



January 1 – December 31, 2018

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, 2018. It explains how to get coverage for the health care services you need.

This is an important legal document. Please keep it in a safe place.

This plan, **Health Net 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).)

Health Net of California, Inc. has a contract with Medicare to offer HMO plans. Enrollment in a Health Net Medicare Advantage plan depends on the renewal of these contracts.

This document is available for free in Spanish.

Please contact our Member Services number at 1-800-275-4737 for additional information. (TTY users should call 711). From October 1 to February 14, you can call us 7 days a week from 8 a.m. to 8 p.m. From February 15 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

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

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2019.

The provider network may change at any time. You will receive notice when necessary.

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CHAPTER 1

Getting started as a member

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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).

Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at: <https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families>, for more information.

There are different types of Medicare health plans. Our plan is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company. Our plan does not include Part D prescription drug coverage.

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.

The word “coverage” and “covered services” refers to the medical care and services available to you as a member of Health Net Seniority Plus Green (HMO).

It's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

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

Section 1.3 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, 2018 and December 31, 2018.

Chapter 1. Getting started as a member

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of our plan after December 31, 2018. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2018.

Medicare must approve our plan each year

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

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

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- *and* -- You live in our geographic service area (Section 2.3 below describes our service area)
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *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 Medicare Advantage plan that was terminated.

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

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

- Medicare Part A generally helps cover services provided by hospitals (for inpatient services, skilled nursing facilities, or home health agencies.)
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment (DME) and supplies).

Section 2.3 Here is the plan service area for Health Net Seniority Plus Green (HMO)

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 continue to reside in the plan service area. The service area is described below.

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Our service area includes these counties in California: Alameda, Placer, Sacramento, Sonoma, Stanislaus.

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

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

Section 2.4 U.S. Citizen or Lawful Presence

A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify Health Net Seniority Plus Green (HMO) if you are not eligible to remain a member on this basis. Health Net Seniority Plus Green (HMO) must disenroll you if you do not meet this requirement.

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. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:

		HMO CMS#: <XXXX-XX> Effective: <MM-DD-YYYY>		FOR MEMBERS Member Services: <X-XXX-XXX-XXXX> <(TTY: XXX)> Mental Health Benefits: <X-XXX-XXX-XXXX> <(TTY: X-XXX-XXX-XXXX)> 24-hr Nurse Advice: <X-XXX-XXX-XXXX> <(TTY: XXX)> ca.healthnetadvantage.com		FOR EMERGENCIES Dial 911 or go to the nearest Emergency Room (ER).	
MEMBER INFORMATION Name: <First Last> Member ID#: <XXXXXXXX-XX> Issuer ID: <(80840)> <9151014609>		PHARMACY INFORMATION  Prescription Drug Coverage Part B Drugs Only Rx Claims Processor: <CVS Caremark> RXBIN: <XXXXXX> RXPCN/RXGRP: <XXXX>		FOR PROVIDERS  For eligibility, prior authorization or case management referrals: <X-XXX-XXX-XXXX>  Pharmacy prior auth: <X-XXX-XXX-XXXX> For help with Part B Drugs: (PHARMACY USE ONLY) <X-XXX-XXX-XXXX>			
PROVIDER INFORMATION PPG Name: <> PPG Phone: <> PCP Name: <> PCP Phone: <> PCP Office Visit: <\$XX>				MEDICAL CLAIMS EDI Payor ID: 95567 Health Net - Attn: Claims P.O. Box 9030, Farmington, MO 63640-9030			

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

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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. (Phone numbers for Member Services are printed on the back cover of this booklet.)

Section 3.2	The <i>Provider Directory</i>: Your guide to all providers in the plan's network
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The *Provider Directory* lists our network providers.

What are “network providers”?

Network providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers is available on our website at <https://ca.healthnetadvantage.com>.

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. In addition, you may be limited to providers within your Primary Care Provider's (PCP's) and/or Medical Group's network. This means that the PCP and/or Medical Group that you choose may determine the specialists and hospitals you can use. See Chapter 3 (Using the plan's coverage for your medical services) for more information about choosing a PCP. The only exceptions are emergencies, urgently needed services 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 (phone numbers are printed on the back cover of this booklet). You may ask Member Services for more information about our network providers, including their qualifications. You can also see the *Provider Directory* at <https://ca.healthnetadvantage.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?

As a member of our plan, you pay a monthly plan premium. For 2018, the monthly premium for our plan is \$139. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

In some situations, your plan premium could be more

If you signed up for extra benefits, also called “optional supplemental benefits,” then you pay an additional premium each month for these extra benefits. If you have any questions about your plan premiums, please call Member Services (phone numbers are printed on the back cover of this booklet).

- If you enroll in Optional Supplemental Benefits Package 1, you pay an additional monthly premium of \$19.
- If you enroll in Optional Supplemental Benefits Package 2, you pay an additional monthly premium of \$30.

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

Many members are required to pay other Medicare premiums

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

Your copy of *Medicare & You 2018* gives information about these premiums in the section called “2018 Medicare Costs.” This explains how the Medicare Part B premium differs for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2018* from the Medicare website (<https://www.medicare.gov>). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

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

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

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

Option 1: You can pay by check or money order

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

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

Health Net of California
PO Box 748658
Los Angeles, CA 90074-8658

Checks or money orders should be made payable to Health Net, Inc., and not to the Centers for Medicare & Medicaid Services (CMS) nor the United States Department of Health and Human Services (HHS). Premium payments may not be dropped off at the plan's office.

Option 2: You can have the plan premium taken out of your monthly Social Security check

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

Option 3: You can have the plan premium taken out of your monthly Railroad Retirement Board (RRB) check

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

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

Your plan premium is due in our office by the 1st of each month. If we have not received your premium by the 7th business day of the month, we will send you a notice telling you that your plan membership will end if we do not receive your premium payment within two months.

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

If we end your membership because you did not pay your premiums, you will have health coverage under Original Medicare.

At the time we end your membership, you may still owe us for premiums you have not paid. In the future, if you want to enroll again in our plan (or another plan that we offer), you will need to pay the late premiums before you can enroll.

If you think we have wrongfully ended your membership, you have a right to ask us to reconsider this decision by making a complaint. Chapter 7, Section 9 of this booklet tells how to make a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your premiums within our grace period, you can ask us to reconsider this decision by calling 1-800-275-4737 between 8:00 a.m. to 8:00 p.m. TTY users should call 711. You must make your request no later than 60 days after the date your membership ends.

Section 4.3	Can we change your monthly plan premium during the year?
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No. We are not allowed to change the amount we charge for the plan's monthly plan premium during the year. If the monthly plan premium changes for next year we will tell you in September and the change will take effect on January 1.

SECTION 5 **Please keep your plan membership record up to date**

Section 5.1	How to help make sure that we have accurate information about you
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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 and Medical Group. For a description of these types of providers, see Chapter 10 (*Definitions of important words*).

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

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Let us know about these changes:

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

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

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

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

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

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

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected
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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 number of people employed by your 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 are still working, your group health plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan that has more than 100 employees.
 - If you’re over 65 and you or your spouse are still working, your group health plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan that has more than 20 employees.
- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

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

CHAPTER 2

*Important phone numbers
and resources*

Chapter 2. Important phone numbers and resources

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Chapter 2. Important phone numbers and resources

SECTION 1 Health Net Seniority Plus Green (HMO) 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.

Method	Member Services – Contact Information
CALL	<p>1-800-275-4737</p> <p>Calls to this number are free. 8:00 a.m. to 8:00 p.m., seven days a week.</p> <p>From October 1 through February 14, our plan operates a toll-free call center for both current and prospective members that is staffed seven days a week from 8:00 a.m. to 8:00 p.m. During this time period, current and prospective members are able to speak with a Member Service representative.</p> <p>However, after February 14, our office hours are 8:00 a.m. to 8:00 p.m., Monday through Friday. On weekends and certain holidays, your call will be handled by our automated phone system. 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.</p> <p>Member Services also has free language interpreter services available for non-English speakers.</p>
TTY	<p>711 (National Relay Services)</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free. 8:00 a.m. to 8:00 p.m., seven days a week.</p>
FAX	1-866-214-1992
WRITE	<p>Health Net Medicare Programs PO Box 10420 Van Nuys, CA 91410-0420</p>
WEBSITE	https://ca.healthnetadvantage.com

Chapter 2. Important phone numbers and resources**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.

Method	Coverage Decisions for Medical Care – Contact Information
CALL	1-800-275-4737 Calls to this number are free. 8:00 a.m. to 8:00 p.m., seven days a week.
TTY	711 (National Relay Services) 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., seven days a week.
FAX	1-800-793-4473 or 1-800-672-2135
WRITE	Health Net Medical Management 21281 Burbank Blvd. Woodland Hills, CA 91367
WEBSITE	https://ca.healthnetadvantage.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)*).

Method	Appeals for Medical Care – Contact Information
CALL	1-800-275-4737 Calls to this number are free. Calls to this number are free. 8:00 a.m. to 8:00 p.m., seven days a week.

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Method	Appeals for Medical Care – Contact Information
TTY	711 (National Relay Services) 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., seven days a week.
FAX	1-877-713-6189
WRITE	Health Net Medicare Programs Appeals and Grievances Dept. PO Box 10344 Van Nuys, CA 91410-0344
WEBSITE	https://ca.healthnetadvantage.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)*).

Method	Complaints about Medical Care – Contact Information
CALL	1-800-275-4737 Calls to this number are free. 8:00 a.m. to 8:00 p.m., seven days a week
TTY	711 (National Relay Services) 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., seven days a week.
FAX	1-877-713-6189

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Method	Complaints about Medical Care – Contact Information
WRITE	Health Net Medicare Programs Appeals and Grievances Dept. PO Box 10344 Van Nuys, CA 91410-0344
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare go to https://www.medicare.gov/MedicareComplaintForm/home.aspx .

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

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

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

Method	Payment Requests – Contact Information
CALL	1-800-275-4737 Calls to this number are free. 8:00 a.m. to 8:00 p.m., seven days a week
TTY	711 (National Relay Services) 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., seven days a week.
FAX	1-800-793-4473 or 1-800-672-2135
WRITE	Health Net of California, Inc. PO Box 14703 Lexington, KY 40512-4703
WEBSITE	https://ca.healthnetadvantage.com

Chapter 2. Important phone numbers and resources

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.

Method	Medicare – Contact Information
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	https://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. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: <ul style="list-style-type: none"> • Medicare Eligibility Tool: Provides Medicare eligibility status information. • Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an <i>estimate</i> of what your out-of-pocket costs might be in different Medicare plans.

Chapter 2. Important phone numbers and resources

Method	Medicare – Contact Information
WEBSITE (CONTINUED)	<p>You can also use the website to tell Medicare about any complaints you have about our plan:</p> <ul style="list-style-type: none"> • Tell Medicare about your complaint: You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. <p>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 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. (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.)</p>

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 the 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.

Method	HICAP (California SHIP)– Contact Information
CALL	1-800-434-0222
TDD/TTY	1-800-735-2929 (CA Relay Service) or 711 (National Relay Service)
WRITE	<p><u>County specific agencies available at:</u></p> <p>www.aging.ca.gov/HICAP/Contact_HICAP/County_List/</p>

Chapter 2. Important phone numbers and resources

Method	HICAP (California SHIP)– Contact Information
WEBSITE	www.aging.ca.gov/hicap

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

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For California, the Quality Improvement Organization is called Livanta.

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

You should contact Livanta in any of these situations:

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

Method	Livanta California’s Quality Improvement Organization)– Contact Information
CALL	1-877-588-1123
TTY	1-855-887-6668 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Livanta BFCC-QIO Program, Area 5 9090 Junction Drive, Suite 10 Annapolis Junction, MD 20701
WEBSITE	www.BFCCQIOAREA5.com

Chapter 2. Important phone numbers and resources**SECTION 5 Social Security**

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

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

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

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

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

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

Chapter 2. Important phone numbers and resources

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

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

Method	Department of Health Care Services (California's Medicaid program)– Contact Information
CALL	<p><u>Eligibility</u> 1-800-541-5555 or 1-916-552-9200</p> <p><u>Managed Care:</u> 1-916-449-5000 or 1-916 636-1980</p> <p><u>DHCS:</u> 1-916-445-4171</p>
TTY	<p>711 (National Relay Service)</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p>
WRITE	<p><u>Managed Care:</u> Department of Health Care Services PO Box 997413, MS 4400 Sacramento, CA 95899-7413</p>
WEBSITE	<p>www.medi-cal.ca.gov</p>

SECTION 7 How to contact the Railroad Retirement Board

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

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

Chapter 2. Important phone numbers and resources

Method	Railroad Retirement Board – Contact Information
CALL	<p>1-877-772-5772</p> <p>Calls to this number are free.</p> <p>Available Mon/Tues/Thurs/Friday: 9:00am to 3:30 pm</p> <p>Wed: 9:00 a.m. to 12:00 p.m.</p> <p>Any calls after 3:15 p.m. will be automatically routed to voicemail.</p> <p>If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.</p>
TTY	<p>1-312-751-4701</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are <i>not</i> free.</p>
WEBSITE	https://secure.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 as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse’s) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this booklet.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

CHAPTER 3

*Using the plan's coverage
for your medical services*

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

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

This chapter explains what you need to know about using the plan to get your medical care 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 when you get this care, use the 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”?
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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 bill us directly for care they give you. When you see a network provider, you 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 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.

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

- **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, our plan 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 services. 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 or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services 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. The plan or your Medical Group 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.
 - The plan covers 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
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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 specializing in family practice, general practice, internal medicine, and gynecologists who provide care for women.

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

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 Sections 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. The PCP you choose must be with a Medical Group located within 30 miles or 30 minutes from where you live or work. Medical Groups (and their affiliated PCPs and hospitals) can be found in the *Provider Directory* or you may visit our website at <https://ca.healthnetadvantage.com>. To confirm the availability of a provider, or to ask about a specific PCP, please contact Member Services at the phone number printed on the back cover of this booklet.

Each Medical Group and PCP may make referrals to certain plan specialists and uses certain hospitals within their network. If there is a particular plan specialist or hospital that you want to use, check first to be sure that the specialists and/or hospitals are in the Medical Group and PCP's network. The name and office telephone number of your PCP are printed on your membership card.

If you do not choose a Medical Group or PCP or if you chose a Medical Group or PCP that is not available with this plan, we will automatically assign you to a Medical Group and PCP near your home.

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 visit our website at <https://ca.healthnetadvantage.com> to make your request.

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). Each Medical Group and PCP may make referrals to certain plan specialists and uses certain hospitals within their network. This means that the Medical Group and PCP you choose may determine the specialists and hospitals you may use. If there are specific specialists or hospitals you want to use, find out if your Medical Group or PCP uses these specialists or hospitals. Member Services will let you know how you can continue with the specialty care and other services you have been getting when you change your PCP. Member Services will also check to be sure the PCP you want to switch to is accepting new patients. Your membership record will be changed to show the name of your new PCP and Member Services will 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?
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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 services from 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. Phone numbers for Member Services are printed on the back cover of this booklet.)

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 care for patients with cancer.
- Cardiologists care for patients with heart conditions.
- Orthopedists 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 additional care, check first to be sure that the referral (approval in advance) you got from your PCP for the first visit covers additional visits to the specialist.

Each Medical Group and PCP may make referrals to certain plan specialists and uses certain hospitals within their network. This means that the Medical Group and PCP you choose may determine the specialists and hospitals you may use. If there are specific specialists or hospitals you want to use, find out if your Medical Group or PCP uses 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. In Section 2.1 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?

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your

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

provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan please contact us so we can assist you in finding a new provider and managing your care.

If you need assistance because a specialist or a network provider is leaving our plan, please call Member Services at the number listed on the back cover of this booklet.

Section 2.4	How to get care from out-of-network providers
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If there is a certain type of service that you need (e.g., when providers of specialized services are not available in our network), 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 services, and kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area, 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 services, please see Section 3 below.

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

Section 3.1 Getting care if you have a medical emergency
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What is a “medical emergency” and what should you do if you have one?

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

If you have a medical emergency:

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

What is covered if you have a medical emergency?

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

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

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

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If 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 services” 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 services
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What are “urgently needed services”?

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

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

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

What to do when you need medical care immediately

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

If your situation is not so severe: Call your PCP or Medical Group or, if you cannot call them or you need medical care right away, go to the nearest medical center, urgent care center, or hospital.

If you are unsure of whether an emergency medical condition exists, you may call your Medical Group or PCP for help.

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

Your Medical Group is available 24 hours a day, seven days a week, to respond to your phone calls regarding medical care that you believe is needed immediately. They will evaluate your situation and give you direction about where to go for the care you need.

If you are not sure whether you have an emergency or require urgently needed services, please call the Member Services number on your Health Net ID card to be connected to the nurse advice services. As a Health Net Member, you have access to triage or screening services, 24 hours a day, 7 days a week.

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

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

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

Section 3.3	Getting care during a disaster
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If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from your plan.

Please visit the following website: <https://ca.healthnetadvantage.com> for information on how to obtain needed care during a disaster.

Generally, if you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing. If you cannot use a network pharmacy during a disaster, you may be able to fill your prescription drugs at an out-of-network pharmacy. Please see Chapter 5, Section 2.5 for more information.

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

Section 4.1	You can ask us to pay our share of the cost of covered services
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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
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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 and were 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. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

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

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

SECTION 5	How are your medical services covered when you are in a "clinical research study"?
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Section 5.1	What is a "clinical research study"?
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A clinical research study (also called a "clinical trial") is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

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

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study

and you have a full understanding and acceptance of what is involved if you participate in the study.

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

If you want to participate in a Medicare-approved clinical research study, you do *not* need to get approval from us or your 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.**

If you plan on participating in a clinical research study, contact Member Services (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what your plan will pay.

Section 5.2	When you participate in a clinical research study, who pays for what?
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Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

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

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

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

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other

documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 5 for more information about submitting requests for payment.

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

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

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication “Medicare and Clinical Research Studies” on the Medicare website (<https://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?
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A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2	What care from a religious non-medical health care institution is covered by our plan?
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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 a facility, the following conditions apply:
 - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care;
 - – *and* – You must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

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

SECTION 7 Rules for ownership of durable medical equipment

Section 7.1	Will you own the durable medical equipment after making a certain number of payments under our plan?
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Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

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

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

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

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. Payments you made while in our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare *before* you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. 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)*

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

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

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

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

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

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. If you think that you are being asked to pay improperly, contact Member Services.

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 2018 is \$3,400. The amounts you pay for copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount (The amount you pay for your plan premium does not count toward your 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

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

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 your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3	Our plan does not allow providers to “balance bill” you
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As a member of our plan, an important protection for you is that you only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called “balance billing.” This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges.

Here is how this protection works.

- If your cost-sharing is a copayment (a set amount of dollars, for example, \$15.00), then you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
 - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan’s reimbursement rate (as determined in the contract between the provider and the plan).
 - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
 - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
- If you believe a provider has “balance billed” you, call Member Services (phone numbers are printed on the back cover of this booklet).

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

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2018* Handbook. View it online at <https://www.medicare.gov> or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.

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

- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2018, either Medicare or our plan will cover those services.



