility

When receiving Emergency Care or Urgent Care from a non-Contracted Provider, you should request that the provider bill ASH Plans directly for services. If the provider bills you directly, ASH Plans will reimburse you charges paid for emergency services and out-of-area urgent care services less any applicable copayments. In order to receive reimbursement, you should submit an itemized bill and completed claim form to ASH Plans. A claim form can be obtained online at www.ashcompanies.com or by contacting ASH Plans at **1-800-678-9133** (TDD/TTY **1-877-710-2746**), Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays.

Completed claim forms should be submitted to:

American Specialty Health Plans
P.O. Box 509002
San Diego, CA 92150-9002

QUESTIONS?

For up-to-date provider information, please contact ASH Plans at **1-800-678-9133** (TDD/TTY **1-877-710-2746)**, Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays, Pacific

Time. Or visit ASH Plans' web site at www.ashcompanies.com for a list of ASH Plans participating providers in your area.

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

Eyewear

You can obtain an annual eye exam with your basic medical benefit through your plan's contracting medical group. In addition to an annual routine eye exam and Medicare-covered eye exams (for diagnosis and treatment for diseases and conditions of the eye), we also offer coverage for your eyewear. The Health Net Vision Plan is serviced by EyeMed Vision Care, LLC. EyeMed will pay your provider its share of the bill for any covered services that are determined to have been Medically Necessary and let you know what, if anything, you must pay your provider.

How to use the plan

- Make arrangements for your routine annual eye exam through your contracting Medical Group or Primary Care Physician (PCP). For referral to a specialist (ophthalmologist or optometrist), please contact your PCP directly. Vision care provided by someone other than a plan contracted optometrist or ophthalmologist will not be covered.
- Go to your eye exam and if you require eyeglasses or contact lenses, a prescription will be written. You are able to purchase eyewear from a list of Health Net Vision participating eyewear providers in California. Please note that the specialist who is authorized to provide your eye exam may not be a Health Net Vision contracting provider. Eyewear supplied by providers other than Health Net Vision Participating Eyewear providers are not covered. For more information or a list of Health Net Vision participating eyewear providers in California, please contact Health Net Vision at **1-866-392-6058** Monday through Saturday, 5:00 a.m. to 8:00 p.m. and Sunday 8:00 a.m. to 5:00 p.m., Pacific time (or **1-866-308-5375 TDD/TTY** for the hearing and speech impaired Monday through Friday from 5:00 a.m. to 2:00 p.m., Pacific time) or visit our website at www.healthnet.com.
- Payment for the prescription order eyewear received from a Health Net Vision participating eyewear provider will be made directly to that Health Net Vision participating provider.

That's all you need to do to get your new eyeglasses or contact lenses. The Health Net Vision participating provider will take care of all of the paperwork and billing for you.

If you have questions about your Vision Care benefits or would like a list of Health Net Vision participating Eyewear providers, you may call the Health Net Vision Member Services at **1-866-392-6058**. Normal business hours are Monday through Saturday, 5:00 a.m. to 8:00 p.m. and Sunday, 8:00 a.m. to 5:00 p.m., Pacific Time. TDD/TTY services are available Monday through Friday during the hours of 5:00 a.m. to 2:00 p.m., Pacific Time, at **1-866-308-5375**.

Eyewear Benefits

Eyewear benefits differ from all others benefits in that no copayment is specified. However, you must pay the difference between the retail price of Eyewear and the Eyewear allowance described below. When the cost sharing column states "Health Net Vision pays in full," you pay nothing.

Eyewear Schedule:

Cost Sharing	
Frames (one pair of frames every 24 months*)	
Frames (Any available frame at provider location)	Health Net Vision pays the first $100. You pay 80% of the remaining balance, if applicable.
Standard Plastic Eyeglass Lenses (one pair every 24 months*)	
Single Vision	Health Net Vision pays in full.
Bifocal	Health Net Vision pays in full.
Trifocal	Health Net Vision pays in full.
Standard Progressive Lenses	You pay $65. Health Net Vision pays the remaining balance.
Premium Progressive Lenses	You pay $65 plus 80% of the retail charge, minus the $120 plan allowance.
Contact Lenses (one pair every 24 months*) – in lieu of eyeglass lenses	
(Contact lens allowance includes materials only.)	
Conventional	Health Net Vision pays the first $100. You pay 85% of the remaining balance, if applicable.
Disposable (If disposable Contact Lenses are used, you need to purchase enough pairs of disposable contact lenses to reach the allowable amount shown in "Eyewear Schedule" at one visit. If you do not use the full allowed amount during the initial purchase, the remaining balance will not carry over.)	Health Net Vision pays the first $100. You pay 100% of the remaining balance, if applicable.
Medically Necessary (Conventional and Disposable)**	Health Net Vision pays in full.

