Commercial

Groups 51–100

Employer *Manual*

Administrative guide for employers in California

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Health Net

Health Net®

This manual has been designed as a resource tool for you. Enclosed you will find explanations of Health Net's policies, procedures, select benefits, tools, and resources available to you and your employees, and much more. If you have any comments about this manual or suggestions for additional information we can include to further help you, please feel free to tell your Health Net account manager.

Easy. Affordable. Reliable. That's Health Net.

Please note: While Health Net endeavors to maintain the accuracy of this manual, it is subject to change without notice. Portions of the manual may be subject to change pursuant to state or federal laws or regulations. This document contains general information about the plans offered by Health Net according to the criteria agreed upon in advance by your company and Health Net. If there is a conflict between the contents of this manual and a member's *Evidence of Coverage (EOC), Certificate of Coverage (COI)* or similar document, the EOC/COI controls.

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Welcome

Section 1

Health Net®

Health Net is committed to providing our members with comprehensive benefits, convenient access to quality providers, and the information they need to properly use their health care benefits.

For our valued customers like you, our commitment extends to being a health plan that is easy to do business with. So you can count on Health Net for:

- Resources you need to best understand the plan(s) offered to your employees.
- Clear guidelines for administering your plan.
- Direct contacts at Health Net to answer your questions.

This manual should answer most of your questions. But if you have any questions that you don't find answered here, call our Account Services Unit (ASU) at **1-800-547-2967**.

For the purposes of this manual, the term "Health Net" means both Health Net of California, Inc. and Health Net Life Insurance Company, except where specifically stated.

Website:

www.healthnet.com

Section 2

Health Net®

HealthNet.com

Your Health Net home on the Web – www.healthnet.com – is styled to make it easy to get more of your to-do list done online. Featuring quick links and streamlined search tools, you'll find the information you need most quickly and easily.

Online access: How-to

Option 1 – Provide your account manager with the name and email address of the person who should represent your company as the client administrator. That person will receive an email with a registration key used to register online as follows:

- Go to www.healthnet.com.
- Click on *Employers* from the home page.
- Confirm your state is listed as *California* on the top right.
- Click on the *Register* button.
- Provide your group number and enter your access key (this is your registration key).
- Enter the requested information for your employer web account.
- Begin to navigate the Health Net Employer website.

Option 2 – If no one has previously been identified as your company's administrator, you can request an access key online to become the client administrator for your company. To do so:

- Go to www.healthnet.com.
- Select *Employers* from the home page.
- Confirm your state is listed as *California* on the top right.
- Click on the *Register* button.
- Provide your group number and indicate you do not have an access key.
- Enter the requested information for your employer web account.
- Health Net will review the request and, once approved, you will receive an access key, which can be used to complete registration, as noted previously.

Employers can also call the Account Services Unit at 1-800-547-2967 for assistance with password resets. To obtain a user name and password, contact your account manager.