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

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

Services that are covered for you	What you must pay when you get these services
<p> Abdominal aortic aneurysm screening</p> <p>A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.</p> <p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for members eligible for this preventive screening</p>
<p>Ambulance services</p> <ul style="list-style-type: none"> • 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 could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. 	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>You pay \$125 per one-way trip for Medicare-covered ambulance services.</p> <p>No charge for more than one trip in a single day.</p>

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

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

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

Services that are covered for you	What you must pay when you get these services
<p> Bone mass measurement</p> <p>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.</p> <p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</p>
<p> Breast cancer screening (mammograms)</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • 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 <p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</p>	<p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for covered screening mammograms.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Cardiac rehabilitation services</p> <p>Comprehensive programs of cardiac rehabilitation services 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.</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for each Medicare-covered cardiac rehabilitation services visit.</p>
<p> Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</p> <p>We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well.</p> <p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</p>	<p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.</p>

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

Services that are covered for you	What you must pay when you get these services
<p> Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).</p> <p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.</p>
<p> Cervical and vaginal cancer screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months <p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</p>	<p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</p>
<p>Chiropractic services</p> <p>Covered services include:</p> <p>We cover only manual manipulation of the spine to correct subluxation</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>You pay \$10 for each</p>

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

Services that are covered for you	What you must pay when you get these services
	<p>Medicare-covered visit for the manual manipulation of the spine to correct subluxation.</p> <p>Routine (Non-Medicare covered) chiropractic services are not covered. However, this plan covers routine chiropractic benefits for an extra cost. Refer to Section 2.2 (<i>Extra "optional supplemental" benefits you can buy</i>) later in this chapter for more information on optional supplemental chiropractic services.</p>

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

Services that are covered for you	What you must pay when you get these services
<p> Colorectal cancer screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • One of the following every 12 months: <ul style="list-style-type: none"> • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) • DNA Based colorectal screening every 3 years • For people at high risk of colorectal cancer, we cover: <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 24 months • For people not at high risk of colorectal cancer, we cover: <ul style="list-style-type: none"> • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy <p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.</p>
<p>Dental services</p> <p>In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover:</p> <p>Medicare-covered dental services include the following:</p> <ul style="list-style-type: none"> • Otherwise non-covered procedures or services, such as tooth removal, when performed by a dentist incident to and as an 	<p>There is no coinsurance, copayment, or deductible for each Medicare-covered dental visit.</p> <p>Routine (Non-Medicare covered) preventive and comprehensive dental</p>

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

Services that are covered for you	What you must pay when you get these services
<p>integral part of an otherwise Medicare-covered procedure.</p> <ul style="list-style-type: none"> • Extractions of teeth to prepare jaw for radiation treatment of neoplastic disease. • Dental exams prior to kidney transplantation 	<p>services are not covered. However, this plan covers routine preventive and comprehensive dental services for an extra cost. Refer to Section 2.2, <i>“Extra ‘optional supplemental’ benefits you can buy,”</i> later in this chapter for more information on optional supplemental dental services.</p>
<p> Depression screening</p> <p>We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.</p> <p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</p>	<p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</p>

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

Services that are covered for you	What you must pay when you get these services
<p> Diabetes screening</p> <p>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.</p> <p>Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</p> <p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for the Medicare covered diabetes screening tests.</p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered fasting plasma glucose tests for persons at risk of diabetes.</p>

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

Services that are covered for you	What you must pay when you get these services
<p> Diabetes self-management training, diabetic services and supplies</p> <p>For all people who have diabetes (insulin and non-insulin users). Covered services include:</p> <p>Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors</p> <ul style="list-style-type: none"> ○ Supplies to monitor your blood glucose may be limited to supplies from select manufacturers. Your PCP will help you arrange or coordinate the covered services. <p>For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting.</p> <p>Diabetes self-management training is covered under certain conditions</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered diabetes supplies.</p> <p>You pay 20% coinsurance for Medicare-covered diabetic therapeutic shoes or inserts for people with diabetes who have severe diabetic foot disease.</p> <p>There is no coinsurance, copayment, or deductible for beneficiaries eligible for the diabetes self-management training preventive benefit.</p>
<p>Durable medical equipment (DME) and related supplies</p> <p>(For a definition of “durable medical equipment,” see Chapter 10 of this booklet.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers.</p> <p>We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at https://ca.healthnetadvantage.com.</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>You pay 20% coinsurance for Medicare-covered durable medical equipment and related supplies.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Emergency care</p> <p>Emergency care refers to services that are:</p> <ul style="list-style-type: none"> • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. <p>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.</p> <p>Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network.</p> <ul style="list-style-type: none"> • Coverage in the United States¹. <p>For coverage outside of the United States¹, please see "Worldwide Emergency/Urgent Coverage" below in this Medical Benefits Chart.</p>	<p>You pay \$100 for each Medicare-covered emergency room visit.</p> <p>You do not pay this amount if you are immediately admitted to the hospital.</p> <p>If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the highest cost-sharing you would pay at a network hospital.</p>
<p>¹United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.</p>	

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

Services that are covered for you	What you must pay when you get these services
<p> Health and wellness education programs</p> <p>Health Education</p> <p>Trained clinicians promote healthy behaviors and help build skills to enhance self-care capabilities. Provides support/education on treatment choices to assist in making health care decisions. Clinicians also send educational materials and advise of educational modules on Health Net's website.</p> <p>Nurse Hotline:</p> <p>Toll-free telephonic coaching and nurse advice from trained clinicians. The Nurse advice line is available 24 hours a day, 7 days a week for assistance with health-related questions. Members can access the nurse advice line by calling 1-800-893-5597, TTY (711).</p>	<p>There is no coinsurance, copayment, or deductible for health and wellness education programs.</p> <p>Refer to “Additional Benefit Information” later in this chapter for more information on these benefits.</p>
<p>Hearing services</p> <p>Diagnostic hearing and balance evaluations performed by your PCP or provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</p> <p>Additional covered services include:</p> <ul style="list-style-type: none"> • Routine (non-Medicare covered) hearing tests, limited to one test per year. 	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>You pay \$10 for each Medicare-covered hearing test.</p> <p>You pay \$10 for each routine (non-Medicare covered) hearing test.</p> <p>You pay 100% for hearing aids.</p>

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

Services that are covered for you	What you must pay when you get these services
<p> HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy <p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.</p>
<p>Home health agency care</p> <p>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • 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 	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered home health visits.</p>
<p>Hospice care</p> <p>You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider.</p> <p>Covered services include:</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p>

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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Drugs for symptom control and pain relief • Short-term respite care • Home care 	<p>When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan.</p>
<p><u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis:</u> Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.</p>	<p>You pay \$10 for the one-time only hospice consultation.</p>
<p><u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal <u>prognosis</u>, your cost for these services depends on whether you use a provider in our plan's network:</p> <ul style="list-style-type: none"> • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare) 	
<p><u>For services that are covered by our plan but are not covered by Medicare Part A or B:</u> Our plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal <u>prognosis</u>. You pay your plan cost-sharing amount for these services.</p>	
<p>Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.</p>	
<p>Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.</p>	

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

Services that are covered for you	What you must pay when you get these services
<p> Immunizations</p> <p>Covered Medicare Part B services include:</p> <ul style="list-style-type: none"> • 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 <p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for the Medicare-covered pneumonia, influenza, and Hepatitis B vaccines.</p> <p>You pay 20% coinsurance for other Medicare-covered vaccines if you are at risk and they meet Medicare Part B coverage rules.</p>
<p>Inpatient hospital care</p> <p>Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.</p> <p>You are covered for unlimited days per benefit period for Medicare-covered stays. Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • 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) 	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>You pay \$275 each day from days 1 through 7 per benefit period, for Medicare-covered inpatient hospital care.</p>

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

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • 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. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Physician services 	<p>There is no coinsurance, copayment, or deductible each day from day 8 and beyond per benefit period, for Medicare-covered inpatient hospital care.</p>
<p>Note: To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an “outpatient.” If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff.</p>	<p>Your inpatient benefits are based upon the date of admission. If you are admitted to the hospital in 2018 and are not discharged until 2019, the 2018 copayments will apply until you are discharged from the hospital or transferred to a skilled nursing facility.</p>
<ul style="list-style-type: none"> • 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 https://www.medicare.gov/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 	<p>If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.</p>
	<p>A benefit period begins the first day you go into a hospital</p>

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

Services that are covered for you	What you must pay when you get these services
<p>days a week.</p>	<p>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.</p>
<p>Inpatient mental health care</p> <p>Covered services include mental health care services that require a hospital stay.</p> <p>You are covered for 90 days per benefit period for Medicare-covered stays.</p> <p>There is a 190-day lifetime limit for inpatient mental health services provided in a psychiatric hospital. The 190-day limit does not apply to mental health services provided in a psychiatric unit of a general hospital. If you have 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</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>You pay \$900 per admission, per benefit period for Medicare-covered inpatient mental health care.</p> <p>Your inpatient benefits are based upon the date of admission. If you are admitted to the hospital in 2018 and are not discharged until 2019, the 2018 copayments will apply until you are discharged from the hospital or</p>

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

Services that are covered for you	What you must pay when you get these services
	<p>transferred to a skilled nursing facility.</p> <p>Refer to “Additional Benefit Information” later in this chapter for more information on mental health services.</p> <p>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.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay</p> <p>If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • 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 patient's physical condition • Physical therapy, speech therapy, and occupational therapy 	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>The listed services will continue to be covered at the cost-sharing amounts shown in the Medical Benefits Chart for the specific service.</p> <p>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.</p>

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

Services that are covered for you	What you must pay when you get these services
<p> Medical nutrition therapy</p> <p>This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor.</p> <p>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 the next calendar year.</p> <p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.</p>
<p> Medicare Diabetes Prevention Program (MDPP)</p> <p>MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans.</p> <p>MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.</p> <p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for the MDPP benefit.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Medicare Part B prescription drugs</p> <p>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:</p> <ul style="list-style-type: none"> • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases 	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>You pay 20% coinsurance for Medicare-covered Part B drugs.</p> <p>You pay 20% coinsurance for Medicare-covered Part B chemotherapy drugs.</p>
<p> Obesity screening and therapy to promote sustained weight loss</p> <p>If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.</p> <p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</p>	<p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.</p>

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

Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests and therapeutic services and supplies	<i>Prior authorization (approval in advance) may be required.</i>
Covered services include, but are not limited to:	
<ul style="list-style-type: none"> • X-rays • Therapeutic radiological services (radiation therapy, radium and isotope), including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts, and other devices used to reduce fractures and dislocations • Laboratory services (includes blood tests, urinalysis, and some screening tests) • Blood – including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests • EKG tests • Diagnostic radiological services (includes complex tests such as CT scans, MRIs, MRAs, SPECT) 	A referral may be required.
	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.
	There is no coinsurance, copayment, or deductible for Medicare-covered x-ray services.
	There is no coinsurance, copayment, or deductible for Medicare-covered laboratory services and other Medicare-covered outpatient

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Services that are covered for you	What you must pay when you get these services
	<p>diagnostic tests.</p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered EKG tests.</p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered blood and blood services.</p> <p>You pay \$60 for Medicare-covered therapeutic radiological services, including technician materials and supplies, and Medicare-covered diagnostic radiological services.</p> <p>If the doctor provides you services in addition to outpatient diagnostic procedures, tests, and lab services, separate cost sharing may apply.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Outpatient hospital services</p> <p>We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</p> <p>Covered services include, but are not limited to:</p> <ul style="list-style-type: none"> • Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies such as splints and casts • Certain drugs and biologicals that you can't give yourself <p>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.</p> <p>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 https://www.medicare.gov/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.</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>You pay the applicable cost sharing amounts shown in this Medical Benefits Chart for the specific service.</p> <p>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.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Outpatient mental health care</p> <p>Covered services include:</p> <p>Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>You pay \$25 for each Medicare-covered individual or group therapy visit.</p> <p>Refer to “Additional Benefit Information” later in this chapter for more information on outpatient mental health services.</p>
<p>Outpatient rehabilitation services</p> <p>Covered services include: physical therapy, occupational therapy, and speech language therapy.</p> <p>Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for each Medicare-covered outpatient rehabilitation service.</p>

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Services that are covered for you	What you must pay when you get these services
<p>Outpatient substance abuse services</p> <p>Covered services include:</p> <p>Substance Use Disorder services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional or program, as allowed under applicable state laws.</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>You pay \$25 for each Medicare-covered individual or group therapy visit.</p> <p>Refer to “Additional Benefit Information” later in this chapter for more information on outpatient substance abuse services.</p>
<p>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers</p> <p>Note: If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>You pay \$275 for each Medicare-covered visit to an outpatient hospital facility (including epidural injections).</p> <p>You pay \$125 for each Medicare-covered visit to an ambulatory surgical center (including epidural injections).</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Partial hospitalization services</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment provided as a hospital outpatient service 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.</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered partial hospitalization.</p> <p>Refer to “Additional Benefit Information” later in this chapter for more information on mental health services.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Physician/Practitioner services, including doctor's office visits</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Medically necessary medical care or surgery 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 • Certain telehealth services including consultation, diagnosis, and treatment by a physician or practitioner for patients in certain rural areas or other locations approved by Medicare • 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) 	<p>You pay \$10 for each Medicare-covered primary care doctor office visit or medically-necessary surgery services furnished in a physician's office.</p>
<p>Additional copayments may be required depending on services rendered.</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p>
	<p>A referral may be required.</p>
	<p>You pay \$10 for each Medicare-covered specialist visit or medically-necessary surgery services furnished in a specialist's office.</p>
	<p>For medically-necessary surgery services furnished in a certified ambulatory surgical center, hospital outpatient department, or any other location, you pay the applicable cost-sharing amount for where the specific service is provided.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Podiatry services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Diagnosis and the medical or surgical 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 limb <p>Additional covered services include:</p> <p>Routine (non-Medicare covered) foot care, limited to 12 visits every year.</p>	<p>A referral may be required.</p> <p>You pay \$10 for each Medicare-covered visit (medically necessary foot care).</p> <p>You pay \$10 for each routine (non-Medicare covered) visit.</p>
<p> Prostate cancer screening exams</p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test <p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for an annual digital rectal exam.</p> <p>There is no coinsurance, copayment, or deductible for an annual PSA test.</p>
<p>Prosthetic devices and related supplies</p> <ul style="list-style-type: none"> • Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair 	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>You pay 20% coinsurance for prosthetic devices and</p>

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

Services that are covered for you	What you must pay when you get these services
<p>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.</p> <ul style="list-style-type: none"> • Medicare- covered parenteral and enteral nutrition (PEN): Covers related supplies and nutrients. Does not cover baby food and other regular grocery products that can be blenderized and used with the enteral system or any additional nutritional supplementation (such as those for daily protein or caloric intake). 	<p>related supplies.</p> <p>You pay 20% coinsurance for Medicare-covered parenteral and enteral related supplies and nutrients.</p>
<p>Pulmonary rehabilitation services</p> <p>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 the chronic respiratory disease.</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for each Medicare-covered pulmonary rehabilitation services visit.</p>

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

Services that are covered for you	What you must pay when you get these services
<p> Screening and counseling to reduce alcohol misuse</p> <p>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent.</p> <p>If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</p> <p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</p>	<p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</p>

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

Services that are covered for you	What you must pay when you get these services
<p> Screening for lung cancer with low dose computed tomography (LDCT)</p> <p>For qualified individuals, a LDCT is covered every 12 months.</p> <p>Eligible members are: people aged 55 – 77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner.</p> <p><i>For LDCT lung cancer screenings after the initial LDCT screening:</i> the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.</p> <p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for the Medicare covered counseling and shared decision making visit or for the LDCT.</p>

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

Services that are covered for you	What you must pay when you get these services
<p> Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</p> <p>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy.</p> <p>We also cover up to two individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor’s office.</p> <p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Services to treat kidney disease and conditions</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3) • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply) <p>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, “Medicare Part B prescription drugs.”</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>You pay 20% coinsurance for each Medicare-covered renal dialysis (kidney) services visit.</p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered kidney disease education services, up to 6 sessions per lifetime.</p>
<p>Skilled Nursing Facility (SNF) Care</p> <p>(For a definition of “skilled nursing facility care,” see Chapter 10 of this booklet. Skilled nursing facilities are sometimes called “SNFs.”)</p> <p>You are covered for 100 days per benefit period. No hospital stay is required prior to SNF admission. Covered services include but are not limited to:</p> <ul style="list-style-type: none"> • Semi-private room (or a private room if medically necessary) • Meals, including special diets • Skilled nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that 	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered skilled nursing facility.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>you need. All other components of blood are covered beginning with the first pint used.</p> <ul style="list-style-type: none"> • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs • X-rays and other radiology services ordinarily provided by SNFs • Use of appliances such as wheelchairs ordinarily provided by SNFs • Physician/Practitioner services <p>Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.</p> <ul style="list-style-type: none"> • 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. 	<p>You pay all costs for each day after day 100 in the benefit period.</p> <p>Your inpatient benefits are based upon the date of admission. If you are admitted to the hospital in 2018 and are not discharged until 2019, the 2018 copayments will apply until you are discharged from the hospital or transferred to a skilled nursing facility.</p> <p>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.</p>
<p> Smoking and tobacco use cessation (counseling to stop smoking)</p>	<p><i>Prior authorization</i></p>

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

Services that are covered for you	What you must pay when you get these services
<p>or tobacco use)</p> <p><u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits.</p>	<p><i>(approval in advance) may be required.</i></p>
<p><u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.</p>	<p>A referral may be required.</p>
<p>Additional online and telephonic smoking cessation counseling is available from trained clinicians which includes guidance on steps of change, planning, counseling and education. Members receive an in-depth assessment and personalized plan to quit smoking. This includes up to 4 proactive, one-on-one coaching calls, and unlimited toll free access to a quit coach Refer to “Decision Power®: Health and Wellness” under “Additional Benefit Information” later in this chapter for more information on this benefit.</p>	<p>There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.</p>
<p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</p>	<p>You pay the applicable cost sharing for Medicare-covered smoking cessation counseling sessions where services are received. For example, if your counseling session is received as part of an outpatient mental health visit, you pay the applicable outpatient mental health cost sharing.</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Urgently needed services</p> <p>Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.</p> <p>Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network.</p> <ul style="list-style-type: none"> Coverage in the United States¹ <p>Urgently needed care received outside of the United States¹ may be considered an emergency under the worldwide emergency/urgent coverage benefit. For more information, see "Worldwide Emergency/Urgent Coverage" in this Medical Benefits Chart below.</p>	<p>You pay \$10 for each Medicare-covered urgently needed service visit.</p> <p>You do not pay this amount if you are immediately admitted to the hospital.</p>
<p>¹United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.</p>	
<p> Vision care</p> <p>Medicare-Covered services include:</p> <p>Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts.</p> <p>For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic-Americans who are 65 or older.</p> <p>For people with diabetes, screening for diabetic retinopathy is covered once per year.</p> <p>One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.)</p>	<p><i>Prior authorization (approval in advance) may be required.</i></p> <p>A referral may be required.</p> <p>You pay \$10 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye).</p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered</p>

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

Services that are covered for you	What you must pay when you get these services
<p>Additional covered services include:</p> <ul style="list-style-type: none"> • Routine eye exam (refraction), limited to 1 exam per year. 	<p>glaucoma screening.</p> <p>You pay \$10 for Medicare-covered diabetic retinopathy screening.</p> <p>There is no coinsurance, copayment, or deductible for Medicare-covered eyewear after cataract surgery.</p> <p>You pay \$10 for each routine (Non-Medicare covered) eye exams.</p> <p>Routine (Non-Medicare covered) eyewear is not covered. However, this plan covers routine eyewear for an extra cost. Refer to Section 2.2 (Extra “optional supplemental” benefits you can buy) later in this chapter for more information on optional supplemental vision services.</p>

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

Services that are covered for you	What you must pay when you get these services
<p> “Welcome to Medicare” Preventive Visit</p> <p>The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.</p> <p>Important: We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor’s office know you would like to schedule your “Welcome to Medicare” preventive visit.</p> <p>For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.</p>	<p>A referral may be required.</p> <p>There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.</p>
<p>Worldwide Emergency/Urgent Coverage</p> <p>Worldwide Emergency/Urgent coverage. Defined as urgent, emergent, and post-stabilization care received outside of the United States.¹</p> <ul style="list-style-type: none"> Limited only to services that would be classified as emergency, urgently needed, or post-stabilization care had they been provided in the United States.¹ Ambulance services are covered in situations where getting to the emergency room in any other way could endanger your health. Foreign taxes and fees (including, but not limited to, currency conversion or transaction fees) are not covered. 	<p>There is no coinsurance, copayment, or deductible for worldwide emergency/urgent coverage received outside of the United States¹.</p> <p>There is an annual limit of \$50,000 for Worldwide emergency/urgent coverage, including ambulance services.</p>

¹United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

Additional Benefit Information

Mental Health Care and Substance Abuse Benefits

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

As a member of our plan you are free to use any MHN-Contracted Mental Health Service Providers listed in the plan's MHN Provider Directory. MHN-Contracted Mental Health Service Providers are also known as MHN Network Providers (Provider contract status changes from time to time; you can contact Health Net or look online for the most current listing of Medicare Advantage MHN Network Providers). A Mental Health Service Provider who does not contract with MHN is known as an Out-of-Network Provider.