**Multi year benefits may not be available in subsequent years.*

*** Contact lenses are defined as Medically Necessary if you are diagnosed with one of the following conditions:*

- *Keratoconus where the patient is not correctable to 20/30 in either or both eyes using standard spectacle lenses.*
- *High Ametropia exceeding -12 D or +9 D in spherical equivalent.*
- *Anisometropia of 3 D or more.*
- *Patients whose vision can be corrected two (2) lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.*

If you are diagnosed with one of the above conditions, the Health Net Vision provider will submit a request for pre-authorization to Health Net Vision. The Health Net Vision Medical Director reviews all requests for Medically Necessary contact lenses. If approved, you will be covered for Medically Necessary contact lenses in full.

Additional Purchases and Out-of-Pocket Discounts

Allowances are one-time use benefits; no remaining balance. Lost or broken materials are not covered.

You receive a 20% discount on eyeglass lens upgrades including UV treatment, tinted lenses (solid or gradient), standard scratch coating, standard polycarbonate, standard anti-reflective coating, polarized lens, and other add-ons.

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

You also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used. You also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization please call **1-877-5LASER6**. After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to you. Details are available at www.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service.

Vision Care Exclusions and Limitations

The following items and services are limited or excluded under Health Net Vision Care:

- Eye exams are not covered under the Eyewear Benefit. Routine eye exams are covered as part of your plan's medical benefit. Please refer to the Medical Benefits Chart earlier in this chapter.
- The fitting or dispensing of more than one set of Frames and one pair of Standard Plastic Eyeglass Lenses or Contact Lenses during any 24-month period is not covered.
- Lenses that correct the vision defect known as aniseikonia are not covered.
- Diagnostic services, and medical or surgical treatment of the eye, eyes or supporting structures are not covered. For covered surgical treatments, please refer to the Medical Benefits Chart earlier in this chapter.
- Services or supplies provided by a provider other than a Health Net Vision Participating Eyewear provider are not covered.
- Non-prescription vision devices and sunglasses are not covered.
- Additional fitting and measurement charges, or special consultation charges due to the purchase of optional Frames, are not covered.
- Orthoptics or vision training aids are not covered.
- Outpatient Prescription Drugs or over-the-counter drugs are not covered as part of your Vision Care benefits. Please refer to the Medical Benefits Chart earlier in this chapter for more information about outpatient prescription drugs under your medical benefits.
- Vision aids (other than Eyeglasses or Contact Lenses) are not covered.
- You pay $65.00 for the Standard Progressive Lenses Eyewear Benefit. Any difference between this amount and the retail price is Health Net Vision's responsibility.
- Cost Sharing amounts are a one-time use benefit; Health Net will not pay any remaining balances.
- Lost or broken materials are not covered, except in the next Benefit Frequency when materials would next become available.
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under the plan.
- Two pair of glasses in lieu of bifocals.
- Services or materials provided by any other group benefit plan providing vision care.
- Services rendered after your coverage ends, except when materials that were ordered before coverage ended are delivered and the services rendered to you are within 31 days from the date of such order.
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state, or subdivisions thereof.

- Discounts or promotional offers do not apply for benefits provided by other benefit plans. If a discount or promotional offer is accepted, plan benefits do not apply for the benefit period. Allowances are one-time use benefits; no remaining balance.

LIABILITY FOR PAYMENT

You will be responsible for the cost of any vision services received from a Health Net Vision nonparticipating provider, as well as any charges for services received from Health Net Vision participating providers that exceed the benefits listed in your Evidence of Coverage.

QUESTIONS?

For up-to-date provider information, to obtain authorization to receive services, or if you have any questions concerning claims about vision care services, please contact Health Net Vision at **1-866-392-6058** Monday through Saturday, 5:00 a.m. – 8:00 p.m. and Sunday 8:00 a.m. – 5:00 p.m. Pacific time (or **1-866-308-5375** TDD/TTY for the hearing and speech impaired Monday through Friday from 5:00 a.m. to 2:00 p.m. Pacific time). Or visit the Health Net Vision web site at www.healthnet.com for a list of Health Net Vision participating providers in your area.

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

Decision Power℠: Health in Balance

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

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

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

→ Staying healthy is just as important as getting well.

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

→ Your health, your time, your choice.

Whether you …

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

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

Log on to www.healthnet.com:

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

viewing, you can test your knowledge about all the pros and cons of specific treatment options with online questionnaires.

- Access information resources, such as Healthwise® Knowledgebase, an online health encyclopedia; HEAR® Audio Library, which contains information on 355 health topics; and Health Crossroads® Web Modules, which explains the pros and cons of various treatments.