What employers can do online	*What members can do online*
Manage Accounts Update online account information Add new user[1] View and edit users[1] **Member and Employee Support** View benefits and eligibility Get *Evidence of Coverage (EOC)* Forms and brochures Decision Power Compare hospitals Compare medical groups Member discounts Preventive care guidelines Pharmacy information and drug lists Find a pharmacy Teen health **Manage Enrollment** Online Enrollment tools and manual Employer Group Manual Health Savings Account (HSA) **Pay My Bill** Online billing **Health Net News** View newsletters **Doctor and Hospital Information** ProviderSearch Supplemental plan provider searches (Behavioral health, dental, vision, and alternative care) Other search tools [1]Available to administrator users only	**My Coverage** View and edit my account profile Access my coverage information Download my *Evidence of Coverage (EOC)* and *Summary of Benefits and Coverage (SBC)* Print my Schedule of Benefits and plan overview View my Prior Authorization List Get answers to medical and pharmacy FAQs Transition of Care information Request a patient's cost estimates Understand out-of-network benefits Request a second opinion **My Prescriptions** Check drug coverage and medication costs Find a pharmacy near me Research drug interactions & side effects Order prescriptions by mail View and download drug lists View my pharmacy copays View my benefits summary Understand my pharmacy benefits View pharmacy FAQs Manage my prescriptions, view history and order medication card Print my prescription report **My Claims** File a medical or pharmacy claim Look up my claim history Research a denied claim View my *Explanation of Benefits (EOBs)* Download and print claim forms **My Account** Print a temporary ID card Order my ID card Change my address Complete a Health Risk Questionnaire (HRQ) **ProviderSearch** Find & compare physicians Search for behavioral health, dental, vision and alternative care options Search for national PPOs, medical groups, hospitals, CA physician groups, and hospital links **Wellness Center** View My Health Guide Get Decision Support Talk to a health coach Complete a health assessment (HRQ) Populate my Personal Health Record (PHR) Quit tobacco Get tips on a healthy pregnancy Access Nurse24 (online or by phone) Print Prevention Reminders and Care Alerts Enroll in a healthy living program Use progress trackers Participate in interactive health conversations (Virtual Coaching) Attend online health seminars Use progress trackers Make a healthy recipe Healthy family eating strategies Research a condition Preventive guidelines Antibiotic awareness Treatment cost advice Find & compare medical groups Compare hospitals Access member discounts Learn about advance directives Symptom checker

Click and go administration

Do more and save time with Health Net online. Protected by advanced security, our website is designed to provide you with quick access to information, tools and transactions. The navigation menu on the left side of the page makes it easy to find and get the information you need.

Choose the Right Plan *(pre-log on only)* features our flexible product portfolio that makes it easy for you to select the right plan at the right price.

ProviderSearch is the fast way to locate participating providers and facilities. Search by criteria such as type of plan, provider, specialty, physician gender, and radius within a specified ZIP code. Information is available on participating alternative care, dental, vision, and behavioral health providers, as are maps to show precise locations.

Manage Accounts makes it easy to change your account information (password, password hint or email address). If you have an administrator account, you can also add users, view users, or edit user access and information.

Manage Enrollment allows you to manage your employee's enrollment selections, add new employees and their dependents, cancel employee or dependent coverage, or change employee or dependent information.

Pay My Bill is the place to view your interactive bill (with online reconciliation) or pay your bills.

Health Net News connects you to Health Net's current and past newsletters.

Member and Employee Support gives you important online tools so that you can find information you or your employees need to know quickly and easily.

- View your Group Service Agreement (GSA)/Group Policy.
- Look up employee benefits and eligibility or *Evidence of Coverage (EOC)/Certificate of Insurance (COI).*
- Access forms and brochures.
- Compare hospitals or medical groups.
- Find a participating pharmacy, or view our up-to-date Essential Drug List (EDL) for nongrandfathered members and Recommended Drug List (RDL) for grandfathered members.

Here you'll also find member tools like Decision Power® – the Health Net exclusive program that helps reduce high-cost service over-utilization and supports workplace productivity by connecting employees with the information, resources and support that fit their health and their lives. Among the Decision Power highlights are:

- Health Risk Questionnaire (HRQ)
- My Personal Health Record (PHR)
- Medication Center
- Disease and Condition Centers
- Wellness Programs
- News and Features
- Treatment Cost Advisor
- Hospital Comparison Report
- Member Discounts (Decision Power Healthy Discounts)

Customer
Service

Section 3

Customer service

At Health Net, customer service is at the heart of everything we do. Health Net employs a team approach to implementing new business and servicing accounts. In addition to your dedicated Health Net account manager, we employ a team of professionals to handle the needs of your account.

Website: www.healthnet.com

Account Services Unit
Phone: 1-800-547-2967
Fax: 1-800-794-3988

Membership/Accounting
Phone: 1-800-909-6362
Fax: (818) 676-7411

Customer Contact Center
Phone: 1-800-522-0088
Para los que hablan español: 1-800-331-1777

Health Net Dental Member Services
Phone: 1-866-249-2382 (English and Spanish)

Health Net Vision Member Services
Phone: 1-866-392-6058 (English and Spanish)

COBRA Direct Pay (DP)
Phone: 1-800-977-2207
Fax: (916) 935-4420

MHN Services
Contact Health Net's Customer Contact Center at 1-800-522-0088 or 1-800-646-5610 for your behavioral health questions.