Inpatient and Alternate Levels of Care (Partial Hospitalization, Electro-Convulsive Therapy (ECT)

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 TTY: **711** for the hearing and speech impaired), Monday-Friday, 8:00 a.m. - 6:00 p.m. MHN will refer you to a nearby MHN Network Provider. That provider will evaluate you to determine if additional treatment is necessary. If you need treatment, the MHN Network Provider 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 TTY: **711** for the hearing and speech impaired Monday-Friday, 8:00 a.m.-6:00 p.m. 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 <https://ca.healthnetadvantage.com>.

Outpatient Office-Based Mental Health Services

For outpatient, office-based mental health services, no pre-authorization or registration is required. You or your provider should contact MHN to verify eligibility, provider network status and discuss your benefits and any applicable copayments. Confirming your outpatient benefits and cost share can help ensure smooth claims payment as your case will be in our system.

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

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

questions regarding your care Monday-Friday, 8:00 a.m.- 6:00 p.m.. To contact MHN, call **1-800-646-5610** (or TTY: **711** for the hearing and speech impaired), Monday-Friday, 8:00 a.m.- 6:00 p.m..

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” and “Outpatient substance abuse services” 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 MHN Network Provider 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 MHN Network Provider 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 MHN Network Provider 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 MHN Network Provider 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.
- You have attempted to follow the plan of care or consulted with the initial MHN Network Provider 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 TTY: **711** for the hearing and speech impaired) Monday-Friday, 8:00 a.m.-6:00 p.m.. MHN Services will review the request, and if a second opinion is considered Medically Necessary, MHN Services will authorize a referral to an MHN Network Provider. When you request a second opinion, you will be responsible for any applicable copayments.

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

Second opinions will only be authorized for MHN Network Providers, unless it is demonstrated that an appropriately qualified MHN Network Provider 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** (TTY: **711** for the hearing and speech impaired), Monday-Friday, 8:00 a.m.-6:00 p.m..

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, and intensive outpatient care, 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.”

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

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** (TTY: **711** 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 an Out-of-Network Provider 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 Out-of- Network Provider 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 to request a copy of our continuity of care policy, please call MHN at **1-800-646-5610** (TTY: **711** for the hearing and speech impaired) Monday-Friday, 8:00 a.m.- 6:00 p.m..

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.”

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

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.
- Treatment at a Residential Treatment Center.
- Treatment at a Partial Hospitalization Program or Intensive Outpatient Program that is not a Medicare certified provider by the Centers for Medicare & Medicaid Service (CMS).

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. CMS excludes Licensed Marriage and Family Therapist (LMFT) and Limited Licensed Professional Counselor (LLPC) licenses for coverage and reimbursement.
- 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 an Out-of-Network Provider, 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

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

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 that 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.
- Transcranial Magnetic Stimulation (TMS) treatment.
- 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. Claim 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** (TTY: **711**, available for the hearing and speech impaired), Monday through Friday from 8:00 a.m. to 7:00 p.m.

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

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

You can also contact MHN Services at **1-800-646-5610** (or TTY: **711** for the hearing and speech impaired) Monday-Friday, 8:00 a.m. 6:00 p.m. 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 an Out-of-Network Provider/Facility

You may be hospitalized at an Out-of-Network 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 an Out-of-Network 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

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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** (TTY: **711**, available for the hearing and speech impaired), Monday through Friday from 8:00 a.m. to 7:00 p.m.

Completed claim forms should be submitted to:

MHN 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** (or TTY: **711** for the hearing and speech impaired) Monday-Friday, 8:00 a.m.- 6:00 p.m.. Calls to these numbers are free. Or visit MHN Services' web site at www.mhn.com for a list of MHN Network 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 and Wellness**A bridge to healthy actions****A bridge to healthy actions**

You have access to Health Net's Decision Power®: Health & Wellness, our integrated health and wellness program that bridges the gap between knowing how to achieve improved wellness, and getting the support and confidence to take action.

Whether you're focused on staying fit, dealing with back pain or facing a serious diagnosis, Decision Power can help you and your doctors make the right health and treatment decisions.

Decision Power® – Here to Help You Achieve Your Health and Wellness Goals

We make it personal, so you can make lasting changes.

Your road to improved health and wellness through Decision Power begins online with our self-directed online tools and programs. With resources like our health risk questionnaire (HRQ) you can better manage your health and enhance healthy habits.

Health Promotion programs

Want a more flexible way to improve your health and wellness – on your terms? Our Decision Power Health Promotion programs offer a self-directed, online way to achieve and maintain your

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health goals. These programs are available online, so you can take steps for positive and lasting changes when and where it's most convenient for you. Topics include weight loss, stress relief, and healthy diet.

Wellness health coaching

One-on-one phone support is available through our wellness health coaching, giving you access to a health educator who will help you reach your goals and sustain positive behavioral change.

Tobacco Cessation

The tobacco cessation program covers any type of tobacco, lets you talk with a coach for encouragement and support, and offers a personalized plan to quit.

Here's a look at what you get:

- In-depth assessment and personalized cessation plans, with medication support recommendations.
- Proactive, one-on-one counseling calls, plus unlimited calls to our program clinicians.

To learn more about these services log in at our Wellness Center at <https://ca.healthnetadvantage.com> to get started.

Valuable tools that put health information in reach**Nurse Advice Line**

Toll-free telephonic nurse advice from trained clinicians is available 24 hours a day, 7 days a week. Health Net's Nurse Advice Line provides real time support to help the member determine the level of care needed at the moment. Members can access the nurse advice line by calling 1-800-893-5597, TTY (711).

Healthy Discounts

We recognize that healthy living goes beyond your covered medical benefits. And, with this in mind, we've developed Decision Power Healthy Discounts, a discount program that gives you valuable discounts on health-related services and products.

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 <https://ca.healthnetadvantage.com> or call the Member Services number on your Health Net ID card for more information or to be connected to the nurse advice services.

Section 2.2 Extra “optional supplemental” benefits you can buy
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Our plan offers some extra benefits that are not covered by Original Medicare and not included in your benefits package as a plan member. These extra benefits are called “**Optional**

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Supplemental Benefits.” If you want these optional supplemental benefits, you must sign up for them : and you may have to pay an additional premium for them. The optional supplemental benefits described in this section are subject to the same appeals process as any other benefits.

How can you enroll in the Optional Supplemental Benefits?

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

- from October 15, 2017 through December 31, 2017 for a January 1, 2018 effective date;
- from January 1, 2018 through January 31, 2018 for a February 1, 2018 effective date; or
- from May 15, 2018 through June 30, 2018, for a July 1, 2018 effective date.

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

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

Optional Supplemental Benefits Package 1 includes coverage for HMO preventive and comprehensive dental care, routine eyewear, chiropractic care, acupuncture, and fitness for an additional monthly premium of \$19.

Optional Supplemental Benefits Package 2 includes coverage for PPO preventive and limited comprehensive dental, routine eyewear, chiropractic care, acupuncture, and fitness for an additional monthly premium of \$30.

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

Enrollment Services
Health Net Medicare Programs
PO Box 10420
Van Nuys, CA 91410-0420

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

How can you disenroll from the Optional Supplemental Benefits?

You may disenroll from these Optional Supplemental Benefits at any time and switch to the basic Medicare Advantage plan benefits. To disenroll from the Optional Supplemental Benefits, send a signed letter to Health Net requesting to be disenrolled. You may also fax the letter to **1-866-214-1992**. It is important that you state your request is for disenrollment from the Optional Supplemental Benefits only. We will then send you a letter that tells you when your Optional

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Supplemental Benefits will end. This is your Optional Supplemental Benefits **disenrollment date**. In most cases, your disenrollment date will be the first day of the month following the month we receive your request to discontinue these benefits.

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

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

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

Additional Information

If you have elected an Optional Supplemental Benefit package, and we do not receive your premium by the 7th business day of the month, we will notify you in writing that your optional supplemental benefits may end.

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

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

****Optional Supplemental Benefits****Package – 1****

You pay \$19 each month in addition to your monthly plan premium shown in Chapter 1, Section 4.1 and the Medicare Part B premium for these optional benefits:

- Dental Services (DHMO)
 - Eyewear
-

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- Chiropractic Services
- Acupuncture
- Fitness

Dental Services – (DHMO)

You pay:

- \$0 for each oral exam
- \$0 for each cleaning
- \$0 for each fluoride treatment
- \$0 for dental x-rays

Additional comprehensive dental benefits are available.

Please refer to the Optional Supplemental Benefit Information below for further information regarding dental services.

Eyewear

\$250 allowance for choice of 1 routine eyewear purchase every 24 months. Limited to 1 set of frames and 1 pair of eyeglass lenses or contact lenses during a 24-month period.*

Medically necessary contact lenses: Covered in full once every 24 months.*

Frames:

You pay 80% of the remaining balance over the allowance.

Routine (non-medically necessary) Contact Lenses (in lieu of eyeglass lenses):

You pay 85% of the remaining balance over the allowance for conventional contact lenses and 100% of the remaining balance over the allowance for disposable contact

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lenses.

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

Additional eyewear benefits are available.

Refer to the Optional Supplemental Benefit Information below for further information regarding eyewear.

Chiropractic Services

Verification of medical necessity- or referral is not required for initial examinations. Medical necessity verification may be required for subsequent chiropractic visits and services.

You pay \$10 for each routine visit up to 30 visits every year (combined with Acupuncture).

Please refer to the Optional Supplemental Benefit Information below for further information regarding chiropractic services.

Acupuncture

Verification of medical necessity or referral is not required for initial examinations. Medical necessity verification may be required for subsequent acupuncture visits and services.

You pay \$10 for each visit up to 30 visits every year (combined with Chiropractic Services).

Please refer to the Optional Supplemental Benefit Information below for further information regarding acupuncture services.

Fitness Benefit (The Silver&Fit® Exercise and Healthy Aging Program)

There is no annual member fee for the Fitness Benefit.

Please refer to the Optional Supplemental Benefit Information below for further information.

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****Optional Supplemental Benefits
Package – 2****

You pay \$30 each month in addition to the monthly plan premium shown in Chapter 1, Section 4.1 and the Medicare Part B premium for these optional benefits:

- Dental Services (DPPO)
- Eyewear
- Chiropractic Services
- Acupuncture
- Fitness

Dental Services – (DPPO)

You can see any licensed dentist to receive covered preventive and limited comprehensive dental services. However, your cost shares are higher when you receive covered services from non-plan providers than from plan providers. Dental services are offered through Health Net Dental network providers. Health Net Dental providers are listed in your Directory of PPO Dental Providers.

Routine preventive and limited comprehensive (non-Medicare covered) dental services include:

- Oral exams
- Cleanings
- Dental x-rays
- Panoramic x-rays
- Fluoride treatments
- Fillings
- Periodontal procedures: scaling and root planing, periodontal maintenance procedures, full-mouth debridement
- Simple (non-surgical) extractions
- Sealants

In-Network

You pay a one-time annual deductible of \$35.

You pay a \$0 copayment for in-network preventive services after you have reached the deductible amount.

You pay 20% of the cost for in-network limited comprehensive services after you have reached the deductible amount.

Out-of-Network

You pay a one-time annual deductible of \$35.

You pay 20% of the Maximum Allowable Charge (MAC) ♦ after you have reached the deductible amount for out-of-network preventive services. You are responsible for the difference between MAC and billed charges.

You pay 40% of the Maximum Allowable Charge (MAC) ♦ after you have reached the deductible amount

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for out-of-network limited comprehensive services. You are responsible for the difference between MAC and billed charges.

For in-network and out-of-network providers, there is a combined annual maximum benefit for routine preventive and comprehensive dental services of \$1,000.

Please refer to the Optional Supplemental Benefit Information below for further information regarding dental services.

- ◆ Maximum Allowable Charge (MAC) is the maximum dollar amount allowed by the plan for a covered dental service. Balance billing occurs when a dentist bills you for the difference between the plan's Maximum Allowable Charge (MAC) and the dentist's total billed charge. Network dentists cannot balance bill you for covered services which exceed the Maximum Allowable Charge (MAC) they have contractually agreed to; however, it is possible that non-network dentists may balance bill you for treatment rendered.

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Eyewear

\$250 allowance for choice of 1 routine eyewear purchase every 24 months. Limited to 1 set of frames and 1 pair of eyeglass lenses or contact lenses during a 24-month period.*

Medically necessary contact lenses: Covered in full once every 24 months.*

Frames:
You pay 80% of the remaining balance over the allowance.

Routine (non-medically necessary) Contact Lenses (in lieu of eyeglass lenses):
You pay 85% of the remaining balance over the allowance for conventional contact lenses and 100% of the remaining balance over the allowance for disposable contact lenses.

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

Additional eyewear benefits are available.

Refer to the Optional Supplemental Benefit Information below for further information regarding eyewear.

Chiropractic Services

Verification of medical necessity- or referral is not required for initial examinations. Medical necessity verification may be required for subsequent chiropractic visits and services.

You pay \$10 for each routine visit up to 30 visits every year (combined with Acupuncture).

Please refer to the Optional Supplemental Benefit Information below for further information regarding chiropractic services.

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

Verification of medical necessity or referral is not required for initial examinations. Medical necessity verification may be required for subsequent acupuncture visits and services.

You pay \$10 for each visit up to 30 visits every year (combined with Chiropractic Services).

Please refer to the Optional Supplemental Benefit Information below for further information regarding acupuncture services.

Fitness Benefit (The Silver&Fit® Exercise and Healthy Aging Program)

There is no annual member fee for the Fitness Benefit.

Please refer to the Optional Supplemental Benefit Information below for further information.

Optional Supplemental Benefit Information**Dental Services (DHMO) - Optional Supplemental Benefits Package 1**

NOTE: *As a Member of our plan, you have Medicare-covered dental benefits. Refer to the Medical Benefits Chart earlier in this chapter for copayment and benefit information. Only members who have purchased the Optional Supplemental Benefit Package 1 have the routine (non-Medicare covered) preventive and comprehensive Dental HMO benefits described below.*

Health Net Dental Plan and covered services are administered by Dental Benefit Administrative Services. Health Net Dental arranges for dental services by contracting with Contracted Dentists to provide services to our Members. We encourage you to take an active role to ensure good dental health, and recommend scheduling a first appointment with a Primary Care General Dentist within 120 days of enrollment. This will allow any conditions to be found and treated.

All services must be provided by a Contracted Dentist to be covered under this plan. Most covered services will be available from and provided by your selected Primary Care General Dentist. Exceptions are described in the sections, Referrals to Specialty Care Dentists and Emergency Dental Care. Please refer to the current Health Net Dental Directory for a listing of available Primary Care General Dentists.

In the event of an emergency, please follow the guidelines in the section, Emergency Dental Care. You may also call Health Net Dental at **1-866-249-2382** (or TTY: **711** for the hearing and speech impaired), Monday-Friday, 5:00 a.m. to 8:00 p.m., except holidays, for assistance in necessary procedures.

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

This section will help you understand the dental plan benefits. It provides a description of the dental copayment requirements, exclusions, limitations, and benefits of this plan. Read this section and keep it readily available for reference when you decide to use the services available through this plan. In the event of an emergency, please follow the guidelines in the section called “Emergency Dental Care.”

For assistance in the necessary emergency procedures or if you have questions about the dental benefits, copayments, limitations, or exclusions, you may call Health Net Dental Member Services at **1-866-249-2382** (TTY: **711** for the hearing and speech impaired), Monday-Friday, 5:00 a.m. to 8:00 p.m., except holidays. Interpreter Services are also available by calling Member Services.

Choosing Your Primary Care General Dentist

You must choose a Primary Care General Dentist from the Health Net Dental Directory. Health Net Dental Member Services is available to provide assistance in the selection of a Primary Care General Dentist. We request that you select your Primary Care General Dentist within the first 30 days of coverage. If a Primary Care General Dentist is not chosen, Health Net Dental will assign one that is near your residence.

Except as specified below, Covered Services must be provided by your Primary Care General Dentist in order to be covered under this dental plan. Health Net Dental does not cover services and supplies provided by a dentist who is not your Primary Care General Dentist, except as specifically described under the following two sections titled Emergency Dental Care and Referrals to Specialty Care Dentists in this section. Your Primary Care General Dentist must obtain approval from Health Net Dental prior to the referral to a specialist. This dental plan does not cover services and supplies provided by non-physician/dentist healthcare practitioners.

Referrals to Specialty Care Dentists

Your Primary Care General Dentist has primary responsibility for your dental care. When treatment is authorized, the dental copayments listed in the Dental Covered Services Schedule will apply. If treatment is not authorized, you will receive a denial notice telling you the reason for the denial and explaining your right to appeal the decision (request a reconsideration). For more information, please refer to Chapter 7 of this *Evidence of Coverage*. Your coverage must be in effect when each procedure is started to be considered covered under this plan. This includes referrals for Orthodontic Care.

Emergency Dental Care

Emergency and Urgent Dental Care Services are “Medically Necessary” services to relieve severe pain or other symptoms. It may also be needed to diagnose and treat a sudden illness that a reasonable person in the same situation would believe it could lead to a serious health threat or impair their health if not treated right away. Emergency dental services and care as defined in the

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California Health & Safety Code means a screening, examination, and evaluation to determine if an emergency medical condition exists.

What Do You Do When You Require Emergency Dental Care or Urgently Needed Services

If you need Emergency Dental Care, you should immediately contact your selected Primary Care General Dentist for an appointment. All contracted dentists will have Emergency Dental Care available 24 hours a day, 7 days a week. If the Primary Care General Dentist is not available, you may seek Emergency Dental Care from any licensed dentist. You may also contact Health Net Dental Member Services at **1-866-249-2382** (TTY: **711** for the hearing and speech impaired), Monday-Friday, 5:00 a.m. to 8:00 p.m., except holidays. Interpreter Services are available by calling our Member Services.

Services provided by a dentist other than the Primary Care General Dentist will be covered only when it is shown that:

- You were not able to get services from your Primary Care General Dentist.
- The services were for Emergency Dental Care.
- The services were Medically Necessary.
- The services are listed as covered benefits under this plan.
- You must pay any dental copayments. If the above conditions are not met, you will need to pay all billed charges at the dentist's Usual and Customary Reasonable Fee (UCR).
- If you are outside the Service Area or more than 35 miles from your Primary Care General Dentist, you may receive Emergency and Urgent Dental Care Services from any licensed dentist. Please follow the rules under Reimbursement for Emergency Dental Care below.