Talk to a Health Coach:

With Decision Power, you get the convenience of a single point of contact for any and every health question, goal or situation. The Health Coach you talk to — a trained professional such as a nurse, respiratory therapist or dietitian — will present choices, explain options and support you based on your individual values, situation and preferences.

- **1:1 consultations** and a single point of contact: you can talk to the same Health Coach every time you call. During each call, your Health Coach will make an appointment for the next one. All our Health Coaches have experience and know-how to help you with your primary concern while exploring and addressing the range of issues that may be related to and complicated by it.
- **Answers** to health questions about fever, diaper rash, cuts, bites, etc. Always call 9-1-1 or go straight to the emergency room in a life-threatening situation.
- **Techniques** for talking to your doctor and evaluating treatment options.
- **Pointers** for setting achievable health goals on topics such as weight management, smoking cessation, stress reduction, cholesterol management, blood pressure control and more.
- **Guidance**/support for living with an ongoing illness such as asthma, diabetes, heart disease and depression, among others.
- **Specialized support** for end-stage diseases, severe trauma — expert nurse case managers work one-on-one with patients and families, facilitating any and all services that may be helpful — home care, hospice, skilled nursing, behavioral health, and more.

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

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

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

You have access to Decision Power® through your current enrollment with any of the following Health Net companies: Health Net of California, Inc. or Health Net Life Insurance Company.

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

SECTION 3 What benefits are not covered by the plan?

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

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

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

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

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

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

- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps you with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by your immediate relatives or members of your household.
- Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Hearing aids, or exams to fit hearing aids.
- Radial keratotomy, LASIK surgery, vision therapy and other low vision aids.
- Outpatient prescription drugs.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.

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

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

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

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

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

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

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

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

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed care from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
    - If the provider is owed anything, we will pay the provider directly.
    - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

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

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

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan.

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

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

- Please call Member Services for additional information about how to ask us to pay you back and deadlines for making your request.

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

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

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

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

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

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

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

Health Net of California
P.O. Box 14703
Lexington, KY 40512

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

Please be sure to contact Member Services if you have any questions. If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

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

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

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

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

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

For the details on how to make this appeal, go to Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is

a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as “appeal.” Then after you have read Section 4, you can go to Section 5.3 to learn how to make an appeal about getting paid back for a medical service.

Chapter 6. Your rights and responsibilities

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

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

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

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. This information is available for free in other languages. Please contact our Member Services at 1-800-275-4737 (TTY/TDD 1-800-929-9955). Hours of operation 8:00 a.m. to 8:00 p.m., 7 days a week. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

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

Debemos proporcionar la información de una manera que le sirva (en idiomas distintos al inglés, en Braille, en letra grande o en otros formatos alternativos, etc.)

Para obtener la información de parte nuestra de una manera que le sirva, llame al Departamento de Servicios al Afiliado (los números de teléfono aparecen en la contraportada de este folleto).

Nuestro plan cuenta con personas y servicios gratuitos de intérprete de idiomas disponibles para responder a las preguntas de los afiliados que no hablan inglés. Esta información también está disponible en forma gratuita en otros idiomas. Comuníquese con el número de nuestro Departamento de Servicios al Afiliado al 1-800-275-4737 para obtener información adicional. (Los usuarios de TTY/TDD deben llamar al 1-800-929-9955. El horario de atención es de 8:00 a.m. a 8:00 p.m., hora del Pacífico, los siete días de la semana. (Las llamadas a estos números son gratuitas). También podemos proporcionarle información en Braille, en letra grande o en otros formatos alternativos si lo necesita. Si usted es elegible para Medicare debido a una discapacidad, se nos exige que le brindemos información sobre los beneficios del plan de una manera que sea accesible y adecuada para usted.

Si tiene dificultades para obtener información de parte de nuestro plan por problemas relacionados con el idioma o la discapacidad, llame a Medicare al 1-800-MEDICARE (1-800-633-4227), las 24 horas del día, los 7 días de la semana, e infórmeles que desea presentar una queja. Los usuarios de TTY deben llamar al 1-877-486-2048.

Chúng tôi phải cung cấp thông tin theo cách mà quý vị sử dụng được (bằng ngôn ngữ khác hơn tiếng Anh, bằng chữ nổi, bản in chữ lớn, hoặc những hình thức khác, v.v.)

Để có thông tin chúng tôi cung cấp mà quý vị sử dụng được, xin vui lòng gọi cho Ban Phục vụ Hội viên (số điện thoại ở bìa sau của tập sách này).