Account Services Unit (ASU) for employers

An additional resource available to you – This is a specialized unit within our Customer Contact Center that is comprised of specially trained, seasoned customer service professionals. It is designed to assist our employer groups, their brokers/consultants and/or benefits staff. Their primary goal is to provide our clients with one-call resolution for the day-to-day administrative issues (e.g., claims questions, benefits questions, verifying eligibility, etc.) that may arise.

Contact the Account Services Unit for the following:

- responses to general inquiries on member benefits and claims
- plan administration
- plan information and materials
- information on policies and procedures

Account Services Unit Monday to Friday, 8:00 a.m. to 5:00 p.m.
Phone: 1-800-547-2967 Fax: 1-866-848-6715 or email us at HN_Account_Services@HealthNet.com

Customer service for members

Customer service at Health Net begins with carefully selected, experienced, courteous, and knowledgeable staff. Customer Contact representatives receive extensive classroom and on-the-job training for a superior understanding of our products and services, but also to reinforce excellent customer service skills. Once on the job, continued coaching and call monitoring ensures prompt, accurate and friendly service. A higher level of quality service is achieved through:

- "One-stop shopping" approach to customer service. Representatives are extensively trained to ensure that they can handle all types of customer issues, thus eliminating confusion over whom to call, as well as reducing inconveniences related to call-transfers and call-holding times.
- State-of-the-art call center technology.
- Automated call-tracking software that allows us to report on recurring issues and trends, on a plan-wide basis or for a specific employer group. Such information is invaluable for developing benefit plans, customer materials and educational programs.
- 24-hour access via the Interactive Voice Response (IVR) unit.
- www.healthnet.com. Members can check eligibility/plan information; check copayment information; order ID cards; order an EOC; request materials; change primary care physician, name and address; and check claims status.
- Tele-interpreters to assist non-English-speaking members, with the advantage of being able to speak to a representative in a specific language.
- Formal member appeal process to provide quick solutions.
- Outbound calls for issue resolution follow-through.

Enrolling in Health Net

Section 4

As required by the Affordable Care Act (ACA), employer groups must provide *Summary of Benefits and Coverage (SBC)* documents to eligible employees and family members for plan years with open enrollment beginning on or after September 23, 2012. Specific details and instructions can be found in Section 5 of this manual.

Enrollment procedures

In this section, you will find information about:

- Your annual open enrollment.
- How to enroll new and rehired employees.
- How to enroll existing and acquired dependents.
- Selecting a participating physician group (PPG) for HMO, Elect Open Access,SM POS and Elect plans.
- The Health Net ID card.

About the forms mentioned in this section

To enroll with Health Net, complete the enrollment/change form that corresponds to your eligibility guidelines found in your Group Service Agreement.

Eligibility waiting period

Eligibility waiting periods are the length of time that employees must wait before they are eligible to enroll with Health Net. They are determined by each employer group subject to regulatory limits, and agreed to by Health Net. California legislation (AB 1083, 2012) limits the probationary or waiting period to 60 calendar days.

For example:
Date of Hire = 1/30/2014
With a 30-day waiting period = 3/1/2014
Coverage must be effective no later than 3/31/2014 to comply with the California 60-day limit. Therefore, coverage will be effective 3/1/2014.

Example 2:
Date of hire = 3/15/2014
With a 30-day waiting period = 4/14/2014
Coverage must be effective no later than 5/14/2014 to comply with the California 60-day limit. Therefore, coverage can be effective on the first of the month following 30 days, which is 5/1/2014.

[1]Varies by employer group.

The effective date of coverage is typically the first of the month following the completion of the eligibility period, if applicable.

Eligibility periods are applied to:

- New full-time employees.
- Employees whose status changes from ineligible to eligible.
- Former employees rehired after 30 days from the last day worked.