Transition of Care for New Members

This is a summary of our policy on Transition of Care. You may call Health Net Dental Member Services to request a formal copy.

New Members who are getting treatment for an Acute condition with a non-Contracted Dentist should call Health Net Dental Member Services at **1-866-249-2382** (TTY: **711** for the hearing and speech impaired), Monday-Friday, 5:00 a.m. to 8:00 p.m., except holidays. Interpreter Services are available by calling Member Services. Your specific situation will be reviewed to determine if you can continue treatment with that dentist or if care should be continued with a Contracted Dentist.

Read the section “What Do You Do When You Require Emergency Dental Care or Urgently Needed Services.” It lists the situations in which Emergency Dental Care for Acute dental conditions may be given by a non-Contracted Dentist.

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An Acute dental condition is defined as Medically Necessary for any urgent condition that requires:

- Relief for severe pain or bleeding.
- Getting rid of an acute infection.
- Treatment of an injury of the teeth that is needed right away.

Transitional Care Limitations

The decision to approve transitional care for an Acute condition lies with Health Net Dental. It will only be covered when approved by Health Net Dental.

- Health Net Dental will approve transitional care with a non-Contracted Provider only until it is appropriate to have you receive care with a Contracted Dentist.
- Health Net Dental will not cover services or provide benefits that are not covered under the terms and conditions of *Evidence of Coverage*.
- Health Net Dental will not cover services or provide benefits that are covered by a prior dental plan.
- Health Net Dental may ask that the non-Contracted Dentist meet the same contractual terms and conditions as those asked of our Contracted Dentists.
- Health Net Dental will not be liable for actions resulting from the negligence, malpractice, or other wrongful acts as a result of transition of care services provided by a non-Contracted Dentist.

Second Opinions

This is a summary of our policy on Second Opinions. A formal copy is available from Member Services.

You may request a second opinion for proposed or completed treatment. Should Health Net Dental approve your request for a second opinion for any reason, Health Net Dental will pay for all necessary charges, including the dental copayment.

You may request a second opinion if:

- You question or do not agree with the reasonableness, necessity, diagnosis and/or treatment plan chosen by your Primary Care General Dentist;
- If you are not happy with the progress or result of treatment you received from a provider;
- The clinical indications are not clear or a diagnosis is in doubt, or;
- The Primary Care General Dentist is unable to diagnose the condition.

You must call Health Net Dental's Member Services to receive approval for a second opinion. If a second opinion is authorized, you will be referred to a Contracted Dentist. An exception to this

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policy may be made if a Contracted Dentist is not available in your area. The second opinion dentist shall be licensed, acting within his or her scope of practice, possess an appropriate clinical background, including training and expertise related to dental care. When you ask for a Second Opinion, you will be financially responsible for any applicable dental copayments shown in the Dental Covered Services Schedule. Charges for second opinions that are not approved by Health Net Dental are not covered under this plan.

If the request for a second opinion is denied, you will be notified in writing of the reason for the denial. The notice will tell you why the second opinion was denied, and explain how you may request a reconsideration under the appeal procedures described in Chapter 7 of this *Evidence of Coverage*.

Utilization Review

Health Net Dental reviews treatment patterns and certain courses of treatment to determine appropriateness. Health Net Dental uses guidelines and set criteria during the review process. These guidelines and certain criteria are available upon request.

Health Net Dental Member Services

Health Net Dental Member Services is available during normal business hours to provide assistance with your dental plan. Normal business hours are Monday through Friday, 5:00 a.m. to 8:00 p.m., except holidays. We are just a toll-free call away. We can provide assistance with questions, explain your dental benefits, dental office selections/transfers, specialty care referrals, second opinions, ID cards, complaints or other matters. We can also provide assistance if you need the services of an interpreter. Interpreter services are available during normal business hours by calling **1-866-249-2382**. TTY services are available during normal business hours at **711**.

Dental Copayments

For Covered Benefits/Services you will be responsible for the fees (“copayments”) listed later in the Dental Covered Services Schedule. You pay dental copayments to the Contracted Dentist (Primary Care General Dentist or Specialty Care Dentist) at the time care is received. You are responsible for the cost of any service received that is not specifically listed as a Covered Benefit. *You are not responsible for payments owed to Contracted Dentists by Health Net Dental.*

Coordination of Benefits

When you have coverage under this plan and any Other Plan, coverage under this plan is primary.

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Member's Liability for Payment

You are responsible for any applicable dental copayments and for payment for non-Covered Services or benefits in excess of specified limitations under the Principal Dental Limitations of Benefits and Principal Dental Exclusions sections. If Health Net Dental does not pay a Contracted Dentist for Covered Services, you will not be liable to the dentist for any sums owed by Health Net Dental. But if Health Net Dental does not pay a non-Contracted Dentist, you may be liable for payment. If you receive non-Emergency Dental Care from a provider other than your Primary Care General Dentist, you will be responsible for payment, except for instances in which the care provided is an out-of-area emergency.

Termination of Contracted Dentist Contract

Upon termination of any Contracted Dentist contract, Health Net Dental shall be liable for payment of Covered Services rendered by such provider (other than any dental Copayment) to you who retains eligibility under the Agreement or by operation of law, who is under the care of such provider at the time of such termination, until the Covered Services being rendered to you by such provider are completed, unless Health Net Dental makes reasonable and Medically appropriate provision for the assumption of such services by another Contracted Dentist. You may elect to continue care with the dentist (if the Dentist Agreement was terminated by the Plan) if care was for an acute or serious chronic condition. If you have questions about or wishes to request continuity of care, you should contact Health Net Dental's Member Services Department.

Independent Contractor Relationship

The relationship between Health Net Dental and Contracted Dentists is that of independent contractors. The Contracted Dentists are independent, community-based practitioners and professional corporations licensed to provide dental services. Although Health Net Dental periodically monitors aspects of the services rendered by Contracted Dentists, the Contracted Dentists are not agents or Employees of Health Net Dental, and Health Net Dental and its Employees and agents are not Employees or agents of any Contracted Dentist. Contracted Dentists maintain the Dentist-Patient relationship with you and are solely responsible to you for all of the services they provide to you. No joint venture, partnership, employment, agency, or other relationships are created by this *Evidence of Coverage* or Agreement.

Dental Malpractice

Health Net Dental and Contracted Dentists are independent entities who have entered into contracts with each other for the purpose of making dental services available to Health Net Dental members, while non-Contracted Dentists may not have relationships with Health Net Dental. Any dispute alleging the medical malpractice, negligence and/or wrongful act of any dentist, shall not include Health Net Dental and shall include only the provider subject to the allegation.

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Third Party Liability

If you are injured through the actions of another person (a third party), Health Net Dental will provide benefits for all Covered Services that are received from Contracted Dentists, as well as Emergency Dental Care as described in this *Evidence of Coverage*. However, if you receive money because of the injuries, you must reimburse Health Net Dental for the value of any services provided through this plan.

If you are injured because of the actions of a third party and wish to receive benefits under this plan, you must cooperate with Health Net Dental's efforts to obtain reimbursement, including telling Health Net Dental the name and address of the third party, if known, telling Health Net Dental the name and address of your lawyer, if you are using a lawyer, and completing other paperwork that Health Net Dental may require. If you receive money because of the injuries sustained, and you have received benefits under this plan for those injuries, you must hold any money you receive in trust, and not use any of it until Health Net Dental is reimbursed for the value of the benefits that it provided.

Unless you receive monies from a Worker's Compensation claim, the amount that you are required to reimburse Health Net Dental, will be limited to one-third of the money that you receive if a lawyer was engaged, or one-half of the money that was received if you did not engage a lawyer. Hospitals or other parties may also have claims for reimbursement, which are separate from any claim of Health Net Dental.

Refusal of Treatment

If you do not accept procedures or treatment recommended by a Contracted Dentist, the dentist may consider this refusal to accept his/her course of action as contrary to maintaining the dentist-patient relationship. The dentist may also consider it preventing the delivery of good dental care. If you refuse to accept such a recommended treatment or procedure, and the Contracted Dentist believes that no professionally acceptable treatment exists, you shall be notified. If you still refuse to accept the recommended treatment or procedure, then neither Health Net Dental nor any Contracted Dentist will have any further responsibility to provide care for the condition under treatment. You have the right to request alternative treatment or/services in this case that he/she believes is covered and to appeal requests that are denied. Please refer to Chapter 7 of this *Evidence of Coverage* for more information. The provisions of this section do not prevent you from changing Primary Care General Dentists upon proper notice to the Member Services Department. The right of a legally competent adult patient to decide whether or not to submit to medical procedures necessarily includes, subject to certain limited exceptions, the right to refuse drugs, treatment or other procedures. A general statement of the right to refuse treatment is set forth in Title 22, California Code of Regulations, Section 70707 (a.k.a. "Patient Bill of Rights").

Public Policy

Health Net Dental permits Members to participate in setting its public policy through its Public Policy Committee. For the purposes of this paragraph, "public policy" means acts performed by

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Health Net Dental and its Employees to assure the comfort, dignity and convenience of Members who rely on Contracted Dentists to provide Covered Services. Call Health Net Dental Member Services if you would like more information.

Right to Receive and Release Information

As a condition of enrollment in this dental plan, Health Net Dental, its agents, independent contractors, and Contracted Dentists shall be allowed to release to, or obtain from, any person, organization or government agency, any information and records, including patient records of Members, which Health Net Dental requires or is obligated to provide pursuant to legal process, federal, state or local law, or requires in the administration of this dental plan.

Non-Assignability of Benefits

The coverage and benefits of this plan may not be assigned without the prior written consent of Health Net Dental. This consent may be withheld for any reason. Health Net Dental reserves the right to make payment of Benefits, at its sole discretion, directly to the attending dentist or to you.

Health Net Dental Privacy Policy

Health Net Dental's privacy notice regarding its policies and procedures for preserving the confidentiality of medical records and Health Net Dental's use and disclosure of Protected Health Information is available to you. This notice is required by State and Federal Privacy laws including the Health Insurance Portability and Accountability Act (HIPAA) and will be furnished to you upon enrollment, upon request and upon material modification.

Fraud and Abuse

Health Net Dental has an anti-fraud program to investigate possible fraudulent or abusive issues. Members and Applicants may report a suspect issue to Health Net Dental and we will investigate it in confidence.

Fraud is a deception or misrepresentation by a provider, you or any person acting on their behalf, with the knowledge that the deception or misrepresentation could result in some unauthorized benefit or payment. A false or fictitious claim may include, or be supported by, false or fictitious statements.

Some examples of fraud are:

- Submitting claims for services, supplies, or equipment not furnished to or used by you.
- Billing or submitting a claim for non-Covered or non-chargeable services, supplies, equipment disguised as covered items.
- Providing services to an ineligible person and billing or submitting a claim for the services in the name of an eligible Member.

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- Misrepresentation of dates, frequency, duration, or description of services rendered.

Abuse is an improper practice or misuse by a provider or you that results in unnecessary costs or benefits. Abuse includes payments for services or supplies that are not Medically necessary or those that fail to meet professionally recognized standards.

Some examples of abuse are:

- A pattern of providing services that is not Medically necessary, or if Medically necessary, not to the extent rendered or provided.
- Care of inferior quality. For example, consistently furnishing dental services that do not meet accepted standards of care.
- Failure to maintain adequate clinical or financial records.
- Excessive use by a Member of controlled drugs (e.g. pain medications), sometimes achieved by using multiple providers.

To report a suspected fraud or abuse issue, Members and Applicants may call Health Net Dental Member Services at **1-866-249-2382** (TTY: **711** for the hearing and speech impaired), Monday-Friday, 5:00 a.m. to 8:00 p.m., except holidays. Interpreter Services are available by calling Member Services.

Principal Dental Limitations of Benefits

Please refer to the Dental Covered Services Schedule to determine your copayment responsibility. Multi-year benefits may not be available in subsequent years.

- 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 calendar year.
- Prophylaxis (cleaning) is limited to two per calendar year at no charge. Additional prophylaxis services will be at a copayment of \$40 for adults (age 18 and older) and \$25 for children (age 17 and under).
- Fluoride treatment is limited to once every calendar year for adults (age 18 and older) and children (age 17 and under).
- Bitewing x-rays are limited to one series of four films in any calendar year.
- Full mouth x-rays are limited to once every twenty-four consecutive months.
- Sealants are covered up to the fourteenth birth date and are limited to permanent first and second molars only.
- Periodontal treatments (gingival curettage and root planing) are limited to four separate quadrants in any twelve consecutive months and no more than two quadrants per date of service.
- Periodontal maintenance procedure/ periodontal prophylaxis (including minor scaling) is limited to two per calendar year following scaling and root planing (active therapy).
- Periodontal surgery (gingivectomy or osseous mucogingival) is limited to once per quadrant in any thirty-six consecutive months.

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- A full or removable partial, upper/lower denture is not to exceed one each in any five-year period, and only if it is unsatisfactory and cannot be made satisfactory by either reline or repair.
- Replacement of a restoration is covered only when it is Dentally Necessary.
- Fixed partial dentures will be covered only when a removable partial denture cannot satisfactorily restore the case. If fixed partial dentures are used when a removable partial denture could satisfactorily restore the case, then the fixed partial denture is considered to be Optional Treatment.
- Full cast crowns, porcelain crowns, porcelain fused to metal or plastic processed to metal type crowns are not a benefit for children under 16 years of age. The Plan covers an acrylic or stainless steel crown.
- A crown placed on a specific tooth is covered only once in any five-year period and only if it cannot be repaired and restored to natural function. A maximum of five units of crown and removable partial dentures will be covered in any one arch, in accordance with the Plan's policies and procedures.
- Crown lengthening, in lieu of all other restorative treatment performed on the same tooth on the same day, is limited to one time per tooth per lifetime.
- Relining or rebasing of complete or immediate dentures, as Dentally Necessary, within six months of installation of the replacement denture is limited to one. After the initial six months, relining and rebasing is limited to one per arch per year at the applicable dental copayment.
- Pedodontic referral for children up to the sixth birth date will be covered only after two attempts for treatment have been made by the Primary Dentist.
- Specialty referral benefits are limited to necessary endodontic, periodontic and oral surgery procedures that cannot be rendered by the assigned Primary Dentist.
- Consultation by a specialist for non-Covered Services is excluded.
- Stayplates are only a benefit to replace extracted anterior teeth for adults.
- Palliative (emergency) treatment of dental pain, considered for payment as a separate benefit only if no other services (except x-rays) are rendered during the visit.

Optional Treatment Provisions

If (1) a less expensive alternative procedure, service or course of treatment can be performed in place of the proposed treatment to correct a dental condition, as determined by the Plan; and (2) the alternate treatment will produce a professionally satisfactory result; then the maximum eligible dental expense to be considered for payment will be the less expensive treatment.

Principal Dental Exclusions

Payment will not be made for:

- Services to which you are entitled under any Workers' Compensation Law or Act or any other insurance plan, even if you did not claim those benefits.

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- Procedures that are: (a) not Dentally Necessary; or are (b) not customarily recognized throughout the dentist's field of specialty as essential for the treatment of the condition; (c) for services that are not prescribed by the attending Contracted Dentist.
- Temporomandibular joint treatment (T.M.J.).
- Elective or cosmetic dentistry, except as listed in the Benefit Schedule as a Covered Service and performed by a Contracted Dentist. Benefits for resin-based composite restorations on posterior teeth (behind the second bicuspid) will be based on the allowance for the corresponding amalgam restoration.
- Oral surgery requiring the setting of fractures or dislocations. Orthognathic surgery or other oral surgical procedures solely for orthodontic purposes.
- Loss or theft of full or partial dentures or other dental appliances.
- Services including:
 - a. dispensing of drugs;
 - b. diagnostic photographs;
 - c. panoramic x-ray, except when used as part of a full mouth series in the Contracted Primary Dentist office only;
 - d. athletic mouthguards;
 - e. precision or semi-precision attachments;
 - f. denture duplication;
 - g. harmful habit appliances;
 - h. congenital or developmental malformations, including, but not limited to cleft palate, congenitally missing or supernumerary teeth;
 - i. a service not specifically listed as a covered benefit;
 - j. x-rays rendered at a specialist's office (except for authorized pedodontic referrals);
 - k. hospital charges of any kind.
- Oral surgical procedures involving:
 - a. recontouring of hard and soft tissues;
 - b. sinus exploration;
 - c. oroantral fistula closure;
 - d. removal of foreign bodies;
 - e. salivary glands and ducts;
 - f. the removal or treatment of cysts, tumors, or neoplasms.
- Any procedure of implantation, reimplantation or related procedures.
- Procedures that are considered Experimental or investigative or that are not widely accepted as proven and effective within the organized dental community.
- Inhalation sedation, oral sedation drugs or intramuscular sedation.
- Treatment or consultations rendered by a specialist if:

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- a. you are deemed unmanageable for treatment by the Primary Dentist, except for children up to the sixth birth date; or
 - b. treatment cannot be rendered by the Primary Dentist due to your medical condition or physical limitations; or
 - c. a consultation is for non-Covered Services.
- Dental expenses incurred under this dental plan that are in connection with any dental procedure started prior to your effective date under this Plan or after termination of your coverage.
- Procedures relating to:
 - a. bite analysis;
 - b. the correction of abrasion, erosion, or attrition;
 - c. the change of contact or contour;
 - d. restorations for the purpose of splinting (except when necessary in conjunction with periodontal treatment);
 - e. grafting;
 - f. the treatment of non-pathologic conditions; and
 - g. overdentures and associated procedures.
- Services that, in the opinion of the Plan, do not have a reasonable, favorable prognosis.
- Disease contracted or injuries sustained as a result of a major disaster, war, declared or undeclared, epidemic conditions, or from exposure to nuclear energy, whether or not a result of war.
- Further liability for additional treatment on a tooth when you and provider have elected a treatment plan that is disallowed by the Plan. (You may appeal denial.)
- Crowns, inlays or onlays for teeth that can be satisfactorily restored by other means that meet professionally recognized standards.
- All crowns and fixed or removable partial dentures for full mouth reconstruction, defined as treatment relating to:
 - a. the change of vertical dimension, or
 - b. the restoration of occlusion, or
 - c. extensive restorative treatment involving all remaining occluding teeth.
- A Contracted Dentist may refuse treatment to any Member who continually fails to follow a prescribed course of treatment.

Orthodontic Benefit Limitations and Exclusions

- Orthodontic benefits are available only at Contracted Orthodontic offices.
- If you relocate to an area and are unable to receive treatment with the original Contracted Orthodontist, coverage under this program ceases and it becomes your obligation to pay

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the Usual and Customary Reasonable Fee (UCR) of the orthodontist where the treatment is completed.

