Health Net Medicare Advantage
Private Fee-for-Service Plan

TERMS AND CONDITIONS OF PAYMENT

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1 *Introduction*

Health Net Pearl is a Medicare Advantage private fee-for-service (PFFS) plan offered by Health Net. Health Net Pearl allows members to use any provider, such as a physician, health professional, hospital, or other Medicare provider in the United States that agrees to treat the member after having the opportunity to review these terms and conditions of payment, as long as the provider is eligible to provide health care services under Medicare Part A and Part B (also known as 'Original Medicare') or eligible to be paid by Health Net for benefits that are not covered under Original Medicare.

The law provides that if you have an opportunity to review these terms and conditions of payment and you treat a Health Net Pearl member, you will be "deemed" to have a contract with us. Section 2 explains how the deeming process works. The rest of this document contains the contract that the law allows us to deem to hold between you, the provider, and Health Net. Any provider in the United States that meets the deeming criteria in Section 2 becomes deemed to have a contract with Health Net for the services furnished to the member when the deeming conditions are met. **No prior authorization, prior notification, or referral is required as a condition of coverage when medically necessary, plan-covered services are furnished to a member.** However, a member or provider may request an advance coverage determination before a service is provided in order to confirm that the service is medically necessary and will be covered by the plan. Note that the terms prior authorization, prior notification, and advance coverage determination have different meanings. Prior authorization and prior notification rules are described in Section 4, and advance coverage determination is described in Section 7.

2 *When a provider is deemed to accept Health Net Pearl terms and conditions of payment*

A provider is considered by law to be ***deemed*** to have a contract with Health Net when all of the following three criteria are met:

1. The provider is aware, in advance of furnishing health care services, that the patient is a member of Health Net Pearl. All of our members receive a member ID card that includes the Health Net Pearl logo that clearly identifies them as PFFS members. The provider may further validate eligibility by calling our Health Net Pearl Service Center at (800) 977-8221. You can also create a Provider Profile and check eligibility for all your patients at www.healthnet.com. Go to the Provider Private Fee-For-Service page and click on the My Health Net Manager link.
2. The provider either has a copy of, or has reasonable access to, our terms and conditions of payment (this document). The terms and conditions are available on our website at https://www.healthnet.com/pffs_terms.pdf. The terms and conditions may also be obtained by calling our Health Net Pearl Service Center at (800) 977-8221.
3. The provider furnishes covered services to a Health Net Pearl member.

If all of these conditions are met, the provider is deemed to have agreed to Health Net Pearl's terms and conditions of payment for that member specific to that visit.
Note: You, the provider, can decide whether or not to accept Health Net Pearl's term and conditions of payment each time you see a Health Net Pearl member. A decision to treat one plan member does not obligate you to treat other Health Net Pearl members, nor does it obligate you to accept the same member for treatment at a subsequent visit.

For example: If a Health Net Pearl member shows you an enrollment card identifying him/her as a member of Health Net Pearl and you provide services to that member, you will be considered a deemed provider. Therefore, it is your responsibility to obtain and review the terms and conditions of payment prior to providing services, except in the case of emergency services (see below).

If you DO NOT wish to accept Health Net Pearl's terms and conditions of payment, then you should not furnish services to a Health Net Pearl member, except for emergency services. If you nonetheless do furnish non-emergency services, you will be subject to these terms and conditions whether you wish to agree to them or not.

Providers furnishing emergency services will be treated as non-contract providers and paid at the payment amounts they would have received under Original Medicare.

3 *Provider qualifications and requirements*

In order to be paid by Health Net for services provided to one of our members, you must:

- Have a National Provider Identifier (NPI) in order to submit electronic transactions to Health Net, in accordance with HIPAA requirements
- Providers must follow the same rules as Original Medicare when submitting non-electronic claims
- Furnish services to a Health Net Pearl member within the scope of your licensure or certification
- Provide only services that are covered by our plan and that are medically necessary by Medicare definitions
- Meet applicable Medicare certification requirements (e.g., if you are an institutional provider such as a hospital or skilled nursing facility)
- Not have opted out of participation in the Medicare program under §1802(b) of the Social Security Act, unless providing emergency or urgently needed services
- Not be on the HHS Office of Inspectors General excluded and sanctioned provider lists
- Not be a Federal health care provider, such as a Veterans' Administration provider, except when providing emergency care
- Comply with all applicable Medicare and other applicable Federal health care program laws, regulations, and program instructions, including laws protecting patient privacy rights and HIPAA that apply to covered services furnished to members
- Agree to cooperate with Health Net to resolve any member grievance involving the provider within the time frame required under Federal law
- For providers who are hospitals, home health agencies, skilled nursing facilities, or comprehensive outpatient rehabilitation facilities, provide applicable beneficiary appeals notices (see Section 10 for specific requirements)
- Not charge the member in excess of cost sharing under any condition, including in the event of plan bankruptcy

Supplemental Services:

Where available as an Optional Supplemental or when part of the core benefit package, non-participating dental and vision providers may balance bill the difference between billed charges and the out-of-network reimbursement amount for coverage offered under the Optional Buy-Up Package or included with the core benefit package.