Chương trình của chúng tôi có nhân viên và dịch vụ thông dịch miễn phí để trả lời câu hỏi từ các hội viên không biết tiếng Anh. Thông tin này cũng được cung cấp miễn phí qua nhiều ngôn ngữ khác. Xin quý vị liên lạc với Ban Phục vụ Hội viên tại số 1-800-275-4737 để biết thông tin chi tiết. (Người dùng TTY/TDD xin gọi 1-800-929-9955. Giờ làm việc từ 8 giờ sáng đến 8 giờ tối, giờ miền Tây, bảy ngày một tuần. (Các số điện thoại này được gọi miễn phí). Ngoài ra, chúng tôi có thể cung cấp thông tin bằng bằng chữ nổi, bản in chữ lớn, hoặc những hình thức khác nếu quý vị cần. Nếu quý vị đủ điều kiện để được hưởng bảo hiểm Medicare vì khuyết tật, chúng tôi bắt buộc phải cung cấp cho quý vị thông tin về quyền lợi của chương trình bằng cách thức quý vị sử dụng, tham khảo được và thích hợp với quý vị.

Nếu quý vị gặp khó khăn trong việc nhận thông tin từ chương trình bảo hiểm chúng tôi vì những vấn đề có liên quan đến ngôn ngữ hoặc tình trạng khuyết tật, xin vui lòng gọi cho Medicare ở số 1-800-MEDICARE (1-800-633-4227), 24/24, 7 ngày một tuần, và cho nhân viên tại đây biết là quý vị muốn nộp đơn khiếu nại. Người dùng TTY xin gọi 1-877-486-2048.

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

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

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

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

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

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

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

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

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

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

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

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
    - For example, we are required to release health information to government agencies that are checking on quality of care.

- Because you are a member of our plan through Medicare, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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

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

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

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

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

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

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

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers.**
  - For example, you have the right to get information from us about the qualifications of the providers in our network and how we pay the providers in our network.
  - For a list of the providers in the plan's network, see the *Provider Directory*.
  - For more detailed information about our providers, you can call Member Services (phone numbers are on the back cover of this booklet) or visit our website at www.healthnet.com

- **Information about your coverage and rules you must follow in using your coverage.**
    - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
    - If you have questions about the rules or restrictions, please call Member Services (phone numbers are on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
    - If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service from an out-of-network provider.
    - If you are not happy or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
    - If you want to ask our plan to pay our share of a bill you have received for medical care, see Chapter 5 of this booklet.

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

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

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan.

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

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

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

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself**,** and to name an alternative person as backup.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself, such as for life support treatment.

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

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker**,** from the California Medical Association by calling 1-800-882-1262 (National Relay Service: 711), or from some office supply stores**.** You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms (phone numbers are on the back cover of this booklet).
- You can also contact Member Services to ask for the forms (phone numbers are on the back cover of this booklet).
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. It must be notarized or witnessed by two qualified individuals. You should consider having a lawyer help you prepare it.

- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

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

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

Physician Orders for Life Sustaining Treatment (POLST)

You may also consider completing a POLST form if you are terminally ill or in frail health. This form must be signed by your physician and allows you to give specific end-of-life treatment instructions, such as for pain management, resuscitation, feeding procedures and other medical interventions. It has the force of a physician's medical order and remains with you wherever you receive care. It is in addition to, and does not replace an advance directive.

What if your instructions are not followed?

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 your local Office for Civil Rights.

Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, Suite 4-100
San Francisco, CA 94103

The telephone number is 1-800-368-1019 or 1-415-437-8310 (TTY: 1-415-437-8311).

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

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

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

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

Section 1.8 Evaluation of new technologies

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

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

Section 1.9 What can you do if you think you are being treated unfairly or your rights are not being respected?

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

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

Is it about something else?

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

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

Section 1.10 How to get more information about your rights

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

- You can **call Member Services** (phone numbers are on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
    - You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf.)
    - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 2.1 What are your responsibilities?

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

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

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

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

- ***Tell us if you move.*** *If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are on the back cover of this booklet).*
    - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
    - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.

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

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

BACKGROUND

COVERAGE DECISIONS AND APPEALS

MAKING COMPLAINTS

BACKGROUND

SECTION 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?

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

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

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

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

Section 2.1 Where to get more information and personalized assistance

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

Get help from an independent government organization

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

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

You can also get help and information from Medicare

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

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

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

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

COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions

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

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

Making an appeal

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

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

If we say no to all or part of your Level 1 Appeal, your case will automatically go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to

us. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

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

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

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

Section 4.3 Which section of this chapter gives the details for <u>your</u> situation?

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

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

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

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

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

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

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

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.
3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.

5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
    - NOTE: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services,** you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
        - Chapter 7, Section 6: *How to ask us for a longer hospital stay if you think you are being asked to leave the hospital too soon.*
        - Chapter 7, Section 7: *How to ask us to keep covering certain medical services if you think your coverage is ending too soon.* This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
    - For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

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

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

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

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

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

How to request coverage for the medical care you want

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

Generally we use the standard deadlines for giving you our decision

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

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

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

- **A fast decision means we will answer within 72 hours.**
  - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing, or if you need time to get

information to us for the review. If we decide to take extra days, we will tell you in writing.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What to do

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

- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
    - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
    - If you wish, you and your doctor may give us additional information to support your appeal.