- Covered treatment cannot be transferred by you from one Contracted Orthodontist to another Contracted Orthodontist.
- No benefit will be paid for an orthodontic treatment program that began before you enrolled in the Orthodontic Plan.
- Plan benefits are limited to 24 months of usual and customary orthodontic treatment (Phase 2 treatment banding).
- If you become ineligible during the course of treatment, coverage under this program ceases and it becomes your obligation to pay the Usual and Customary Reasonable Fee (UCR) incurred for the entire remaining balance of treatment.
- Orthognathic surgery cases and cases involving cleft palate, micrognathia, macroglossia, hormonal imbalances, temporomandibular joint disorders (T.M.J.), or myofunctional therapy.
- Re-treatment of orthodontic cases, changes in treatment necessitated by an accident of any kind, and treatment due to neglect or non-cooperation are excluded.
- The following are not included in the orthodontic benefits and the orthodontist's usual and customary charges apply:
 - a. initial diagnostic work-up and x-rays;
 - b. tracings;
 - c. Phase 1 orthodontic treatment (prior to full mouth banding)
 - d. records; functional appliances; headgear; pre-banding devices, appliances or therapy; biteplanes; palatal expansion appliances; thumb or tongue appliances; positioners; active vertical correctors; or tooth guidance appliances.
 - e. lingual or clear brackets;
 - f. extractions or other oral surgical procedures for orthodontic purposes;
 - g. study models;
 - h. replacement of lost or broken appliances, bands, brackets or orthodontic retainers.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**Dental Covered Services Schedule**

Copayments for the following routine (non-Medicare covered) dental services are not applied to your maximum out-of-pocket amount for covered medical services described in Section 1.2 earlier in this chapter.

CODE	SERVICE	YOU PAY
DIAGNOSTIC		
D0120	Periodic oral evaluation – established patient	No charge
D0140	Limited oral evaluation – problem focused	No charge
D0145	Oral evaluation – patient under three years of age and counseling with primary caregiver	No charge
D0150	Comprehensive oral evaluation – new or established patient	No charge
D0170	Re-evaluation – limited, problem focused (established patient; non-post-operative visit)	No charge
D0171	Re-evaluation - post-operative office visit	No charge
D0180	Comprehensive periodontal evaluation – new or established patient	No charge
D0210	Intraoral – complete series (includes bitewings)	No charge
D0220	Intraoral – periapical first film	No charge
D0230	Intraoral – periapical – each additional film	No charge
D0240	Intraoral – occlusal film	No charge
D0250	Extraoral – first film	No charge
D0251	Extra-oral posterior dental radiographic image	No charge
D0260	Extraoral – each additional film	No charge
D0270	Bitewing – single film	No charge
D0272	Bitewings – two films	No charge
D0273	Bitewings – three films	No charge
D0274	Bitewings – four films	No charge
D0277	Vertical bitewings – seven to eight films	No charge
D0330	Panoramic film	No charge
D0350	Oral/facial photographic images	No charge
D0351	3D photographic image	No charge
D0460	Pulp vitality tests	No charge
D0470	Diagnostic casts	\$15
D0472	Accession of tissue, gross examination preparations and transmission of written report	No charge
D0473	Accession of tissue, gross microscopic examination preparation and transmission of written report	No charge
D0474	Accession of tissue, gross and microscopic examination, including assessment of surgical margins for presence of disease, preparation and transmission of written report	No charge
D0486	Accession of brush biopsy sample, microscopic examination preparation and transmission of written report	No charge
D0600	Non-ionizing diagnostic procedure	No charge

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CODE	SERVICE	YOU PAY
PREVENTIVE		
D1110	Prophylaxis – adult	No charge
D1110	Prophylaxis – adult (in addition to 2 allowed every calendar year)	\$40
D1120	Prophylaxis – child	No charge
D1120	Prophylaxis – child (in addition to 2 allowed every calendar year)	\$25
D1203	Topical application of fluoride (prophylaxis not included) – child	No charge
D1204	Topical application of fluoride (prophylaxis not included) – adult	No charge
D1206	Topical fluoride, varnish; therapeutic application for moderate to high risk patients	No charge
D1310	Nutritional counseling for control of dental disease	No charge
D1330	Oral hygiene instructions	No charge
D1351	Sealant – per tooth	\$12
D1353	Sealant repair - per tooth	\$12
D1354	Interim caries arresting medicament application	\$15
D1510	Space maintainer, fixed – unilateral	\$55
D1515	Space maintainer, fixed – bilateral	\$55
D1520	Space maintainer, removable – unilateral	\$55
D1525	Space maintainer, removable – bilateral	\$55
D1550	Re-cementation of space maintainer	\$10
D1555	Removal of fixed space maintainer	\$10
D1575	Distal shoe space maintainer - fixed unilateral	\$55
RESTORATIVE		
D2140	Amalgam – 1 surface, primary or permanent	\$18
D2150	Amalgam – 2 surfaces, primary or permanent	\$20
D2160	Amalgam – 3 surfaces, primary or permanent	\$22
D2161	Amalgam – 4 or more surfaces, primary or permanent	\$27
D2330	Resin-based composite – 1 surface, anterior (primary or permanent)	\$20
D2331	Resin-based composite – 2 surfaces, anterior (primary or permanent)	\$24
D2332	Resin-based composite – 3 surfaces, anterior (primary or permanent)	\$40
D2335	Resin-based composite – 4 or more surfaces or involving incisal angle, anterior (primary or permanent)	\$50
D2390	Resin-based composite crown, anterior (primary or permanent)	\$50
D2391	Resin-based composite – 1 surface, posterior (primary or permanent)	\$80
D2392	Resin-based composite – 2 surfaces, posterior (primary or permanent)	\$85
D2393	Resin-based composite – 3 surfaces, posterior (primary or permanent)	\$90
D2394	Resin-based composite – 4 or more surfaces, posterior (primary or permanent)	\$100

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CODE	SERVICE	YOU PAY
D2510	Inlay – metallic – one surface ¹	\$225
D2520	Inlay – metallic – two surfaces ¹	\$225
D2530	Inlay – metallic – three or more surfaces ¹	\$225
D2542	Onlay – metallic – two surfaces ¹	\$225
D2543	Onlay – metallic – three surfaces ¹	\$225
D2544	Onlay – metallic – four or more surfaces ¹	\$225
D2740	Crown – porcelain/ceramic substrate	\$300
D2750	Crown – porcelain fused to high noble metal ¹	\$225
D2751	Crown – porcelain fused to predominantly base metal	\$225
D2752	Crown – porcelain fused to noble metal ¹	\$225
D2780	Crown – 3/4 cast high noble metal ¹	\$225
D2781	Crown – 3/4 cast predominantly base metal	\$225
D2782	Crown – 3/4 cast noble metal ¹	\$225
D2783	Crown – 3/4 porcelain/ceramic	\$225
D2790	Crown – full cast high noble metal ¹	\$225
D2791	Crown – full cast predominantly base metal	\$225
D2792	Crown – full cast noble metal ¹	\$225
D2794	Crown – titanium	\$225
D2910	Recement inlay, onlay, or partial coverage restoration	\$10
D2915	Recement cast or prefabricated post and core	\$10
D2920	Recement crown	\$10
D2930	Prefabricated stainless steel crown – primary tooth	\$25
D2931	Prefabricated stainless steel crown – permanent tooth	\$35
D2940	Sedative filling	No Charge
D2950	Core buildup, including any pins ¹	\$30
D2951	Pin retention, per tooth in addition to restoration ¹	\$15
D2952	Post and core in addition to crown indirectly fabricated ¹	\$75
D2953	Each additional indirectly fabricated post – same tooth ¹	\$40
D2954	Prefabricated post and core in addition to crown	\$55
D2955	Post removal (not in conjunction with endodontic therapy)	\$10
D2970	Temporary crown (fractured tooth)	No Charge
ENDODONTICS		
D3110	Pulp cap, direct (excluding final restoration)	\$5
D3120	Pulp cap, indirect (excluding final restoration)	\$5
D3220	Therapeutic pulpotomy (excluding final restoration)	\$18
D3221	Pulp debridement, primary and permanent teeth	\$18
D3230	Pulpal therapy (resorbable filling) – anterior, primary tooth (excluding final restoration)	\$25

¹ Dental copayments have an additional charge not to exceed the actual lab cost for precious and semi-precious metals.

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CODE	SERVICE	YOU PAY
D3240	Pulpal therapy (resorbable filling) – posterior, primary tooth (excluding final restoration)	\$25
D3310	Endodontic therapy – anterior (excluding final restoration)	\$85
D3320	Endodontic therapy – Bicuspid I (excluding final restoration)	\$145
D3330	Endodontic therapy – molar (excluding final restoration)	\$225
D3332	Incomplete endodontic therapy; inoperable, unrestorable or fractured tooth	\$85
D3346	Retreatment of previous root canal therapy - anterior	\$170
D3347	Retreatment of previous root canal therapy – bicuspid	\$245
D3348	Retreatment of previous root canal therapy - molar	\$275
D3351	Apexification/recalcification – initial visit (apical closure/calcific repair of perforations, root resorption, etc.)	\$65
D3352	Apexification/recalcification – interim medication replacement (apical closure/calcific repair of perforations, root resorption, etc.)	\$65
D3353	Apexification/recalcification – final visit (includes completed root canal therapy – apical closure/calcific repair of perforations, root resorption, etc.)	\$65
D3410	Apicoectomy/periradicular surgery – anterior	\$125
D3421	Apicoectomy/periradicular surgery – bicuspid (first root)	\$150
D3425	Apicoectomy/periradicular surgery – molar (first root)	\$160
D3426	Apicoectomy/periradicular surgery – (each additional root)	\$125
D3430	Retrograde filling – per root	\$95
D3450	Root amputation – per root	\$150
D3920	Hemisection (including any root removal), not including root canal therapy	\$125
PERIODONTICS		
D4210	Gingivectomy or gingivoplasty, four or more contiguous teeth or bounded teeth spaces – per quadrant	\$100
D4211	Gingivectomy or gingivoplasty, one to three contiguous teeth or bounded teeth spaces – per quadrant	\$35
D4240	Gingival flap procedure, including root planing – four or more contiguous teeth or bounded teeth spaces – per quadrant	\$275
D4241	Gingival flap procedure, including root planing - one to three contiguous teeth or bounded teeth spaces – per quadrant	\$275
D4249	Clinical crown lengthening – hard tissue	\$160
D4260	Osseous surgery (including flap entry and closure) – four or more contiguous teeth or bounded teeth spaces – per quadrant	\$350
D4261	Osseous surgery (including flap entry and closure) – one to three contiguous teeth or bounded teeth spaces – per quadrant	\$350
D4270	Pedicle soft tissue graft procedure	\$375
D4271	Free soft tissue graft (including donor site surgery)	\$375

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CODE	SERVICE	YOU PAY
D4273	Subepithelial connective tissue graft procedures	\$375
D4274	Distal or proximal wedge procedure (when not performed in conjunction with surgical procedures in the same anatomical area)	\$50
D4283	Autogenous connective tissue graft procedure - each additional contiguous tooth, implant or edentulous tooth	\$375
D4341	Periodontal scaling and root planing - four or more teeth- per quadrant	\$40
D4342	Periodontal scaling and root planing – one to three teeth- per quadrant	\$40
D4346	Scaling in presence of generalized moderate or severe gingival inflammation	\$35
D4355	Full mouth debridement to enable comprehensive evaluation and diagnosis	\$40
D4381	Localized delivery of antimicrobial agents via a controlled release vehicle into diseased crevicular tissue, per tooth, by report	\$60
D4910	Periodontal maintenance	\$35
D4999	Unspecified periodontal procedure, by report	No Charge
PROSTHODONTICS (REMOVABLE DENTURES/PARTIALS)		
D5110	Complete denture – maxillary	\$200
D5120	Complete denture – mandibular	\$200
D5130	Immediate denture – maxillary	\$200
D5140	Immediate denture – mandibular	\$200
D5211	Maxillary partial denture – resin base (including any conventional clasps, rests and teeth)	\$200
D5212	Mandibular partial denture – resin base (including any conventional clasps, rests and teeth)	\$225
D5213	Maxillary partial denture – cast metal framework, resin denture bases (including any conventional clasps, rests and teeth)	\$250
D5214	Mandibular partial denture – cast metal framework, resin denture base (including any conventional clasps, rests and teeth)	\$250
D5221	Immediate maxillary partial denture - resin base	\$70
D5222	Immediate mandibular partial denture - resin base	\$70
D5223	Immediate maxillary partial denture - cast metal framework with resin denture bases	\$70
D5224	Immediate mandibular partial denture-cast metal framework with resin denture bases	\$70
D5410	Adjust complete denture – maxillary	\$15
D5411	Adjust complete denture – mandibular	\$15
D5421	Adjust partial denture – maxillary	\$15
D5422	Adjust partial denture – mandibular	\$15

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CODE	SERVICE	YOU PAY
D5510	Repair broken complete denture base	\$25
D5520	Replace missing or broken tooth complete denture (each tooth)	\$25
D5610	Repair resin denture base	\$30
D5620	Repair cast framework	\$35
D5630	Repair or replace broken clasp	\$30
D5640	Replace broken teeth – per tooth	\$35
D5650	Add tooth to existing partial denture	\$35
D5660	Add clasp to existing partial denture	\$35
D5710	Rebase complete maxillary denture	\$100
D5711	Rebase complete mandibular denture	\$100
D5720	Rebase maxillary partial denture	\$100
D5721	Rebase mandibular partial denture	\$100
D5730	Reline complete maxillary denture (chairside)	\$45
D5731	Reline complete mandibular denture (chairside)	\$45
D5740	Reline maxillary partial denture (chairside)	\$45
D5741	Reline mandibular partial denture (chairside)	\$45
D5750	Reline complete maxillary denture (laboratory)	\$70
D5751	Reline complete mandibular denture (laboratory)	\$70
D5760	Reline maxillary partial denture (laboratory)	\$70
D5761	Reline mandibular partial denture (laboratory)	\$70
D5810	Interim complete denture – maxillary	\$100
D5811	Interim complete denture – mandibular	\$100
D5820	Interim partial denture – maxillary	\$70
D5821	Interim partial denture – mandibular	\$70
D5850	Tissue conditioning – maxillary	\$25
D5851	Tissue conditioning – mandibular	\$25
PROSTHODONTICS – FIXED		
D6210	Pontic – cast high noble metal ¹	\$225
D6211	Pontic – cast predominantly base metal	\$225
D6212	Pontic - cast noble metal ¹	\$225
D6214	Pontic – titanium	\$225
D6240	Pontic – porcelain fused to high noble metal ¹	\$225
D6241	Pontic – porcelain fused to predominantly base metal ¹	\$225
D6242	Pontic – porcelain fused to noble metal ¹	\$225
D6245	Pontic – porcelain/ceramic	\$225
D6750	Crown – porcelain fused to high noble metal ¹	\$225
D6751	Crown – porcelain fused to predominantly base metal	\$225
D6752	Crown – porcelain fused to noble metal ¹	\$225
D6780	Crown – 3/4 cast high noble metal ¹	\$225
D6781	Crown – 3/4 cast predominantly base metal	\$225
D6782	Crown – 3/4 cast noble metal ¹	\$225

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CODE	SERVICE	YOU PAY
D6790	Crown – full cast high noble metal ¹	\$225
D6791	Crown – full cast predominantly base metal	\$225
D6792	Crown – full cast noble metal ¹	\$225
D6794	Crown – titanium	\$225
D6930	Recement fixed partial denture	No Charge
D6970	Cast post and core in addition to fixed partial denture retainer indirectly fabricated ¹	\$70
D6972	Prefabricated post and core in addition to fixed partial denture retainer	\$55
D6973	Core build up for retainer, including any pins ¹	\$30
D6976	Each additional indirectly fabricated post – same tooth ¹	\$40
D6977	Each additional prefabricated post – same tooth	\$20
ORAL SURGERY		
D7111	Extraction, coronal remnants – deciduous tooth	\$15
D7140	Extraction, erupted tooth or exposed root (evaluation and/or forceps removal)	\$15
D7210	Surgical removal of erupted tooth requiring evaluation of mucoperiosteal flap and removal of bone and/or section of tooth	\$40
D7220	Removal of impacted tooth – soft tissue	\$60
D7230	Removal of impacted tooth – partially bony	\$80
D7240	Removal of impacted tooth – completely bony	\$125
D7241	Removal of impacted tooth – completely bony, with unusual surgical complications	\$150
D7250	Surgical removal of residual tooth roots (cutting procedure)	\$50
D7270	Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth	\$110
D7280	Surgical access exposure of an unerupted tooth	\$175
D7285	Biopsy of oral tissue – hard (bone, tooth)	\$60
D7286	Biopsy of oral tissue – soft (all others)	\$60
D7310	Alveoloplasty in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	\$55
D7311	Alveoloplasty in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	\$18
D7320	Alveoloplasty not in conjunction with extractions – four or more teeth or tooth spaces, per quadrant	\$70
D7321	Alveoloplasty not in conjunction with extractions – one to three teeth or tooth spaces, per quadrant	\$23
D7510	Incision and drainage of abscess – intraoral soft tissue	No Charge
D7511	Incision and drainage of abscess – intraoral soft tissue – complicated (includes drainage of multiple fascial spaces)	No Charge
D7881	Occlusal orthotic device adjustment	\$15

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CODE	SERVICE	YOU PAY
D7963	Frenuloplasty	\$45
D7960	Frenulectomy(frenectomy or frenotomy) – separate procedure	\$45
D7971	Excision of pericoronal gingiva	\$60
ORTHODONTICS		
D8050	Interceptive orthodontic treatment of the primary dentition	\$725
D8060	Interceptive orthodontic treatment of the transitional dentition	\$725
D8070	Comprehensive orthodontic treatment of the transitional dentition	\$1,950
D8080	Comprehensive orthodontic treatment of adolescent dentition	\$1,950
D8090	Comprehensive orthodontic treatment of the adult dentition	\$2,250
D8660	Pre-orthodontic treatment visit	No Charge
D8670	Periodontic orthodontic treatment visit (as part of contract)	No Charge
D8680	Orthodontic retention (removal of appliances, construction and placement of retainers(s))	\$250
D8681	Removable orthodontic retainer adjustment	No Charge
D8693	Rebonding or recementing; and/or repair, as required of fixed retainers	No Charge
D8999	Start-up fee (including exam, beginning records, x-rays, tracings, photos and models) construction replacement of retainers	\$250
D8999	Post-treatment records	\$150
D8999	Monthly orthodontic fee (for comprehensive treatment beyond 24 months)	\$35
ADJUNCTIVE		
D9120	Fixed partial denture sectioning	No Charge
D9210	Local anesthesia not in conjunction with operative or surgical procedures	No Charge
D9211	Regional block anesthesia	No Charge
D9215	Local anesthesia	No Charge
D9219	Evaluation for deep sedation or general anesthesia	No Charge
D9220	Deep sedation/general anesthesia – first 30 minutes	\$125
D9221	Deep sedation/general anesthesia – each additional 15 minutes	\$60
D9223	Deep sedation/general anesthesia-each 15 minute increment	\$60
D9241	Intravenous conscious sedation/analgesia – first 30 minutes	\$125
D9242	Intravenous conscious sedation/analgesia – each additional 15 minutes	\$60
D9243	Intravenous moderate (conscious) sedation/analgesia-each 15 minute increment	\$60
D9310	Consultation – diagnostic service provided by dentist or physician other than requesting dentist or physician	No Charge

¹ Dental copayments have an additional charge not to exceed the actual lab cost for precious and semi-precious metals.