Example:
Hired: 1/15/2014
Eligibility waiting period:
First of the month (FOM) following one month.
Coverage effective: 3/1/2014

Rehires

If a terminated employee is rehired within 30 days, she or he and dependent(s) will be reinstated without a coverage lapse (i.e., a period where there is no coverage).

Example:
Terminated: 8/25/2014
Coverage ends: 9/01/2014
Rehired: 9/18/2014
Coverage reinstated: 9/01/2014

Since the period between termination and rehire is less than 30 days, continuous coverage is provided.

If more than 30 days have elapsed between the termination and rehire dates, the employee must again fulfill your group's eligibility period as if she or he were a new hire. This will produce a coverage lapse. The eligibility period varies with each group.

Example:
Terminated: 8/25/2014
Coverage ends: 9/01/2014
Rehired: 10/09/2014

Eligibility period:
First of the month following one month[1]
Coverage reinstated: 12/01/2014

An important reminder

Please send completed enrollment/change forms of new enrollments throughout the month as they occur. We must receive signed notification within 30 days of eligibility or they must wait until the next open enrollment. Prompt submission of membership changes will allow Health Net to better serve your account in the following ways.

- The effective dates of coverage for your employees and their dependents will be recorded sooner, resulting in the member receiving the ID card sooner.
- Eligibility will be visible to providers sooner.
- There will be fewer billing adjustments.

To ensure that your employees receive their Health Net ID cards as close as possible to the effective date of coverage, forms must be submitted no later than 10 business days before the effective date of the enrollment. Enrollment forms may be submitted as early as two months prior to the effective date of coverage; however, **enrollment forms must be signed and received no later than 30 days after the effective date of enrollment or the open enrollment period (whichever applies).**

Annual open enrollment

Requirements

- Employers must conduct an annual open enrollment for Health Net.
- The employer determines the date for open enrollment.
- The open enrollment period must last at least ten (10) days.
- The open enrollment coincides with the employer's renewal date and occurs during the same month each year.
- In subsequent years, the open enrollment should occur during the same month as the first open enrollment.
- The employer must provide copies of SBCs to eligible employees and their families as specified in Section 5 of this manual.

What is accomplished during the open enrollment period?

- Eligible employees and their dependents may join Health Net for the first time.
- Transfer from one health carrier offered by the employer to Health Net.
- Members may add eligible dependents.
- Transfer from one plan or type of plan to another if you offer more than one plan.
- You may add or change plans or product line, if eligible.

What if an employee will not be at work during the open enrollment because of vacation or leave of absence?

We suggest that you present the open enrollment opportunity to that individual before he or she departs. If this is not possible, we suggest mailing the individual information regarding the open enrollment.

What if an employee has not met the eligibility waiting period? May he or she enroll during open enrollment?

No, the eligibility waiting period is not waived because the annual open enrollment occurs. All employees must meet the eligibility waiting period as specified in your Application for Group Service Agreement.

How does Health Net help during open enrollment?

Health Net account managers are available to assist you during open enrollment. They can provide services ranging from supplying enrollment kits, SBCs and forms to conducting open enrollment meetings with employer

groups for question-and-answer sessions. Please contact your account manager in advance to arrange the best program for your company.

Selecting a physician group and primary care physician (for HMO, and the HMO level of benefits for Elect Open Access, POS and Elect)

As part of the enrollment process for HMO and POS, the subscriber and each enrolled dependent should choose a Health Net participating physician group (PPG) and a primary care physician (PCP) from the HMO Provider Directory or online at www.healthnet.com. The area established by Health Net within which the subscriber may select a PPG to assure reasonable access to care (within a 30-mile radius from the residence or work address)[2] is known as Health Net's enrollment area. We are constantly updating our HMO provider network, so please confirm a physician's participation and availability prior to receiving service. For up-to-date provider availability, please call the Customer Contact Center at 1-800-522-0088 for assistance in selecting a PPG or PCP or to request a Health Net HMO Provider Directory. As an added convenience, you can access up-to-date directory listings over the Internet by visiting us at www.healthnet.com.