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

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

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

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

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

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

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
    - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days.** If we decide to take extra days to make the decision, we will tell you in writing.
    - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

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

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

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

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

Section 5.4 Step-by-step: How to make a Level 2 Appeal

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

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

Step 1: The Independent Review Organization reviews your appeal.

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

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

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

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

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

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

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

- **If the review organization says yes to part or all of what you requested,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
    - The written notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

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

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

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

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

Asking for reimbursement is asking for a coverage decision from us

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

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. (When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

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

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

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

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

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

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

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

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

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

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

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

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

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

3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
   - If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
   - To look at a copy of this notice in advance, you can call Member Services or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

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

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

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

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

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

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

What is the Quality Improvement Organization?

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

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)

- If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
- If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.

- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.

Ask for a "fast review":

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

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

<u>Step 2:</u> The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process.

Section 6.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If we turn down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this

review only if you stayed in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **We must continue providing coverage for your hospital care for as long as it is medically necessary.**
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made on your Level 1 Appeal and will not change it. This is called "upholding the decision."
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 6.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 6.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you

leave the hospital and no later than your planned discharge date). If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms	A "fast" review (or "fast appeal") is also called an **"expedited appeal"**.

Step 1: Contact us and ask for a "fast review."

- For details on how to contact our plan, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are making an appeal about your medical care*.
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast" review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your hospital services ends as of the day we said coverage would end.

- If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

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

Step-by-Step: How to make a Level 2 *Alternate* Appeal

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

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

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your hospital services for as long as it is medically necessary. You must continue to pay your share

of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 7.1 *This section is about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is about the following types of care *only*:

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 10, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 10, *Definitions of important words*.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any

limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Section 7.2 We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice.
   - The written notice tells you the date when we will stop covering the care for you.
   - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms	In telling you what you can do, the written notice is telling how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 7.3 below tells how you can request a fast-track appeal.)

Legal Terms	The written notice is called the "**Notice of Medicare Non-Coverage."** To get a sample copy, call Member Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or see a copy online at http://www.cms.hhs.gov/BNI/

2. **You must sign the written notice to show that you received it.**
   - You or someone who is acting on your behalf must sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan that it's time to stop getting the care.

Section 7.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 9 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services (phone numbers are on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care*.

- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers informed us of your appeal, and you will also get a written notice from us that gives our reasons for ending our coverage for your services.

Legal Terms	This notice explanation is called the "**Detailed Explanation of Non-Coverage.**"

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** We will stop paying its share of the costs of this care.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is "Level 1" of the appeals process. If reviewers say *no* to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Section 7.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If we turn down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.

- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms	A "fast" review (or "fast appeal") is also called an **"expedited appeal"**.

Step 1: Contact us and ask for a "fast review."

- For details on how to contact us, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are making an appeal about your medical care*.
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast" review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a "fast review," we are allowed to decide whether to agree to your request and give you a "fast review." But in this situation, the rules require us to give you a fast response if you ask for it.)

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** then your coverage will end on the date we have told you and we will not pay after this date. We will stop paying its share of the costs of this care.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

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

Step-by-Step: How to make a Level 2 *Alternate* Appeal

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

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

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 9 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 8 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 Taking your appeal to Level 3 and beyond

Section 8.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal	**A judge who works for the Federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **If the Administrative Law Judge says yes to your appeal, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the judge's decision.
  - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge says no to your appeal, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.

- If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal	The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over -** We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Medicare Appeals Council denies the review request, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the **Federal District Court** will review your appeal.

- This is the last step of the administrative appeals process.

MAKING COMPLAINTS

SECTION 9 How to make a complaint about quality of care, waiting times, customer service, or other concerns

? If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 9.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint"

Quality of your medical care

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Member Services has treated you?
- Do you feel you are being encouraged to leave the plan?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors or other health professionals? Or by our Member Services or other staff at the plan?
    - Examples include waiting too long on the phone, in the waiting room, or in the exam room.

Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

Information you get from us

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

The next page has more examples of possible reasons for making a complaint

Possible complaints
(continued)

These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in sections 4-8 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast response" for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 9.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms

- What this section calls a **"complaint"** is also called a **"grievance."**
- Another term for **"making a complaint"** is **"filing a grievance."**
- Another way to say "**using the process for complaints"** is "**using the process for filing a grievance."**

Section 9.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. 1-800-275-4737. Calls to this number are free. Hours of Operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. TTY/TDD: 1-800-929-9955.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- If you ask for a written response, file a written complaint (grievance), or if your complaint is related to quality of care, we will respond to you in writing. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaint. We call this the Grievance Procedure.** To make a complaint, or if you have questions about this procedure, please call Member Services at the phone number above. Or, you may mail or fax us a written request to the address or fax number listed under Appeals for Medical Care or Complaints about Medical Care in Chapter 2 of this booklet.
    - You need to file your complaint within 60 calendar days after the event. You can submit your complaint, formally, in writing or via fax at the address or fax number listed under Appeals for Medical Care or Complaints about Medical Care in Chapter 2 of this booklet.
    - We must notify you of our decision about your complaint as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.
    - In certain cases, you have the right to ask for a fast review of your complaint . This is called the Expedited Grievance Procedure. You are entitled to a fast review of your complaint if you disagree with our decision in the following situations:
        - We deny your request for a fast review of a request for medical care.
        - We deny your request for a fast review of an appeal of denied services.
        - We decide additional time is needed to review your request for medical care.
        - We decide additional time is needed to review your appeal of denial medical care.
    - You may submit this type of complaint by phone by calling Member Services at the number on the back cover of this booklet. You may also submit the complaint to us in writing or by fax at the address or fax number listed under Appeals for

Medical Care or Complaints about Medical Care in Chapter 2 of this booklet. Once we receive the expedited grievance (complaint), a Clinical Practitioner will review the case to determine the reasons for the denial of your request for a fast review or if the case extension was appropriate. We will notify you of the decision of the fast case orally and in writing within 24 hours of receiving your complaint.

- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.

- **If you are making a complaint because we denied your request for a "fast response" to a coverage decision or appeal, we will automatically give you a "fast" complaint.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours.**

Legal Terms	What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.

- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).

- The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

- To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.

- **Or, you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Chapter 8. Ending your membership in the plan

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

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

- You might leave our plan because you have decided that you *want* to leave.
    - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
    - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the annual Medicare Advantage Disenrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (also known as the "Annual Coordinated Election Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7 in 2011.
- **What type of plan can you switch to during the Annual Enrollment Period?** During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your

coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:

- Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
- Original Medicare *with* a separate Medicare prescription drug plan.
- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited

You have the opportunity to make *one* change to your health coverage during the annual **Medicare Advantage Disenrollment Period**.

- **When is the annual Medicare Advantage Disenrollment Period?** This happens every year from January 1 to February 14.

- **What type of plan can you switch to during the annual Medicare Advantage Disenrollment Period?** During this time, you can cancel your Medicare Advantage Plan enrollment and switch to Original Medicare. If you choose to switch to Original Medicare during this period, you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage.

- **When will your membership end?** Your membership will end on the first day of the month after we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of our plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (http://www.medicare.gov):
  - Usually, when you have moved.
  - If you have Medicaid.

  - If we violate our contract with you.
  - If you are getting care in an institution, such as a nursing home or long-term care hospital.
  - If you enroll in the Program of All-inclusive Care for the Elderly (PACE).

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.

- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can **call Member Services** (phone numbers are on the back cover of this booklet).
- You can find the information in the ***Medicare & You 2012*** Handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (http://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 How do you end your membership in our plan?

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. (Contact Member Services if you need more information on how to do this.)
- --*or*--You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health plan.	• Enroll in the new Medicare health plan. You will automatically be disenrolled from our plan when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from our plan when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan.	• **Send us a written request to disenroll.** Contact Member Services if you need more information on how to do this (phone numbers are on the back cover of this booklet).

If you would like to switch from our plan to:	This is what you should do:
	• You can also contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from our plan when your coverage in Original Medicare begins.

SECTION 4 Until your membership ends, you must keep getting your medical services through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care through our plan.

- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 Our plan must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

Our plan must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you move out of our service area for more than six months.
    - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area.

- If you become incarcerated (go to prison).
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
    - We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get medical care.
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for 90 days.
    - We must notify you in writing that you have 90 days to pay the plan premium before we end your membership.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Member Services** for more information (phone numbers are on the back cover of this booklet).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 9 for information about how to make a complaint.

Chapter 9. Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

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

SECTION 3 Membership card

A membership card issued by Health Net under this Evidence of Coverage is for identification purposes only. Possession of a membership card does not confer any right to services or other benefits under this Evidence of Coverage. To be entitled to services or benefits under this Evidence of Coverage, the holder of the card must be eligible for coverage and be a member under this Evidence of Coverage. Any person receiving services to which he or she is not then entitled under this Evidence of Coverage will be responsible for payment for those services. A Member must present their Health Net membership card, not their Medicare card, when receiving services. Please call Member Services at the number located on the back cover of this booklet if you need your membership card replaced.