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

CODE	SERVICE	YOU PAY
D9311	Consultation with a medical health care professional	\$0
D9430	Office visit for observation (during regularly scheduled hours) – no other services performed	No Charge
D9440	Office visit – after regularly scheduled hours	\$20
D9630	Other drugs and/or medicaments by report	\$15
D9910	Application of desensitizing medicament	\$15
D9940	Occlusal guard by report	\$100
D9942	Repair and/or reline of occlusal guard	\$45
D9943	Occlusal adjustment	\$15
D9951	Occlusal adjustment – limited	No Charge
D9952	Occlusal adjustment – complete	\$75
D9999	Record transfer – transfer of all materials with or without an X-ray	\$15
MATERIAL UPGRADES FOR NON-ELECTIVE DENTAL SERVICES (COSTS REFLECTED BELOW ARE IN ADDITION TO COPAYMENT FOR SERVICES)		
D2750	Porcelain on molars ²	\$75
D2999	Noble or high noble metal for crowns – lab cost ²	Lab cost
D2740	Lucite-reinforced pressed crown/Empress ²	\$300 + copayment
D2750	Gold composite reinforced crown/Captex ²	\$300 + copayment
D5110	Comfort Flex (complete upper denture) acetyl resin homopolymer ²	\$400 + copayment
D5120	Comfort Flex (complete lower denture) acetyl resin homopolymer ²	\$400 + copayment
D5211	Comfort Flex (upper partial denture) acetyl resin homopolymer ²	\$425 + copayment
D5212	Comfort Flex (lower partial denture) acetyl resin homopolymer ²	\$425 + copayment
COSMETIC DENTAL SERVICES (ELECTIVE SERVICES)		
D2330	Resin based-composite, one surface anterior	\$80
D2331	Resin based-composite, two surfaces anterior	\$95
D2332	Resin based-composite, three surfaces anterior	\$105
D2335	Resin based-composite, four or more surfaces or involving incisal angle (anterior)	\$125
D2391	Resin based-composite, one surface posterior	\$85
D2392	Resin based-composite, two surfaces posterior	\$100
D2393	Resin based-composite, three surfaces posterior	\$110
D2394	Resin based-composite, four or more surfaces posterior	\$130
D2740	Lucite-reinforced pressed crown/Empress	\$700

² In addition to copayment for services.

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

CODE	SERVICE	YOU PAY
D2962	Labial veneer/porcelain laminate	\$450
D5110	Comfort Flex (complete upper denture) acetyl resin homopolymer	\$650
D5120	Comfort Flex (complete lower denture) acetyl resin homopolymer	\$650
D5211	Comfort Flex (upper partial denture) acetyl resin homopolymer	\$725
D5212	Comfort Flex (lower partial denture) acetyl resin homopolymer	\$725
D9772	External bleaching – per arch	\$125
EMERGENCY DENTAL CARE (NON ROUTINE, NON MEDICARE-COVERED)		
D9110	Palliative (emergency) treatment of dental pain – minor procedure	No Charge

²In addition to copayment for services.

How to File a Claim for Dental Care Services

In most cases your Primary Care General Dentist will submit your claims to Health Net Dental. To file a claim you may have, please send us a letter or complete a Health Net Dental claim form. If you need a claim form, go online to <https://ca.healthnetadvantage.com> or contact Health Net Dental Member Services at **1-866-249-2382** (TTY: **711** for the hearing and speech impaired), Monday-Friday, 5:00 a.m. to 8:00 p.m., except holidays. Interpreter Services are available by calling Member Services. You can also get a claim form at Health Net Dental's website at <https://ca.healthnetadvantage.com>.

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

Health Net Dental
PO Box 30567
Salt Lake City, UT 84130-0567

We will mail you notification of our determination on your claim within 72 hours of receipt of your claim. If a reimbursement is due to you, a check will be mailed within 30 days of receipt of your claim.

Reimbursement for Emergency Dental Care

If you see a dentist other than your Primary Care General Dentist for emergency or urgent dental care services, the dentist may ask for payment at the time the service is provided.

If you pay a bill for covered emergency or urgent dental care services, you should send a copy of the paid bill and proof of payment to:

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

Health Net Dental
PO Box 30567
Salt Lake City, UT 84130-0567

All such claims must be sent to Health Net Dental to be considered for payment. Please include either the dentist's completed claim form or a separate sheet of paper, if a form is unavailable, that includes the following information:

- Name, address, ID number, and group number from your identification card.
- Name and address of the dentist who provided the service (unless stated on the bill).
- An explanation of the condition that made emergency or urgent treatment necessary.
- An itemized receipt that specifies the Covered Services provided.

If additional information is needed, you will be advised in writing. If all or part of the claim is denied, you will receive written notice of the decision within 30 days including:

- The reason for denial.
- Reference to the pertinent *Evidence of Coverage* provision(s) on which the denial is based.
- Notice of the right to request reconsideration of the denial and an explanation of the appeal process.

If you receive Emergency Dental Care from a dentist that is not your Primary Care General Dentist, you should return to your Primary Care General Dentist for follow-up care.

Non-Qualifying Emergency or Urgent Dental Care Services

Emergency or urgent dental care services do not include these services:

- Normal diagnostic and preventive services.
- Permanent restorative and prosthetic services.
- Complete endodontic services.
- Complete periodontic services.
- Orthodontic services.
- Oral surgery for conditions that are not severe.
- Other services that are not required for Emergency Dental Care.

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

QUESTIONS?

For up-to-date Primary Care General Dentist information or to obtain authorization to receive services, please contact Health Net Dental Member Services at **1-866-249-2382** (TTY: **711** for the hearing and speech impaired), Monday-Friday, 5:00 a.m. to 8:00 p.m., except holidays. Interpreter Services are available by calling Member Services. Or, visit the Health Net Dental web site at <https://ca.healthnetadvantage.com> for a list of Health Net Dental 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.

Dental Services (DPPO) – Optional Supplemental Benefits Package 2
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Insert for buy-up: NOTE: As a Member of our plan, you have Medicare covered dental benefits. Refer to the Medical Benefits Chart earlier in this chapter for copayment and benefit information. Only members who have purchased the Optional Supplemental Benefit Package 2 have routine (non-Medicare covered) preventive and comprehensive PPO dental benefits described below.

Health Net Dental Plan and covered services are administered by Dental Benefit Administrative Services. You can see any licensed dentist to receive covered dental services. However, your cost shares are higher when you receive covered services from non-plan providers than from plan providers. Dental services are offered through Health Net Dental network providers. Health Net Dental providers are listed in your provider directory. Please contact Health Net Dental Member Services for a list of plan providers at the toll-free number **1-866-249-2382** (or TTY: **711** for the hearing and speech impaired), Monday through Friday, 5:00 a.m. to 8:00 p.m., except holidays.

What Health Net Dental services are covered?

Preventive and limited comprehensive services listed below from plan and non-plan providers are covered.

- Periodic 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)
- Fluoride
- Fillings
- Simple (non-surgical) extractions
- Periodontal procedures: scaling and root planing, periodontal maintenance procedures, full-mouth debridement
- Sealants

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

DESCRIPTION	In-Network You Pay:	Out-of-Network You Pay:
Calendar Year Deductible	\$35	\$35
Calendar Year Maximum	\$1,000 combined for all in-network and out-of-network services	
Preventive Services		
Periodic (routine) oral exam	\$0 after deductible	20% of Maximum Allowable Charge (MAC)◆ after deductible and the difference between MAC and billed charges
Teeth cleaning and routine scaling	\$0 after deductible	20% of Maximum Allowable Charge (MAC)◆ after deductible and the difference between MAC and billed charges
Fluoride treatment	\$0 after deductible	20% of Maximum Allowable Charge (MAC)◆ after deductible and the difference between MAC and billed charges
Sealant	\$0 after deductible	20% of Maximum Allowable Charge (MAC)◆ after deductible and the difference between MAC and billed charges
Bitewing and full-mouth or panoramic x-rays (as part of a general exam)	\$0 after deductible	20% of Maximum Allowable Charge (MAC)◆ after deductible and the difference between MAC and billed

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

DESCRIPTION	In-Network You Pay:	Out-of-Network You Pay:
		charges
General Services		
Fillings	20% after deductible	40% of Maximum Allowable Charge (MAC) ♦ after deductible and the difference between MAC and billed charges
Simple (non-surgical) extractions	20% after deductible	40% of Maximum Allowable Charge (MAC) ♦ after deductible and the difference between MAC and billed charges
Periodontal procedures: scaling and root planing, periodontal maintenance procedures, full-mouth debridement	20% after deductible	40% of Maximum Allowable Charge (MAC) ♦ after deductible and the difference between MAC and billed charges
Major Services		
Crowns, removable and fixed bridges, complete and partial dentures, endodontics, periodontics, and oral surgery	Not Covered	Not Covered
Orthodontia (Adult and Child)		
All orthodontia services	Not Covered	Not Covered

♦ Maximum Allowable Charge (MAC): Maximum Allowable Charge (MAC) is the maximum dollar amount allowed by the plan for a covered dental service. Balance billing occurs when a dentist bills you for the difference between the plan's Maximum Allowable Charge (MAC) and the dentist's total billed charge. Network dentists cannot balance bill you for covered services which exceed the Maximum Allowable Charge (MAC) they have contractually agreed to; however, it is possible that non-network dentists may balance bill you for treatment rendered.

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

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

In addition to any exclusions or limitations described later in this chapter, the following items and services are not covered by your plan as part of the routine dental benefits provided by Health Net Dental. Additionally, multi-year benefits may not be available in subsequent years.

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 calendar year.
2. Complete series or panorex radiographs limited to one time per 36 months.
3. Bitewing radiographs limited to 2 series of films per calendar year.
4. Dental prophylaxis and fluoride treatments are limited to 2 times per calendar year.
5. Periodontal root scaling and planing is limited to 1 one time per quadrant per 24 months.
6. Periodontal full mouth debridement is limited to one treatment per lifetime.
7. Periodontal maintenance procedures (following active periodontal therapy) are limited to 2 per calendar year.
8. Health Net Dental has a \$35 deductible for in-network dental services.
9. Health Net Dental has a \$35 deductible for out-of-network dental services.
10. Health Net Dental has a \$1,000 Plan Maximum per year combined for in-network and out-of-network Preventive and limited Comprehensive 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?

When you see a non-plan dentist, you will have to file a claim with Health Net Dental. Health Net Dental will pay your provider its share of the bill for any covered services that are

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

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 for a claim form and claim filing instructions at the toll-free number **1-866-249-2382** (or TTY: **711** for the hearing and speech impaired), Monday through Friday, 5:00 a.m. to 8:00 p.m., except holidays. You can also get a claim form at Health Net Dental's website at <https://ca.healthnetadvantage.com>.

The bill should be submitted to the following address:

Health Net Dental
PO Box 30567
Salt Lake City, UT 84130-0567

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

Eyewear – Optional Supplemental Benefits Package 1 or 2

NOTE: As a Member of our plan, you have Medicare-covered vision and annual routine eye exam benefits. Refer to the Medical Benefits Chart earlier in this chapter for copayment and benefit information. Only members who have purchased the Optional Supplemental Benefits Package 1 or 2 have the routine (non-Medicare covered) Eyewear benefits described below.

The Optional Supplemental Benefits Package Eyewear Benefit offers 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 how much, if anything, you must pay your provider.

Annual routine eye exams are covered under your medical benefit and are not covered under the Optional Supplemental Benefits Package Eyewear Benefit. For information on how to access your annual routine eye exam, refer to the "Vision care" section in the Medical Benefits Chart earlier in this chapter.

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 annual routine eye exam covered under your medical benefit, 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 Member Services at **1-866-392-6058** (or TTY 711 for the hearing and speech impaired) Monday through Saturday, 4:30 a.m. to 8:00 p.m. and

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

Sunday, 8:00 a.m. to 5:00 p.m., except major holidays or visit our website at <https://ca.healthnetadvantage.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 Eyewear benefits or would like a list of Health Net Vision participating Eyewear providers, you may call Health Net Vision Member Services at **1-866-392-6058** (or TTY 711 for the hearing and speech impaired). Normal business hours are Monday through Saturday, 4:30 a.m. to 8:00 p.m. and Sunday, 8:00 a.m. to 5:00 p.m., except major holidays

Chiropractic Care – Optional Supplemental Benefits Package 1 or 2

NOTE: As a Member of our plan, you have Medicare-covered Chiropractic benefits (manual manipulation of the spine to correct subluxation). Please see the Medical Benefits Chart earlier in this chapter for copayment and benefit information. Only members who have purchased the Optional Supplemental Benefit Package 1 or 2 have routine (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 verification of medical necessity of the treatment plan he or she develops for you. For a list of ASH Plans-Contracted Chiropractors, please call ASH Plans at **1-800-678-9133** (TTY users call 711), Monday through Friday, 5:00 a.m. to 6:00 p.m., excluding holidays.

Chiropractic Services are covered up to the maximum of 30 medically necessary visits (combined with Acupuncture Services visits) 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 Urgent and Emergency Chiropractic Services from a non-Contracted Practitioner; and
- If covered Chiropractic Services are not available and accessible, you may obtain covered Chiropractic Services from a non-Contracted Practitioner who is available and accessible to you upon referral by ASH Plans.

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

The following Chiropractic Services do not require medical necessity review 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◆.

◆ Please refer to the Chiropractic Covered Services section for ASH Plans benefit definition as it pertains to 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, and/or Urgent and Emergency Services may require verification of Medical Necessity.
- A new patient exam, or an established patient exam, for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of Chiropractic Services. A new patient is one who has not received any professional services from the practitioner, or another practitioner of the same specialty who belongs to the same group practice, within the past three years.
- Established patient exams assess the need to initiate, continue, extend, or change a Course of Treatment. The established patient exam may require verification of Medical Necessity. An established patient is one who has received professional services from the practitioner, or another practitioner of the same specialty who belongs to the same group practice, within the past three years.
- Adjunctive physical medicine and rehabilitation services 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 an ASH Plans-Contracted Chiropractor and verified by ASH Plans as being Medically Necessary. Radiological consultations are a covered benefit when verified by ASH Plans as being 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 verified by ASH Plans as Medically Necessary for the treatment of either Musculoskeletal and Related Disorders, Pain Syndromes.
- Urgent Services▲.
- Emergency Services▼.

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◀ Covered Chiropractic Supports and Appliances may include cervical collars, cervical pillows, heel lifts, non-electric heat pads, cushions, rib belts and home-traction lumbar. You would receive the Chiropractic Support/Appliance, or a prescription for one would be received from the ASH Plans-Contracted Chiropractor, and you would submit a claim to ASH Plans for reimbursement.

▲ Urgent Services are Covered Services that are Chiropractic Services necessary to prevent serious deterioration of the health of a Member, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until you return to the Service Area. ASH Plans shall determine whether Chiropractic Services constitute Urgent Services.

▼ Emergency Services consist of Covered Services that are Chiropractic Services provided to manage an injury or condition with a sudden and unexpected onset which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health or medicine could reasonably expect the absence of immediate clinical attention to result in (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; or (4) decreasing the likelihood of maximum recovery. ASH Plans shall determine whether Chiropractic Services constitute 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 for each visit.

X-ray services with radiological consultations are a covered benefit when verified by ASH Plans as being 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.

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

- 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 Practitioner, 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 physical medicine and rehabilitation services, 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 Musculoskeletal and Related 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 practitioner’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.
- Services and other treatments that are classified as Experimental or Investigational.
- 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 practitioner 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, contact ASH Plans at

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

1-800-678-9133 (TTY users call 711), Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays.

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

Claims Administration
American Specialty Health Plans, Inc.
PO 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 completed claim.

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

When receiving Emergency Care or Urgent Care from a non-Contracted Practitioner, you should request that the practitioner bill ASH Plans directly for services. If the practitioner bills you directly, ASH Plans will reimburse you for the eligible charges paid for emergency services and out-of-area urgent care services, less any applicable copayments. To receive reimbursement, you should submit an itemized bill and completed claim form to ASH Plans. A claim form can be obtained by contacting ASH Plans at **1-800-678-9133** (TTY users call 711), Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays.

Completed claim forms should be submitted to:

Claims Administration
American Specialty Health Plans, Inc.
PO Box 509002
San Diego, CA 92150-9002

QUESTIONS?

For up-to-date practitioner information, please contact ASH Plans at **1-800-678-9133** (TTY users call 711), Monday through Friday, 5:00 a.m. to 6:00 p.m., excluding holidays.

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 – Optional Supplemental Benefits Package 1 or 2

Only members who have purchased the Optional Supplemental Benefit Package 1 or 2 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

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

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/ or she develops for you.

Acupuncture Services are covered up to the maximum of 30 visits (combined with Chiropractic Services visits) 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 Urgent or Emergency Acupuncture Services from a non-Contracted Practitioner; and
- If covered Acupuncture Services are not available and accessible, you may obtain covered Acupuncture Services from a non-Contracted Practitioner who is available and accessible to you upon referral by ASH Plans.

The following Acupuncture Services do not require verification of medical necessity 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♥.

♥Please refer to the Acupuncture Covered Services section for the ASH Plans benefit description as it applies to 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 practitioner, or another practitioner of the same specialty who belongs to the same group practice, within the past three years.
- Established patient exams assess the need to initiate, continue, extend, or change a Course of Treatment. The established patient exam is only covered when used to determine the appropriateness of Acupuncture Services. The established patient exam may require verification of Medical Necessity. An established patient is one who has received professional services from the practitioner, or another practitioner of the same specialty who belongs to the same group practice, within the past three years.
- Adjunctive Therapies or Modalities within the scope of practice of the acupuncture provider may be covered, but only when provided during the same Course of Treatment

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

and in support of Acupuncture Services. However, the following exception applies for the application of acupressure; if (a) a Contracted Practitioner of Acupuncture Services would recommend Acupuncture Services for a Member as a Covered Service but cannot do so in accordance with a professionally-recognized, valid, evidence-based standards of practice because the insertion of needles is contraindicated (e.g., for a patient with an infectious disease that may be transmitted through blood or other bodily fluids), and (b) professionally-recognized, valid, evidence-based standards of practice indicate that acupressure would be efficacious in the treatment of the member, then Acupuncture Services shall be deemed to include acupressure in that circumstance, even if Acupuncture Services are not provided to the Member at the same time and the Member shall be entitled to receive other Adjunctive Therapies or modalities in conjunction with the provision of acupressure, in that circumstance, to the same extent as would be the case if the Member were receiving Acupuncture Services.

- 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 verified by ASH Plans as Medically Necessary for the treatment of Musculoskeletal and Related Disorders, Nausea and/or Pain or pain syndromes.
- Urgent Services♣.
- Emergency Services♠.

♣Urgent Services are Covered Services that are Acupuncture Services necessary to prevent serious deterioration of the health of a Member, resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy, for which treatment cannot be delayed until the Member returns to the Service Area. ASH Plans shall determine whether Acupuncture Services constitute Emergency Services.

♠Emergency Services consist of Covered Services that are Acupuncture Services provided to manage an injury or condition with a sudden and unexpected onset, which manifests itself by acute symptoms of sufficient severity, including severe pain, such that a prudent layperson who possesses an average knowledge of health or medicine could reasonably expect the absence of immediate clinical attention to result in (1) placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy; (2) serious impairment to bodily functions; (3) serious dysfunction of any bodily organ or part; or (4) decreasing the likelihood of maximum recovery. ASH Plans shall determine whether Acupuncture Services constitute 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:

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- 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 Musculoskeletal and Related Disorders, Nausea, Pain or pain syndromes.
- Services or treatments delivered by a Non-Contracted Practitioner, 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.
- 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 practitioner's scope of practice.

How to File a Claim for Acupuncture Services

In most cases, your Acupuncture service practitioner 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, contact ASH Plans at

1-800-678-9133 (TTY users call 711), Monday through Friday, 5:00 a.m. to 6:00 p.m., excluding holidays.

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

Claims Administration
American Specialty Health Plans, Inc.
PO 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 Practitioner/Facility

When receiving Emergency Care or Urgent Care from a non-Contracted Practitioner, you should request that the practitioner bill ASH Plans directly for services. If the practitioner bills you directly, ASH Plans will reimburse you for the eligible charges paid for emergency services and out-of-area urgent care services, less any applicable copayments. To receive reimbursement, you should submit an itemized bill and completed claim form to ASH Plans. A claim form can be obtained by contacting ASH Plans at **1-800-678-9133** (TTY users call 711), Monday through Friday, 5:00 a.m. to 6:00 p.m., excluding holidays.