DENTAL SERVICES

Health Net Dental providers, contracting with Dental Benefit Providers, are reimbursed the contract amounts for covered services offered under the Optional Buy-Up Package or included with the core benefit package. Non-participating

providers are reimbursed at usual, customary and reasonable dental allowances, based on the 80th percentile of Health Insurance Association of America (HIAA), which are amounts collected, maintained and reported throughout the country.

VISION SERVICES

Health Net Vision providers, contracting with EyeMed Vision Care, are reimbursed the contract amounts for covered services offered under the Optional Buy-Up Package or included with the core benefit package. Non-participating provider reimbursement is reasonable and customary for vision exams and up to $100 for eyeglasses (frames and lenses) and contact lens packages.

CHIROPRACTIC COVERAGE

Balance billing is prohibited by deemed chiropractic providers who provide services to Health Net PFFS members. Chiropractic providers for the Optional Buy-Up Package do not need to be Medicare-participating providers; however, they are paid according to the PFFS terms and conditions at 100 percent of the Medicare fee schedule. For additional information, refer to the Health Net PFFS Plan Reimbursement Methodology and Fee Schedules.

Medicare-covered chiropractic services (manual manipulation of the spine to correct a displacement or misalignment of a joint or body part) are covered under your basic Health Net Pearl plan. Medicare-covered chiropractic services are not included as part of the Optional Supplemental Benefit Package.

For additional information please visit our website at www.healthnet.com and click on the Medicare Coverage PFFS plan link and open the Optional Buy-up Package document.

4 *Payment to providers*

Health Net reimburses deemed providers at 102 percent of the Medicare Fee Schedule for Physician Services and 100 percent for Hospital Services, minus any member required cost sharing, for all medically necessary services covered by Medicare. We will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, then we will pay interest on the claim according to Medicare guidelines. Section 5 has more information on prompt payment rules. For more detailed information about our payment methodology for all provider types, go to https://www.healthnet.com/static/provider/unprotected/pdfs/national/2009_PFFS_gen_reimbursement_grid_1_6.pdf

Services covered under Health Net Pearl that are not covered under Original Medicare are reimbursed using the following fee schedule located at https://www.healthnet.com/static/provider/unprotected/pdfs/national/2009_PFFS_gen_reimbursement_grid_1_6.pdf

Deemed providers furnishing such services must accept the fee schedule amount, minus applicable member cost sharing, as payment in full.

MEMBER BENEFITS AND COST SHARING

Payment of cost sharing amounts is the responsibility of the member. Providers should collect the applicable cost sharing from the member at the time of the service when possible. **You can only collect from the member the appropriate Health Net Pearl co-payments or coinsurance amounts described in these terms and conditions.** After collecting cost sharing from the member, the provider should bill Health Net for covered services. Section 5 provides instructions on how to submit claims to us. If a member is a dual-eligible Medicare beneficiary (that is, the member is enrolled in our PFFS plan and a state Medicaid program) that the state holds harmless for Medicare cost sharing, then the provider cannot collect any cost sharing from the member at the time of service. Instead, the provider may only look to the State Medicaid agency to collect the Medicaid allowable cost sharing amount(s).

To view a complete list of covered services and member cost sharing amounts under Health Net Pearl, go to https://www.healthnet.com/portal/provider/content.do?mainResourceFile=/content/general/unprotected/html/national/medicare_pffs.html.

You may call us at (800) 977-8221 to obtain more information about covered benefits, plan payment rates, and member cost sharing amounts under Health Net Pearl. Be sure to have the member's ID number when you call.

Health Net follows Medicare coverage decisions for Medicare-covered services. Services not covered by Medicare are not covered by Health Net, unless specified by the plan. Information on obtaining an advance coverage determination can be found in Section 7. Health Net does not require members or providers to obtain prior authorization, prior notification, or referrals from the plan as a condition of coverage. Under prior authorization, a plan requires beneficiaries or providers to seek authorization from the plan prior to obtaining services. There is no such requirement for Health Net Pearl members. For information on Health Net Pearl's prior notification policies, see section on "Prior notification rules" below.

Note: Medicare supplemental policies, commonly referred to as Medigap plans, cannot cover cost sharing amounts for Medicare Advantage plans, including PFFS plans. All cost sharing is the member's responsibility.