Health Net PPGs are multispecialty medical groups with all physicians located at a single site. Other medical groups are structured as Independent Practice Associations (IPAs) that, while doctors are located in their own offices at various locations, in every other way function as a PPG. IPAs have a central administrative office.

Each member must select his or her own PPG and PCP. Family members covered under the subscriber may all select a different PPG, but they do have to enroll in the same health plan.

If members do not select a PPG and/or PCP, Health Net will assign them one. Notification will be mailed to the member reflecting the assignment, including instructions on changing the PPG or PCP, if desired.

All newborn infants are assigned to the mother's PPG for the first 30 days after birth. If the mother is not a current enrolled dependent, the newborn is assigned to the father's PPG.

After that, infants may be transferred to a newly requested physician if enrolled within 30 days.

If a new member chooses a PCP who is currently his or her primary care provider, please indicate "Prior Patient" on the New Enrollment form.

How does a member transfer from one PPG to another?

Transferring from one PPG to another is allowed monthly "at will."[3]

If you have any questions concerning PPG transfers, or would like to request a list of PPGs or a map of our service area, please contact the Health Net Customer Contact Center, your account manager, or visit our website at www.healthnet.com. Members must request PPG transfers on or before the 15th of the month in order for the change to be effective on the first of the following month.

Selecting a participating or preferred provider (for PPO, and the PPO level of benefits for POS and Elect Open Access)

Employees and their dependents do not have to select a participating or preferred provider at the time of enrollment. However, benefits may be more cost-effective for the member if

[2]Generally 30 miles, but greater in some rural areas.

[3]If the member is receiving acute care, the transfer may be allowed upon consideration of unusual or serious circumstances.

they choose a network preferred provider at the time they receive health care.

Members should check the PPO provider directory for information on contracted health care providers who are members of the PPO network. Also, members should refer to the *Certificate of Insurance* for information on benefits.

Health and Safety Code Section 1373.3

To comply with Health and Safety Code Section 1373.3, Health Net allows members to select a provider near[2] their home or work address.

Health Net requires the actual physical work address to accompany requests to enroll members into near-work providers. The physical work address for members must be within 30 miles of the provider.

Enrolling new employees

When does a new employee become eligible for Health Net membership?

New employees are eligible to become Health Net members if they are full-time permanent employees working 30 hours per week or more and have satisfied the eligibility period for your group. If you offer coverage to all part-time (20 hours a week or more) employees, permanent part-time employees may also become Health Net members. If you have any questions concerning eligibility requirements, please contact Health Net's Account Services Unit.

How are eligible new employees enrolled?

To enroll eligible new employees, you must submit a New Enrollment/Change form.

All new employees who wish to enroll must complete, sign and date their own New Enrollment/Change form and must receive a copy of their SBC. Missing or incomplete information will cause a delay in enrollment.

The new employee should retain a copy of the enrollment form for their records. This should be presented to the health care provider as proof of coverage.[4]

If a new member is receiving care from the PPG, the PPG will require that the member present their ID card before care is received. A new member may be asked to present their ID card to the provider prior to receiving care. They may contact the Customer Contact Center (CCC) to request a verification of eligibility form, log in to the www.healthnet.com website to print out a temporary ID card, or direct the provider to contact Provider Services at 1-800-641-7761 for benefit clarification.

Health Net does not require that payment be submitted when you enroll newly eligible members. Payment is due when you receive your statement.

Qualifying events

When can an eligible employee enroll outside of the employer's open enrollment period?

- An employee may enroll with Health Net or add dependents outside of the open enrollment period due to a change in or loss of benefits or contribution levels in current coverage from another group sponsored plan. The individual must request enrollment within 60 days of the change. You must submit a New Enrollment/Change form, a letter to Health Net explaining the change in benefits or contribution level, including the effective date of that change, and proof of prior coverage.