Completed claim forms should be submitted to:

Claims Administration
American Specialty Health Plans, Inc.
PO Box 509002
San Diego, CA 92150-9002

QUESTIONS?

For up-to-date practitioner information, please contact ASH Plans at **1-800-678-9133** (TTY users call 711), Monday through Friday, 5:00 a.m. to 6:00 p.m., excluding holidays.

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.

The Silver&Fit Program – Optional Supplemental Benefits Package 1 or 2

Only members who have purchased the Optional Supplemental Benefit Package 1 or 2 have non-Medicare covered health and fitness benefits described below.

The Silver&Fit program is an Exercise and Healthy Aging Program which provides a no-cost membership at a participating Silver&Fit fitness center, or membership in the Silver&Fit Home Fitness Program for members who are unable to visit a fitness center or prefer to work out at home. The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated. There are no copays, co-insurance, or deductibles to participate in the Silver&Fit Program.

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Prior to participating in any exercise or weight management program, it is important for you to seek the advice of a physician or other qualified health professional.

How do I enroll?

Simply choose a participating fitness center online at SilverandFit.com or call Silver&Fit customer service at 1-888-797-7757 or TTY phone 711, Monday – Friday, 5:00 a.m. – 6:00 p.m., excluding holidays to choose a facility. Once you have chosen a fitness center, take your fitness card, located on the enrollment flier, to the fitness center of your choice. You may be required by the fitness center you choose to sign a membership agreement. The membership agreement that you may be required to sign at the fitness center is for a no-cost “standard fitness center membership,” which includes the covered services available through the program, described below. If you choose to access fitness center services otherwise available by the fitness center at an additional fee, then the agreement may reflect costs associated with those non Silver&Fit program related services.

If you wish to enroll in the Silver&Fit Home Fitness program, you can enroll online at www.SilverandFit.com or by calling Silver&Fit customer service at 1-888-797-7757 or TTY 711 (National Relay Service), Monday – Friday, 5:00 a.m. – 6:00 p.m., excluding holidays.

Explanation of Covered Services (i.e. what is a “standard fitness center membership?”)**Fitness Clubs**

The standard fitness club membership with the Silver&Fit program includes all of the services and amenities included with your fitness club membership, such as:

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

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

Exercise Centers

The standard exercise center membership with the Silver&Fit program typically includes classes on strength, cardiovascular, and/or flexibility training, depending on what is available at the exercise center. Exercise centers may include Pilates, yoga studios, or others.

Explanation of Covered Services (i.e. what is “the Silver&Fit Home Fitness Program?”)

If during enrollment you choose to participate in the Silver&Fit Home Fitness Program, you may choose to receive up to two of the following kits per benefit year:

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

- Cardio Strength Kit
- Walking Kit (pedometer and walking program instructions)
- Yoga Kit
- Tai Chi Beginner Kit
- Tai Chi for Balance Intermediate Kit
- Chair Pilates Kit
- Aquatic Exercise Kit
- Stress Management Kit
- Chair Dancing Kit
- Chair Boxing Kit
- Chair Resistance Band Kit
- Chair Tai Chi Kit
- Chair Aerobics Kit
- Chair Yoga Kit
- Exercise for the Bed Ridden Kit
- Signature Series: Explore
- Signature Series: Experience
- Signature Series: Excel
- Barre Fitness
- Barre Fitness for All Levels
- Chair Dancing Celebration
- Diabetes Workout

The Silver&Fit Home Fitness Program kits may include:

- A DVD
- A booklet with general information about the topic
- A “Quick Start” guide that explains how to start using the items in the kit – this may be part of the booklet, or it may be separate

Services offered through the "Customer Service Hotline"

You may call Silver&Fit member services at 1-888-797-7757 or TTY 711, Monday through Friday, 5:00 a.m. – 6:00 p.m., excluding holidays, for information on any of the following:

- Fitness center search
- Enrollment
- Program design
- Eligibility
- Changing fitness centers
- Fitness center nominations

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

Silver&Fit Website

As a Silver&Fit eligible member, you have access to the Silver&Fit website, www.SilverandFit.com, which is a valuable resource to you. You may:

- Utilize the fitness center search
- Access Healthy Aging classes to help you make better health decisions
- Utilize the Silver&Fit Connected![™] program, a fun and easy way to track your exercise at a fitness center or through a wearable fitness device, app, or exercise equipment and earn rewards*
- Access to *The Silver Slate*[®] newsletter
- Access to other web tools such as challenges, online classes, and more

Exclusions and limitations

The following services are not offered:

- Services or supplies provided by any person, company or fitness center other than a Silver&Fit participating fitness center
- All education materials other than those produced for Silver&Fit by American Specialty Health Incorporated
- Telecommunications devices, telephone handset amplifiers, television recorders, and telephones compatible with hearing aids
- Education program services for individuals other than the member
- Prescription drugs, over-the-counter products, dietary supplements, herbal supplements, vitamins, minerals, weight control products, meal-replacement beverages or powders, or any other types of food or food product, whether or not it is recommended, prescribed, or supplied by a health care provider, fitness center, or program
- All listening devices, including, but not limited to, audiotape and CD players
- Services for members with serious medical conditions for which Silver&Fit services are not appropriate.
- Purchase of a wearable fitness device or app is not included.

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.

* Purchase of a wearable fitness device, app, or exercise equipment is not included. Rewards are subject to change.

The Silver&Fit program, Silver&Fit Connected! and The Silver Slate are trademarks of American Specialty Health Incorporated and used with permission herein.

Chapter 4. Medical Benefits Chart (what is covered and what you pay)**SECTION 3 What services are not covered by the plan?****Section 3.1 Services we do not cover (exclusions)**

This section tells you what services are “excluded” from Medicare coverage and therefore, are not covered by this plan. If a service is “excluded,” it means that this plan doesn’t cover the service.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself. We won’t pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found upon appeal to be a medical service 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.)

All exclusions or limitations on services are described in the Benefits Chart or in the chart below.

Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare	✓	
Experimental medical and surgical procedures, equipment and medications. 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.		✓ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Private room in a hospital.		✓ Covered only when medically necessary.

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.	✓	
Full-time nursing care in your home.	✓	
*Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	✓	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	✓	
Fees charged for care by your immediate relatives or members of your household.	✓	
Cosmetic surgery or procedures		<p style="text-align: center;">✓</p> <ul style="list-style-type: none"> • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Non-routine dental care.		<p style="text-align: center;">✓</p> <p>Non-routine dental care is offered as an optional supplemental benefit that you can buy. See Section 2.2 above for information.</p>
Routine chiropractic care		<p style="text-align: center;">✓</p> <p>Manual manipulation of the spine to correct a subluxation is covered.</p>

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine foot care (podiatry)		<p style="text-align: center;">✓</p> Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes.
Home-delivered meals	✓	
Orthopedic shoes		<p style="text-align: center;">✓</p> If 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		<p style="text-align: center;">✓</p> Orthopedic or therapeutic shoes for people with diabetic foot disease.
Routine hearing exams, hearing aids, or exams to fit hearing aids.	✓	
Routine eye examinations, eyeglasses, radial keratotomy, LASIK surgery, vision therapy and other low vision aids.		<p style="text-align: center;">✓</p> Eye exam and one pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Reversal of sterilization procedures and/or non-prescription contraceptive supplies.	✓	
Acupuncture		<p style="text-align: center;">✓</p> Acupuncture is offered as an optional supplemental benefit that you can buy. See Section 2.2 above for information
Naturopath services (uses natural or alternative treatments).	✓	
Dentures		<p style="text-align: center;">✓</p> Partial or Complete Dentures are offered as an optional supplemental benefit that you can buy. See Section 2.2 above for information
Hearing aids, or exams to fit hearing aids	✓	

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Transportation	✓	

*Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.

CHAPTER 5

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

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

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

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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 services 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.

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

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called “balance billing.” This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don’t pay certain provider charges. For more information about “balance billing,” go to Chapter 4, Section 1.3
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan

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

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

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

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

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

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

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

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

- You don’t have to use the form, but it will help us process the information faster.

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

- Either download a copy of the form from our website (<https://ca.healthnetadvantage.com>) or call Member Services and ask for the form. (Phone numbers for Member Services are printed on the back cover of this booklet.)

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

Health Net of California, Inc.
PO Box 14703
Lexington, KY 40512-4703

Please note, effective 1/1/2018 the address will be changing to:

Health Net of California, Inc.
P.O. Box 9030
Farmington, MO 63640-9030

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

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

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

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

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

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

Chapter 6. Your rights and responsibilities

Chapter 6. Your rights and responsibilities

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Chapter 6. Your rights and responsibilities

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

Section 1.1 We must provide information in a way that works for you (in languages other than English, in audio, in large print, or other alternate formats, etc.)
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To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

Our plan has people and free interpreter services available to answer questions from disabled and non-English speaking members. For assistance with this information in another language, please contact Member Services at 1-800-275-4737 (TTY: 711). Hours of operation: 8:00 a.m. to 8:00 p.m., 7 days a week. We can also give you information in audio, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet) or contact our Grievance department at the same number.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Services (phone numbers are printed on the back cover of this booklet). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227), or directly with the Office of Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact Member Services for additional information.

Debemos proporcionar la información de una manera que le sirva (en idiomas distintos al inglés, en audio, 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 de intérprete gratuitos disponibles para responder las preguntas de los afiliados que presentan una discapacidad y que no hablan inglés. Si desea información en otro idioma, comuníquese con el Departamento de Servicios al Afiliado al 1-800-275-4737 para obtener información adicional. (Los usuarios de TTY deben llamar al 711.) El horario de atención es de 8:00 a.m. a 8:00 p.m., los 7 días de la semana. También podemos proporcionarle información en audio, en letra grande o en otros formatos alternativos si lo necesita, sin cargo. Se nos exige que le brindemos información sobre los beneficios del plan en un formato que sea accesible y adecuado para usted. 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 cuadernillo) o comuníquese con el Departamento de Quejas Formales al mismo número.

Chapter 6. Your rights and responsibilities

Si tiene dificultades para obtener información de parte de nuestro plan en un formato que sea accesible y adecuado para usted, llame para presentar una queja formal ante el Departamento de Servicios al Afiliado (los números de teléfono aparecen en la contraportada de este cuadernillo). También puede presentar una queja ante Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente a la Oficina de Derechos Civiles. Se incluye la información de contacto en esta *Evidencia de Cobertura* o en este correo. Para obtener información adicional, puede comunicarse con el Departamento de Servicios al Afiliado.

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

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

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

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

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

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 printed 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.)

Chapter 6. Your rights and responsibilities

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

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

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

How do we protect the privacy of your health information?

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

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

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

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

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

Chapter 6. Your rights and responsibilities

of privacy practices is listed in Chapter 9, Section 9.

Section 1.5	We must give you information about the plan, its network of providers, and your covered services
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As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English and in large print or other alternate formats.)

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

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

Chapter 6. Your rights and responsibilities

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
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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:

Chapter 6. Your rights and responsibilities

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

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

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

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the California Department of Public Health.

Chapter 6. Your rights and responsibilities

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

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

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

If you have any questions or concerns about the rights and responsibilities or if you have suggestions to improve our member rights policy, share your thoughts with us by contacting Member Services at the number on the back cover of this booklet.

Section 1.9 Evaluation of new technologies

New technologies include procedures, drugs, biological product, or devices that have recently been developed for the treatment of specific diseases or conditions, or are new applications of existing procedures, drugs, biological products, and devices. Our plan follows Medicare's National and Local Coverage Determinations when applicable.

In the absence of a Medicare coverage determination, Our plan assesses new technology or new applications of existing technologies for inclusion in applicable benefits plans to ensure members have access to safe and effective care by performing a critical appraisal of the current published medical literature from peer-reviewed publications including systematic reviews, randomized controlled trials, cohort studies, case control studies, diagnostic test studies with statistically significant results that demonstrate safety and effectiveness and review of evidence based guidelines developed by national organizations and recognized authorities. Our plan also considers opinions, recommendations and assessments by practicing physicians, nationally recognized medical associations including Physician Specialty Societies, consensus panels, or other nationally recognized research or technology assessment organizations, reports and publications of government agencies (for example, the Food and Drug Administration [FDA], Centers for Disease Control [CDC], National Institutes of Health [NIH]).

Chapter 6. Your rights and responsibilities

Section 1.10 What can you do if you believe you are being treated unfairly or your rights are not being respected?**If it is about discrimination, call the Office for Civil Rights**

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

Is it about something else?

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

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

Section 1.11 How to get more information about your rights

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

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the SHIP**. 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 "Medicare Rights & Protections." (The publication is available at: <https://www.medicare.gov/Pubs/pdf/11534.pdf>);
 - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Chapter 6. Your rights and responsibilities

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

Section 2.1 What are your responsibilities?

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

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
 - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
- **If you have any other health insurance coverage in addition to our plan, or separate prescription drug coverage, you are required to tell us.** Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).
 - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “**coordination of benefits**” because it involves coordinating the health benefits you get from our plan with any other benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
 - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. 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.

Chapter 6. Your rights and responsibilities

- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - You must pay your plan premiums to continue being a member of our plan.
 - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
 - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services.
 - If you get any medical services that are not covered by our plan or by other insurance you may have, you must pay the full cost.
 - If you disagree with our decision to deny coverage for a service, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).
 - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
 - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
 - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
 - Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.
 - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 7

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

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

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

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(coverage decisions, appeals, complaints)**

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**Chapter 7. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)****BACKGROUND****SECTION 1 Introduction****Section 1.1 What to do if you have a problem or concern**

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

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

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

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

Section 1.2 What about the legal terms?

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

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

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

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

**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 (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.

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

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.

Go on to the next section of this chapter, **Section 4, “A guide to the basics of coverage decisions and appeals.”**

No. My problem is not about benefits or coverage.

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

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For example, your plan network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular

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

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 appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we 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. Under certain circumstances, which we discuss later, you can request an expedited or “fast coverage decision” or fast appeal of a coverage 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 additional levels of appeal.

Section 4.2	How to get help when you are asking for a coverage decision or making an appeal
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Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services** (phone numbers are printed on the back cover of this booklet).
- To **get free help from an independent organization** that is not connected with our plan, contact your SHIP (see Section 2 of this chapter).
- **Your doctor can make a request for you.** For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.

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

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - There may be someone who is already legally authorized to act as your representative under State law.
 - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf> or on our website at <https://ca.healthnetadvantage.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?
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There are three different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

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

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

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

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



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

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

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

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

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

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

Which of these situations are you in?

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

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

Legal Terms

When a coverage decision involves your medical care, it is called an “**organization determination**.”

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

Legal Terms

A “fast coverage decision” is called an “**expedited determination**.”

How to request coverage for the medical care you want

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

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

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

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

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

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

- **A fast coverage decision means we will answer within 72 hours.**
 - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
 - You can get a fast coverage decision *only* if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)
 - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision.
 - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).

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- This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
- The letter will also tell how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)

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

Deadlines for a “fast coverage decision”

- Generally, for a fast coverage decision, we will give you our answer **within 72 hours**.
 - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 9 of this chapter.)
 - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision, we will authorize or provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a detailed written explanation as to why we said no.

Deadlines for a “standard coverage decision”

- Generally, for a standard coverage decision, we will give you our answer **within 14 calendar days of receiving your request**.
 - We can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
 - If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the

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process for making complaints, including fast complaints, see Section 9 of this chapter.)

- If we do not give you our answer within 14 calendar 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 calendar days after we received your request. If we extended the time needed to make our coverage decision, we will authorize or 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.

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

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

Section 5.3

Step-by-step: How to make a Level 1 Appeal

(how to ask for a review of a medical care coverage decision made by our plan)

Legal Terms

An appeal to the plan about a medical care coverage decision is called a plan **“reconsideration.”**

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

What to do

- **To start an appeal you, your doctor, or your representative, must contact us.** For details on how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1 and look for section called, *How to contact us when you are making an appeal about your medical care.*
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.**

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- If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the “Appointment of Representative” form. It is also available on Medicare’s website at <http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf> or on our website at <https://ca.healthnetadvantage.com>.) While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.
- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1 (*How to contact us when you are making an appeal about your medical care*).
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
 - You have the right to ask us for a copy of the information regarding your appeal.
 - If you wish, you and your doctor may give us additional information to support your appeal.

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

Legal Terms
A “fast appeal” is also called an “expedited reconsideration.”

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

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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 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 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

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on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 calendar days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

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

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

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

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

Legal Terms

The formal name for the “Independent Review Organization” is the “**Independent Review Entity.**” It is sometimes called the “**IRE.**”

Step 1: The Independent Review Organization reviews your appeal.

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

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

- 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 for standard requests or within 72 hours from the date the plan receives the decision from the review organization for expedited requests.
- **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.”)
 - If the Independent Review Organization “upholds the decision” you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

**Chapter 7. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)****Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.**

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

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

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

Asking for reimbursement is asking for a coverage decision from us

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

We will say yes or no to your request

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

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

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 Section 5.3 of this Chapter. Go to this section 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 covered 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**.”
- 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.

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

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

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

1. Read this notice carefully and ask questions if you don't understand it. It tells you about your rights as a hospital patient, including:

- Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
- Your right to be involved in any decisions about your hospital stay, and 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.

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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 two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
 - To look at a copy of this notice in advance, you can call Member Services (phone numbers are printed on the back cover of this booklet) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>.

Section 6.2	Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date
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If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your SHIP, 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 for your state and ask for a “fast review” of your hospital discharge. You must act quickly.

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

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

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

Act quickly:

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

Ask for a “fast review”:

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

Legal Terms
A “fast review” is also called an “immediate review” or an “expedited review.”

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.

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- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

**Chapter 7. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)****Section 6.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date**

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

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

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

- You must ask for this review **within 60 calendar days** after the day 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 of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.***If the review organization says yes:***

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

If the review organization says no:

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

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

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

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

You can appeal to us instead

As explained above in Section 6.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. (“Quickly” means before you leave the hospital and no later than your planned discharge date.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

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

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

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

Legal Terms

A “fast review” (or “fast appeal”) is also called an “**expedited appeal.**”

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

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

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

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to

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see if the decision about when you should leave the hospital was fair and followed all the rules.

- In this situation, we will use the “fast” deadlines rather than the “standard” deadlines for giving you the answer to this review.

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

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

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

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

Step-by-Step: Level 2 Alternate Appeal Process

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, an **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. ”

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

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

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

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

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

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

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

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

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

Section 7.1	<i>This section is about three services <u>only</u>:</i> Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services
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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
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1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
 - The written notice tells you the date when we will stop covering the care for you.

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

- 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.)

The written notice is called the “**Notice of Medicare Non-Coverage.**” To get a sample copy, call Member Services (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. (TTY users should call 1-877-486-2048.) Or see a copy online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html>

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 not mean you agree** with the plan that it’s time to stop getting the care.

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

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

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

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

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization for 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 for a “fast-track appeal” (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.

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

- By the end of the day the reviewers inform us of your appeal, and you will also get a written notice from us that explain in detail our reasons for ending our coverage for your services.

Legal Terms

This notice of explanation is called the “**Detailed Explanation of Non-Coverage.**”

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

What happens if the reviewers say yes to your appeal?

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

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** We will stop paying our share of the costs of this care on the date listed on the notice.
- 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 the Quality Improvement Organization

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turns 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 of receipt of your appeal request, 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.

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

You can appeal to us instead

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

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

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

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms

A “fast review” (or “fast appeal”) is also called an “**expedited appeal.**”

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

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

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

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.
- We will use the “fast” deadlines rather than the “standard” deadlines for giving you the answer to this review.