PRIOR NOTIFICATION RULES

No prior authorization or referral is required as a condition of coverage when medically necessary, plan-covered services are furnished to members. However, to assist us in better managing care for our members, we request that you notify us prior to the member receiving any of the following services: Inpatient Admissions, SNF Admissions, Home Health, High End DME.

Health Net Pearl does not require the member or the provider to prior notify the plan as a condition for covering services. To provide prior notification or to obtain more information about our prior notification rules, call us at (800) 977-8221.

BALANCE BILLING OF MEMBERS

A provider may collect only applicable plan cost sharing amounts from Health Net Pearl members and may not otherwise charge or bill members. Balance billing is prohibited by providers who furnish plan-covered services to Health Net Pearl members.

HOLD HARMLESS REQUIREMENTS

In no event, including, but not limited to, nonpayment by Health Net, insolvency of Health Net, and/or breach of these terms and conditions, shall a deemed provider bill, charge, collect a deposit from, seek compensation, remuneration or reimbursement from, or have any recourse against a member or persons acting on their behalf for plan-covered services provided under these terms and conditions. This provision shall not prohibit the collection of any applicable coinsurance, co-payments, or deductibles billed in accordance with the terms of the member's benefit plan.

If any payment amount is mistakenly or erroneously collected from a member, you must make a refund of that amount to the member.

5 *Filing a claim for payment*

- You must submit a claim to Health Net for an Original Medicare covered service within the same time frame you would have to submit under Original Medicare, which is within 15-27 months from the date of service. Failure to be timely with claim submissions may result in non-payment. The criteria for Original Medicare submission of claims can be found in section 70 of Chapter 1 of the Medicare Claims Processing Manual located at http://www.cms.hhs.gov/manuals/downloads/clm104c01.pdf
- **Prompt Payment** – Health Net will process and pay clean claims within 30 days of receipt. If a clean claim is not paid within the 30-day time frame, Health Net will pay interest on the claim according to Medicare guidelines. A clean claim includes the minimum information necessary to adjudicate a claim, not to exceed the information required by Original Medicare. Health Net will process all non-clean claims and notify providers of the determination within 60 days of receiving such claims
- Submit claims using the standard CMS-1500, CMS-1450 (UB-04), or the appropriate electronic filing format
- Use the same coding rules and billing guidelines as Original Medicare, including Medicare CPT Codes, HCPCS codes and defined modifiers. Bill diagnosis codes to the highest level of specificity
- Include the following on your claims:
  - National Provider Identifier
  - The member's ID number
  - Date(s) of service
- For providers that are paid based upon interim rates, include with your claim a copy of your current interim rate letter if the interim rate has changed since your previous claim submission
- Coordination of Benefits: All Medicare secondary payer rules apply. These rules can be found in the Medicare Secondary Payer Manual located at http://www.cms.hhs.gov/Manuals/IOM/list.asp. Providers should identify primary coverage and provide information to Health Net at the time of billing
- Where to submit a claim:
  - For electronic claim submission, please use the following Payer ID numbers: Professional SX185 or Institutional 12X48. You can also submit claims through www.MyHealthNetManager.com once you create a provider profile
  - For paper claim submission, please submit paper claims to: Health Net PFFS Claims P.O.Box 2226, Augusta, GA 30903-2226, or fax to (888) 557-3856
- If you have problems submitting claims to us or have any billing questions, contact our technical billing resource at (800) 868-2505

6 *Maintaining medical records and allowing audits*

Deemed providers shall maintain timely and accurate medical, financial and administrative records related to services they render to Health Net Pearl members. Unless a longer time period is required by applicable statutes or regulations, the provider shall maintain such records for at least 10 years from the date of service. Deemed providers must provide Health Net, the Department of Health and Human Services, the Comptroller General, or their designees access to any books, contracts, medical records, patient care documentation, and other records maintained by the provider pertaining to services rendered to Medicare beneficiaries enrolled in a Medicare Advantage plan, consistent with Federal and state privacy laws. Such records may be used for activities in the following situations: Centers for Medicare & Medicaid Services and Health Net audits of risk adjustment data; Health Net determinations of whether services are covered under the plan, are reasonable and medically necessary, and whether the plan was billed correctly for the service; and in order to make advance coverage determinations. Health Net will not use medical record reviews to create artificial barriers that would delay payments to providers. Both voluntary and mandatory provision of medical records must be consistent with HIPAA privacy law requirements.

7 *Getting an advance coverage determination*

Providers may choose to obtain a written advance coverage determination (also known as an organization determination) from us before furnishing a service in order to confirm whether the service is medically necessary and will be covered by Health Net. To obtain an advance coverage determination, call our Health Net Pearl Service Center at (800) 977-8221. Health Net will make a decision and notify you within 14 days of receiving the request, with a possible 14-day extension either due to the member's request or Health Net justification that the delay is in the member's best interest. In cases where you believe that waiting for a decision under this time frame could place the member's life, health, or ability to regain maximum function in serious jeopardy, you can request an expedited determination. To obtain an expedited determination, call us at (800) 977-8221. We will notify you of our decision within 72 hours.