Note: Any member knowingly permitting abuse or misuse of the membership card may be disenrolled for cause. Health Net is required to report a disenrollment that results from membership card abuse or misuse to the Office of the Inspector General, which may result in criminal prosecution.

SECTION 4 Independent contractors

The relationship between Health Net and each participating provider is an independent contractor relationship. Participating providers are not employees or agents of Health Net and neither Health Net, nor any employee of Health Net, is an employee or agent of a participating provider. In no case will Health Net be liable for the negligence, wrongful act, or omission of any

participating or other health care provider. Participating physicians, and not Health Net, maintain the physician-patient relationship with the member. Health Net is not a provider of care.

SECTION 5 Health care plan fraud

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

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

SECTION 6 Circumstances beyond Health Net's control

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

SECTION 7 Recovery of benefits paid by Health Net under your Health Net Seniority Plus Green (HMO) plan

When you are injured

If you are ever injured through the actions of another person, or yourself (responsible party), Health Net will provide benefits for all covered services that you receive through this Plan. However, if you receive money or are entitled to receive money because of your injuries, whether through a settlement, judgment or any other payment associated with your injuries, Health Net or the medical providers retain the right to recover the value of any services provided to you through this Plan.

As used throughout this provision, the term responsible party means any party actually or potentially responsible for making any payment to a Member due to a Member's injury, illness or condition. The term responsible party includes the liability insurer of such party or any insurance coverage.

Some examples of how you could be injured through the actions of a responsible party are:

- You are in a car accident;
- You slip and fall in a store.

Health Net's rights of recovery apply to any and all recoveries made by you or on your behalf from the following sources, including but not limited to:

- Payments made by a third party or any insurance company on behalf of a third party;
- Uninsured or underinsured motorist coverage;
- Personal injury protection, no fault or any other first party coverage;
- Workers Compensation or Disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' insurance coverage, umbrella coverage;
- Medical expenses incurred as a result of medical malpractice; and
- Any other payments from any other source received as compensation for the responsible party's actions.

By accepting benefits under this Plan, you acknowledge that Health Net has a first priority right of subrogation and reimbursement that attaches when this Plan has paid for health care benefits for expenses incurred due to the actions of a responsible party and you or your representative recovers or is entitled to recover any amounts from a responsible party.

By accepting benefits under this Plan, you also grant Health Net an assignment of your right to recover medical expenses from any coverage available to the extent of the full cost of all covered services provided by the Plan and you specifically direct such carriers to directly reimburse the Plan on your behalf.

By accepting benefits under this Plan, you also grant Health Net a first priority lien on any recovery, settlement or judgment, or other source of compensation and all reimbursement due Health Net for the full cost of benefits paid under the Plan that are associated with injuries through a responsible party regardless of whether specifically identified as recovery for medical expenses and regardless of whether you are made whole or fully compensated for your loss. Health Net may recover the full cost of all benefits provided by this Plan without regard to any claim of fault on the part of the Member, whether by comparative negligence or otherwise. No attorney fees may be deducted from Health Net's recovery, and Health Net is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue the claim or lawsuit against any responsible party.

Steps you must take

If you are injured because of a responsible party, you must cooperate with Health Net and/or the medical providers' efforts to recover its expenses, including:

- Telling Health Net and the medical providers the name and address of the responsible party, if you know it, the name and address of your lawyer, if you are using a lawyer, the name and address of any insurance company involved with your injuries and describing how the injuries were caused.
- Completing any paperwork that Health Net or the medical providers may reasonably require to assist in enforcing the lien.
- Promptly responding to inquiries from Health Net about the status of the case and any settlement discussions.
- Notifying Health Net immediately upon you or your lawyer receiving any money from the responsible parties, any insurance companies, or any other source.
- Pay the health care lien from any recovery, settlement or judgment, or other source of compensation and all reimbursement due Health Net for the full cost of benefits paid under the Plan that are associated with injuries through a responsible party regardless of whether specifically identified as recovery for medical expenses and regardless of whether you are made whole or fully compensated for your loss;
- Do nothing to prejudice Health Net's rights as set forth above. This includes, but is not limited to, refraining from any attempts to reduce or exclude from settlement or recovery the full cost of all benefits paid by the plan; and
- Hold any money that you or your lawyer receive from the responsible parties, or from any other source, in trust, and reimbursing Health Net and the medical providers for the amount of the lien as soon as you are paid.