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

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the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say no to your fast appeal**, then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, 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: Level 2 Alternate Appeal Process

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, an **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.)

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(coverage decisions, appeals, complaints)**

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.

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

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

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

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

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

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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”

Complaint	Example
Quality of your medical care	<ul style="list-style-type: none"> • Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	<ul style="list-style-type: none"> • 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	<ul style="list-style-type: none"> • 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?

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Complaint	Example
Waiting times	<ul style="list-style-type: none"> • Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan? <ul style="list-style-type: none"> ○ Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.
Cleanliness	<ul style="list-style-type: none"> • Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	<ul style="list-style-type: none"> • 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?
Timeliness (These types of complaints are all related to the <i>timeliness</i> of our actions related to coverage decisions and appeals)	<p>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:</p> <ul style="list-style-type: none"> • If you have asked us to give you a “fast coverage decision” or a “fast appeal,” and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

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

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. Hours of Operation: 8:00 a.m. to 8:00 p.m., seven days a week. TTY: 711.
- **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.

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

- In certain cases, you have the right to ask for a fast review of your complaint. This is called the Expedited Grievance Procedure. You are entitled to a fast review of your complaint if you disagree with our decision in the following situations:
 - We deny your request for a fast review of a request for medical care.
 - We deny your request for a fast review of an appeal of denied services.
 - We decide additional time is needed to review your request for medical care.
 - We decide additional time is needed to review your appeal of denied medical care.
- You may submit this type of complaint by phone by calling Member Services at the number on the back cover of this booklet. You may also submit the complaint to us in writing or by fax at the address or fax number listed under Appeals for Medical Care or Complaints about Medical Care in Chapter 2 of this booklet. Once we receive the expedited grievance (complaint), a Clinical Practitioner will review the case to determine the reasons for the denial of your request for a fast review or if the case extension was appropriate. We will notify you of the decision of the fast case orally and in writing within 24 hours of receiving your complaint.
- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint.”** If you have a “fast complaint,” it means we will give you **an answer within 24 hours.**

Legal Terms
What this section calls a “fast complaint” is also called an “expedited grievance.”

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.

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

- **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
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You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
 - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
 - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or, you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 9.5	You can also tell Medicare about your complaint
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You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to <https://www.medicare.gov/MedicareComplaintForm/home.aspx>. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

CHAPTER 8

Ending your membership in the plan

Chapter 8. Ending your membership in the plan

Chapter 8. Ending your membership in the plan

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SECTION 1 Introduction

Section 1.1	This chapter focuses on ending your membership in our plan
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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
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You can end your membership during the **Annual Enrollment Period** (also known as the “Annual Coordinated Election Period”). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** You can choose to keep your current coverage or make changes to your coverage for the

Chapter 8. Ending your membership in the plan

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 (<https://www.medicare.gov>):
 - Usually, when you have moved.
 - If you have Medi-Cal Medicaid.
 - If we violate our contract with you.

Chapter 8. Ending your membership in the plan

- If you are getting care in an institution, such as a nursing home or long-term care (LTC) 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 your request to change your plan is received.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the *Medicare & You 2018* 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 (<https://www.medicare.gov>). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 How do you end your membership in our plan?

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 in this chapter for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).
- *--or--* You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
Another Medicare health plan.	Enroll in the new Medicare health plan. You will automatically be disenrolled from our plan when your new plan’s coverage begins.
Original Medicare <i>with</i> 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 <i>without</i> a separate Medicare prescription drug plan.	Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). 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 We must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

We must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
 - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Member Services are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Chapter 8. Ending your membership in the plan

- If you do not pay the plan premiums for two months.
 - We must notify you in writing that you have two months 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 printed on the back cover of this booklet).

Section 5.2	We cannot ask you to leave our plan for any reason related to your health
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We are not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3	You have the right to make a complaint if we end your membership in our plan
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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 file a grievance or make a complaint about our decision to end your membership. You can look in Chapter 7, Section 9 for information about how to make a complaint.

CHAPTER 9

Legal notices

Chapter 9. Legal notices

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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 non-discrimination

We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. 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, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason

Health Net complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Net:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).
- Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at: 1-800-431-9007 (Jade, Sapphire, Amber and HMO SNP), 1-800-275-4737 (All Other HMO) (TTY: 711). From October 1 to February 14, you can call us 7 days a week from 8 a.m. to 8 p.m. From February 15 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you.

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You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at <https://ocrportal.hhs.gov/ocr/portal/lobby.jsf> or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019 (TTY: 1-800-537-7697).

Complaint forms are available at <http://www.hhs.gov/ocr/office/file/index.html>.

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, our plan, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Recovery of benefits paid by Our plan 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), our plan 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, our plan and/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; or
- You slip and fall in a store.

Our plan's right of recovery applies to any and all recoveries received by you, made to you by a third party, or made 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;

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- 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;
- Any settlement received arising out of legal action or a lawsuit;
- Any judgment received arising out of legal action or a lawsuit;
- 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 or omissions.

By accepting benefits under this Plan, you acknowledge that our plan 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 or omissions 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 (i) grant our plan 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 (ii) you agree to specifically direct such third parties or insurance carriers to directly reimburse the Plan on your behalf.

By accepting benefits under this Plan, you also grant our plan a first priority lien on any recovery, settlement or judgment, or other source of compensation and all reimbursement due to our plan for the full cost of benefits paid under the Plan that are associated with injuries, illnesses or conditions due to the actions or omissions of a responsible party regardless of whether specifically identified as a recovery for medical expenses and regardless of whether you are made whole or fully compensated for your loss. our plan 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 our plan's recovery, and our plan is not required to pay or contribute to paying court costs or attorneys' fees for the attorney hired 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 our plan and/or the medical providers' efforts to recover its expenses, including:

- Telling our plan or the medical providers the name and address of the responsible party and/or his or her lawyer, 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 or claim, including a description of how the injuries were caused.
- Completing any paperwork that our plan or the medical providers may reasonably require to assist in enforcing the lien or right of recovery at issue.
- Promptly responding to inquiries from our plan about the status of the case or claim and any settlement discussions.

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- Notifying our plan immediately upon you or your lawyer receiving any money from the responsible party(s), any insurance companies, or any other source.
- Pay the health care lien or Plan recovery amount from any recovery, settlement or judgment, or other source of compensation, including payment of all reimbursement due to our plan for the full cost of benefits paid under the Plan that are associated with injuries, illnesses or conditions due to 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 our plan'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 or any attempts to deny our plan its first priority right of recovery; and hold any money that you or your lawyer receive from the responsible party(s), or from any other source, in trust, and reimbursing our plan and the medical providers for the amount of the recovery due to the Plan as soon as you are paid and prior to payment of any other potential lien holders or third parties claiming a right to recover.

SECTION 5 Membership card

A membership card issued by our plan 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 the plan's membership card, not Medicare card, at the time of service. 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. Our plan 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 6 Independent contractors

The relationship between our plan and each participating provider is an independent contractor relationship. Participating providers are not employees or agents of our plan and neither our plan, nor any employee of our plan, is an employee or agent of a participating provider. In no case will our plan be liable for the negligence, wrongful act, or omission of any participating or other health care provider. Participating physicians, and not our plan, maintain the physician-patient relationship with the member. Our plan is not a provider of health care.

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SECTION 7 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 8 Circumstances beyond the plan'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 our plan, results in our plans facilities or personnel not being available to provide or arrange for services or benefits under this *Evidence of Coverage*, the plan's obligation to provide such services or benefits shall be limited to the requirement that our plan make a good faith effort to provide or arrange for the provision of such services or benefits within the current availability of its facilities or personnel.

SECTION 9 Notice of privacy practices

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

PLEASE REVIEW IT CAREFULLY.

Effective 08.14.2017

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.

Covered Entities Duties:

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

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

Health Net reserves the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your PHI we already have as well as any of your PHI we receive in the future. Health Net will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your rights, our legal duties, or other privacy practices stated in the notice. We will make any revised Notices available on the Health Net website.

Internal Protections of Oral, Written and Electronic PHI:

Health Net protects your PHI. We have privacy and security processes to help. These are some of the ways we protect your PHI.

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

Permissible Uses and Disclosures of Your PHI:

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

- ***Treatment*** - We may use or disclose your PHI to a physician or other health care provider providing treatment to you, to coordinate your treatment among providers, or to assist us in making prior authorization decisions related to your benefits.
- ***Payment*** - We may use and disclose your PHI to make benefit payments for the health care services provided to you. We may disclose your PHI to another health plan, to a health care provider, or other entity subject to the federal Privacy Rules for their payment purposes. Payment activities may include processing claims, determining eligibility or coverage for claims, issuing premium billings, reviewing services for medical necessity, and performing utilization review of claims.
- ***HealthCare Operations*** - We may use and disclose your PHI in the performance of our health care operations. These activities may include providing customer services,

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responding to complaints and appeals, providing case management and care coordination, conducting medical review of claims and other quality assessment and improvement activities. We may also in our health care operations disclose PHI to business associates with whom we have written agreements containing terms to protect the privacy of your PHI. We may disclose your PHI to another entity that is subject to the federal Privacy Rules and that has a relationship with you for its health care operations relating to quality assessment and improvement activities, reviewing the competence or qualifications of health care professionals, case management and care coordination, or detecting or preventing healthcare fraud and abuse.

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

Other Permitted or Required Disclosures of Your PHI:

- **Fundraising Activities** – We may use or disclose your PHI for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance their activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.
- **Underwriting Purposes** – We may use or disclosure your PHI for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your PHI for underwriting purposes, we are prohibited from using or disclosing your PHI that is genetic information in the underwriting process.
- **Appointment Reminders/Treatment Alternatives** - We may use and disclose your PHI to remind you of an appointment for treatment and medical care with us or to provide you with information regarding treatment alternatives or other health-related benefits and services, such as information on how to stop smoking or lose weight.
- **As Required by Law** - If federal, state, and/or local law requires a use or disclosure of your PHI, we may use or disclose your PHI information to the extent that the use or disclosure complies with such law and is limited to the requirements of such law. If two or more laws or regulations governing the same use or disclosure conflict, we will comply with the more restrictive laws or regulations.
- **Public Health Activities** - We may disclose your PHI to a public health authority for the purpose of preventing or controlling disease, injury, or disability. We may disclose your PHI to the Food and Drug Administration (FDA) to ensure the quality, safety or effectiveness products or services under the jurisdiction of the FDA.
- **Victims of Abuse and Neglect** - We may disclose your PHI to a local, state, or federal government authority, including social services or a protective services agency authorized by law to receive such reports if we have a reasonable belief of abuse, neglect or domestic violence.
- **Judicial and Administrative Proceedings** - We may disclose your PHI in judicial and administrative proceedings, as well as in response to an order of a court, administrative

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tribunal, or in response to a subpoena, summons, warrant, discovery request, or similar legal request.

- **Law Enforcement** - We may disclose your relevant PHI to law enforcement when required to do so, such as in response to a court order, court-ordered warrant, subpoena or summons issued by a judicial officer, or a grand jury subpoena. We may also disclose your relevant PHI for the purpose of identifying or locating a suspect, fugitive, material witness, or missing person.
- **Coroners, Medical Examiners and Funeral Directors** - We may disclose your PHI to a coroner or medical examiner. This may be necessary, for example, to determine a cause of death. We may also disclose your PHI to funeral directors, as necessary, to carry out their duties.
- **Organ, Eye and Tissue Donation** - We may disclose your PHI to organ procurement organizations or entities engaged in the procurement, banking or transplantation of cadaveric organs, eyes or tissues.
- **Threats to Health and Safety** - We may use or disclose your PHI if we believe, in good faith, that the use or disclosure is necessary to prevent or lessen a serious or imminent threat to the health or safety of a person or the public.
- **Specialized Government Functions** - If you are a member of U.S. Armed Forces, we may disclose your PHI as required by military command authorities. We may also disclose your PHI to authorized federal officials for national security and intelligence activities, the Department of State for medical suitability determinations and for protective services of the President or other authorized persons.
- **Workers' Compensation** - We may disclose your PHI to comply with laws relating to workers' compensation or other similar programs, established by law, that provide benefits for work-related injuries or illness without regard to fault.
- **Emergency Situations** - We may disclose your PHI in an emergency situation, or if you are incapacitated or not present, to a family member, close personal friend, authorized disaster relief agency, or any other person previously identified by you. We will use professional judgment and experience to determine if the disclosure is in your best interests. If the disclosure is in your best interest, we will only disclose the PHI that is directly relevant to the person's involvement in your care.
- **Inmates** - If you are an inmate of a correctional institution or under the custody of a law enforcement official, we may release your PHI to the correctional institution or law enforcement official, where such information is necessary for the institution to provide you with health care; to protect your health or safety; or the health or safety of others; or for the safety and security of the correctional institution.
- **Research** - Under certain circumstances, we may disclose your PHI to researchers when their clinical research study has been approved and where certain safeguards are in place to ensure the privacy and protection of your PHI.

Uses and Disclosures of Your PHI That Require Your Written Authorization

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

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

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

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

Individuals Rights

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

- ***Right to Revoke an Authorization*** - You may revoke your authorization at any time, the revocation of your authorization must be in writing. The revocation will be effective immediately, except to the extent that we have already taken actions in reliance of the authorization and before we received your written revocation.
- ***Right to Request Restrictions*** - You have the right to request restrictions on the use and disclosure of your PHI for treatment, payment or healthcare operations, as well as disclosures to persons involved in your care or payment of your care, such as family members or close friends. Your request should state the restrictions you are requesting and state to whom the restriction applies. We are not required to agree to this request. If we agree, we will comply with your restriction request unless the information is needed to provide you with emergency treatment. However, we will restrict the use or disclosure of PHI for payment or health care operations to a health plan when you have paid for the service or item out of pocket in full.
- ***Right to Request Confidential Communications*** - You have the right to request that we communicate with you about your PHI by alternative means or to alternative locations. This right only applies if the information could endanger you if it is not communicated by the alternative means or to the alternative location you want. You do not have to explain the reason is for your request, but you must state that the information could endanger you if the communication means or location is not changed. We must accommodate your request if it is reasonable and specifies the alternative means or location where you PHI should be delivered.
- ***Right to Access and Received Copy of your PHI*** - You have the right, with limited exceptions, to look at or get copies of your PHI contained in a designated record set. You may request that we provide copies in a format other than photocopies. We will use the format you request unless we cannot practicably do so. You must make a request in writing to obtain access to your PHI. If we deny your request, we will provide you a

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written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

- ***Right to Amend your PHI*** - You have the right to request that we amend, or change, your PHI if you believe it contains incorrect information. Your request must be in writing, and it must explain why the information should be amended. We may deny your request for certain reasons, for example if we did not create the information you want amended and the creator of the PHI is able to perform the amendment. If we deny your request, we will provide you a written explanation. You may respond with a statement that you disagree with our decision and we will attach your statement to the PHI you request that we amend. If we accept your request to amend the information, we will make reasonable efforts to inform others, including people you name, of the amendment and to include the changes in any future disclosures of that information.
- ***Right to Receive an Accounting of Disclosures*** - You have the right to receive a list of instances within the last 6 years period in which we or our business associates disclosed your PHI. This does not apply to disclosure for purposes of treatment, payment, health care operations, or disclosures you authorized and certain other activities. If you request this accounting more than once in a 12-month period, we may charge you a reasonable, cost-based fee for responding to these additional requests. We will provide you with more information on our fees at the time of your request.
- ***Right to Receive a Copy of this Notice*** - You may request a copy of our Notice at any time by using the contact information list at the end of the Notice. If you receive this Notice on our web site or by electronic mail (e-mail), you are also entitled to request a paper copy of the Notice.
- ***Right to File a Complaint*** - If you feel your privacy rights have been violated or that we have violated our own privacy practices, you can file a complaint with us in writing or by phone using the contact information at the end of this Notice. For Medi-Cal member complaints, members may also contact the California Department of Health Care Services listed in the next section.

You can also file a complaint with the Secretary of the U.S. Department of Health and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201 or calling 1-800-368-1019, (TTY: 1-800-537-7697) or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/.

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

Contact Information

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

Health Net Privacy Office

Telephone: 1-800-522-0088

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Attn: Privacy Official

Fax: 1-818-676-8314

PO Box 9103

Email: Privacy@healthnet.com

Van Nuys, CA 91409

For Medi-Cal members only, if you believe that we have not protected your privacy and wish to complain, you may file a complaint by calling or writing:

Privacy Officer

c/o Office of Legal Services

California Department of Health Care Services

1501 Capitol Avenue, MS 0010

PO Box 997413

Sacramento, CA 95899-7413

Phone: 1-916-445-4646 or 1-866-866-0602 (TTY:TDD: 1-877-735-2929)

E-mail: Privacyofficer@dhcs.ca.gov**FINANCIAL INFORMATION PRIVACY NOTICE**

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

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

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

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

Disclosure of Information: We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law,

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disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

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

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

Questions about this Notice:

If you have any questions about this notice:

Please **call the toll-free phone number on the back of your ID card** or contact Health Net at 1-800-522-0088.

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CHAPTER 10

Definitions of important words

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Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – A set time each fall when members can change their health or drug plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or 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 – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare 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 after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Complaint – The formal name for "making a complaint" is "filing a grievance." 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. See also "Grievance," in this list of definitions.

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.

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Copayment (or “copay”) – 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 a set amount, rather than a percentage. For example, you might pay \$10 or \$20 for a doctor’s visit or prescription.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services are received. (This is in addition to the plan’s monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed “copayment” amount that a plan requires when a specific service is received; or (3) any “coinsurance” amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

Covered Services – The general term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare’s standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don’t have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn’t pay for custodial care.

Deductible – The amount you must pay for health care before our plan begins to pay.

Disenroll or Disenrollment – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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.

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

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

Grievance - A type of complaint you make about us, 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.

Hospice – A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an “outpatient.”

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins three months before the month you turn 65, includes the month you turn 65, and ends three 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 medical services. Amounts you pay for your plan premiums and 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 two or more physicians and non-physician practitioners legally organized in a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association in which each physician who is a member of the

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group provides substantially the full range of services which the physician routinely provides (including medical care, consultation, diagnosis, or treatment) through the joint use of shared office space, facilities, equipment, and personnel.

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, 2018.

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**. Our plan 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-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, and Programs of All-inclusive Care for the Elderly (PACE).

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

“Medigap” (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

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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.”

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

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. 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.

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PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) 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.**”

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 Providers.

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 Benefits Chart in Chapter 4.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

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

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it’s also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan’s service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

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Special Enrollment Period – A set time when members can change their health or drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

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

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

Health Net Seniority Plus Green (HMO) Member Services

Method	Member Services – Contact Information
CALL	1-800-275-4737 Calls to this number are free. From October 1 to February 14, you can call us 7 days a week from 8 a.m. to 8 p.m. From February 15 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays. Member Services also has free language interpreter services available for non-English speakers
TTY	711 (National Relay Services) 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., seven days a week.
FAX	1-866-214-1992
WRITE	Health Net Medicare Programs PO Box 10420 Van Nuys, CA 91410-0420
WEBSITE	https://ca.healthnetadvantage.com

Health Insurance Counseling and Advocacy Program (HICAP) (California SHIP)

HICAP is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	HICAP (California SHIP) -Contact Information
CALL	1-800-434-0222
TDD/TTY	1-800-735-2929 (CA Relay Service) or 711 (National Relay Service) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	<u>County specific agencies available at:</u> www.aging.ca.gov/HICAP/Contact_HICAP/County_List/
WEBSITE	www.aging.ca.gov/hicap

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