In the absence of an advance coverage determination, Health Net can retroactively deny payment for a service furnished to a member if we determine that the service was not covered by our plan or was not medically necessary. However, providers have the right to dispute our decision by exercising member appeals rights.

8 *Provider payment dispute resolution process*

If you believe that the payment amount you received for a service is less than the amount indicated in our terms and conditions of payment, you have the right to dispute the payment amount by following our dispute resolution process.

To file a payment dispute with Health Net, send a written dispute to Health Net Pearl Claims:

P.O. Box 1728, Augusta, GA 30903-1728, or call us at (800) 977-8221. A copy of our Provider Payment Dispute Resolution Form is available at www.healthnet.com. Click on Medicare Coverage for Private Fee-For-Service (for Providers). Additionally, please provide appropriate documentation to support your payment dispute. Claims must be disputed within 120 days from the date payment is initially received by the provider.

We will review your dispute and respond to you within 30 days from the time the provider payment dispute is first received. If we agree with your payment dispute, then we will pay you the additional amount with any interest that is due. We will inform you in writing if your payment dispute is denied.

After completing Health Net Pearl's dispute resolution process, if you believe that we have reached an incorrect decision regarding your payment dispute, you may file a request for review of this determination with an independent entity contracted by CMS.

To file a request for review of a payment dispute with the independent entity, you may contact First Coast Service Options, Inc. directly by email, fax or mail. Emailed documents should not contain any protected health information (PHI) and may be sent to IREPFFS@FCSO.com. Faxes may be sent to (904) 361-0551, and hard copy requests may be mailed to First Coast Service Options, Inc., PFFS Payment Disputes, P.O. Box 44017, Jacksonville, Florida 32231-4017.

9 *Member and provider appeals and grievances*

Health Net Pearl members have the right to file appeals and grievances when they have concerns or problems related to coverage or care. Members may appeal a decision made by Health Net to deny coverage or payment for a service or benefit that they believe should be covered or paid for. Members should file a grievance for all other types of complaints.

A provider may appeal decisions on behalf of a member as an appointed representative, or appeal on his or her own right using the member's appeal process by signing a waiver of liability (promising to hold the member harmless regardless of the outcome). There must be existing potential member liability (e.g., a claim, as opposed to an advance coverage determination, is denied as not a medically necessary or a covered service) in order for a provider to appeal utilizing the member's appeal process. If you appeal on your own right, you agree to abide by the statutes, regulations, standards, and guidelines applicable to the Medicare PFFS Member appeals and grievance process.

The Health Net Pearl Member Evidence of Coverage (EOC) provides more detailed information about the member appeal and grievance process. The member EOC is posted under the member benefits link on the member information section of our website located at www.healthnet.com. You can call Health Net Pearl Service Center at (800) 977-8221 for more information on our member appeals and grievance policies and procedures.

10 *Providing members with notice of their appeals rights – Requirements for Hospitals, SNFs, CORFs, and HHAs*

Hospitals must notify Medicare beneficiaries who are hospital inpatients about their discharge appeal rights by complying with the requirements for providing the Important Message from Medicare (IM), including the time frames for delivery. For copies of the notice and additional information regarding this requirement, go to:

http://www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp

Skilled nursing facilities, home health agencies, and comprehensive outpatient rehabilitation facilities must notify Medicare beneficiaries about their right to appeal a termination of services decision by complying with the requirements for providing Notice of Medicare Non-Coverage (NOMNC), including the time frames for delivery.

For copies of the notice and the notice instructions, go to: http://www.cms.hhs.gov/MMCAG/Downloads/NOMNCInstructions.pdf. In addition, the provider should send a copy of any NOMNC issued to Health Net, 180 Grand Ave, Oakland, CA 94612, Attention Denial Compliance Unit.

Health Net will provide members with a detailed explanation if a member notifies the Quality Improvement Organization (QIO) that the member wishes to appeal a decision regarding a hospital discharge or termination of home health agency, comprehensive outpatient rehabilitation facility or skilled nursing facility services within the time frames specified by law.

11 *If you need additional information or have questions*

If you have general questions about Health Net Pearl's terms and conditions of payment, contact us at our Pearl Service Center at (800) 977-8221 (seven days a week, 8:00 am. to 8:00 pm.) or write to us at Health Net Pearl Correspondence, P.O. Box 1728, Augusta, GA 30903-1728, or fax to Claims Unit at (888) 557-7222.

- If you have questions about submitting claims, call us at (800) 977-8221
- If you have questions about plan payments, call us at (800) 977-8221

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