SECTION 8 Notice of privacy practices

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

*Nonpublic personal financial information includes personally identifiable financial information that you provided to us to obtain insurance or we obtained in providing benefits to you. Examples include Social Security numbers, account balances and payment history. We do not disclose any nonpublic personal information about you to anyone, except as permitted by law. This Notice tells you about the ways in which Health Net (referred to as "we" or "the Plan") may collect, use and disclose your protected health information and your rights concerning your protected health information. "Protected health information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We are required by federal and state laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in

this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

How we may use and disclose your protected health information

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

- **Payment.** We use and disclose your protected health information in order to pay for your covered health coverage or expenses. For example, we may use your protected health information to process claims, to be reimbursed by another insurer that may be responsible for payment or for premium billing.

- **Health Care Operations.** We use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or Member Services.

- **Treatment.** We may use and disclose your protected health information to assist your health care providers (doctors, pharmacies, hospitals and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.

- **Plan Sponsor.** If you are enrolled through a group health plan, we may provide non-identifiable summaries of claims and expenses for enrollees in your group health plan to the plan sponsor, which is usually the employer.

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

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

Other Permitted or Required Disclosures

- **As Required by Law.** We must disclose protected health information about you when required to do so by law.

- **Public Health Activities.** We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.

- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose protected health information to government agencies about abuse, neglect or domestic violence.

- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g., California Department of Health Services) for activities authorized by law.

- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.

- **Law Enforcement**. We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

- **Coroners, Funeral Directors, Organ Donation**. We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.

- **Research.** Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.

- **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Special Government Functions.** We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.

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

Other Uses or Disclosures with an Authorization

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

Your rights regarding your protected health information

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

- **Right to Access Your Protected Health Information.** You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.

- **Right to Amend Your Protected Health Information.** If you feel that protected health information maintained by the Plan is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by the Plan, as is often the case for health information in our records, or you ask to amend a record that is already accurate and complete.

  If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.

- **Right to an Accounting of Disclosures by the Plan.** You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

  Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.

- **Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. *We may*

not agree to your request. If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

- **Right to Receive Confidential Communications.** You have the right to request that we use a certain method to communicate with you about the Plan or that we send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice**. You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.

- **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by contacting our Privacy Office. See the end of this Notice for the contact information.

Health Information Security

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

Changes to This Notice

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

Address: Health Net Privacy Office
Attention: Director, Information Privacy
P.O. Box 9103
Van Nuys, CA 91409

You may also contact us at:

Telephone: 1-800-522-0088
Fax: 1-818-676-8314

Email: Privacy@healthnet.com

Chapter 10. Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – A set time each fall when members can change their health or drugs plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7, 2011.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for an item or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Balance Billing – A situation in which a provider (such as a doctor or hospital) bills a patient more than the plan's cost-sharing amount for services. As a member of our plan, you only have to pay the plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" you. See Chapter 4, Section 1.3 for more information about balance billing.

Benefit Period –The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services. Coinsurance is usually a percentage (for example, 20%).

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription.

Cost Sharing – Cost sharing refers to amounts that a member has to pay when services are received. Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed "copayment" amount that a plan requires when a specific service is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

Covered Services – The general term we use to mean all of the health care services and supplies that are covered by our plan.

Custodial Care – Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Deductible – The amount you must pay for health care before our plan begins to pay.

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

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

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

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to 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.

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.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, if you're eligible for Part B when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered services. Amounts you pay for your Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.2 for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medical Group – A group of Physicians, who are organized as a legal entity, that has an agreement in effect with our plan to provide Medicare care to our members.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a PACE plan, or a Medicare Advantage Plan.

Medicare Advantage Disenrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to Original Medicare. The Medicare Advantage Disenrollment Period is from January 1 until February 14, 2012.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Health Net Seniority Plus Green (HMO) does not offer Medicare 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 Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

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

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

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

Organization Determination – The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for "cost sharing" above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's "out-of-pocket" cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

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

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1 for information about Primary Care Provider.

Prior Authorization – Approval in advance to get services. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

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

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's

also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drugs plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

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 – Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care, but the plan's network of providers is temporarily unavailable or inaccessible.

Usual, Customary and Reasonable (UCR) – Maximum allowable amount for a dental service based on fees usually charged by providers for that service in the same geographic area.

Health Net Seniority Plus Green (HMO) Member Services

CALL	1-800-275-4737 Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. Please see Chapter 2, Section 1 under "Member Services" for Member Services hours of operation during the annual enrollment period. Member Services also has free language interpreter services available for non-English speakers.
TTY/TDD	1-800-929-9955 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	1-818-676-8100
WRITE	Health Net Medicare Programs P.O. Box 10198 Van Nuys, CA 91410-0198
WEBSITE	www.healthnet.com

California Health Insurance Counseling Advocacy Program (HICAP)

HICAP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

CALL	1-800-434-0222
TTY/TDD	1-800-735-2929 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	HICAP 1300 National Drive, Suite 200 Sacramento, CA 95834-1992
WEBSITE	www.cahealthadvocates.org