  Examples of qualifying events include, but are not limited to:
  - The subscriber of the other plan has ceased being covered except for either failure to pay premium contribution, a

[4]In addition to the temporary ID card, the PPG may require that a new member complete an Eligibility Certification form if his or her name does not appear on the current Eligibility Report.

“for cause” termination such as fraud or misrepresentation of an important fact, or voluntary termination.

- The other group-sponsored plan is terminated and not replaced with other group coverage.
- The employee loses coverage as a dependent under the spouse’s plan due to divorce or legal separation.
- If an employee is enrolled as a dependent in another group-sponsored health plan, and the subscriber of that plan chooses a different plan.
- If an employee gains new dependents due to birth, adoption or marriage, the employee may enroll himself or herself, and the new dependent. For a new spouse, the effective date of coverage will be the date of marriage or the first of the month following the date of marriage, according to the rules established by the group. For a newborn, coverage will commence at the moment of birth; however, the assigned effective date will be the first of the month following the date of birth. For adoption, the effective date will be the date the birth parent or appropriate legal authority grants the employee or his or her spouse, in writing, the right to control the child’s health care.

You must submit a letter to Health Net explaining the change in benefits or contribution level, including the effective date of that change. Proof of prior coverage must also be submitted with this letter.

Enrolling rehired employees

Who qualifies as a rehired employee?

Former employees who have been rehired.

Do eligibility periods affect the rehire’s effective date of coverage?

If rehired within 30 days, the eligibility period is waived. If rehired after 30 days, the eligibility period must be met.

How are rehired employees enrolled?

Submit a completed New Enrollment/Change form for each rehire you wish to enroll. The Rehire/Re-enroll option should be indicated.

If the rehire is not a former Health Net member, please follow the instructions found in the “Enrolling new employees” section (page 17).

If the employee is rehired after 30 days of the last day previously worked, the employee does not qualify as a rehire and is not eligible to enroll in Health Net until he or she completes the eligibility period according to the “Enrolling new employees” section in this manual.

Enrolling formerly ineligible employees

What effect will eligibility periods have on a formerly ineligible employee’s effective date of coverage?

If an existing employee was previously ineligible for Health Net coverage, the eligibility period ordinarily imposed on newly hired employees must be met. The eligibility period begins on the date the employee begins employment as an eligible employee.

How are formerly ineligible employees enrolled?

Please follow the instructions found in the “Enrolling new employees” section.

Enrolling dependents

What is the definition of a dependent?

Health Net defines eligible dependents as members of the employee’s family[5] who meet the eligibility requirements for coverage listed

[5]For the purposes of enrolling in Health Net, a family is defined as the employee and his or her spouse and children, including legally adopted children or children for whom the employee or spouse is legal guardian. Health Net is required by California law to treat domestic partners in the same manner as spouses for new and renewing group contracts beginning on or after 1/2/05.

below and who are included on the New Enrollment/Change form completed and signed by the subscriber.

- The subscriber's lawful spouse. (Coverage for domestic partners is also available; refer to the Group Service Agreement/Group Policy to determine if this eligibility option is applicable to your group.)
- A child of the subscriber or spouse, or both. The child may be a natural child, adopted child, legal dependent, or stepchild. The child of a domestic partner who meets the above requirements is also an eligible dependent, provided domestic partner eligibility is applicable to your group and is required for all Health Net of California and Health Net Life plans.
- A covered over-age dependent is defined as a child of the subscriber and/or spouse up to 26 years old.[6] The child of a domestic partner[7] who meets the above requirements is also an eligible dependent, provided domestic partner eligibility is applicable to your group and is required for all Health Net of California and Health Net Life plans.
- A child who is mentally or physically handicapped and is incapable of self-sustaining employment and remains dependent upon the subscriber or spouse for at least 50 percent of his or her support. The disability must have been present prior to the dependent reaching this limiting age where he or she would have ceased to be an eligible dependent.

Important: Qualifications for dependent children vary by plan. We have highlighted some of the most common qualifications; however, your group's requirements may be significantly different. Please check your Application for Group Service Agreement/ Group Policy for details.

Newborns of the subscriber or spouse are covered automatically for the first 30 days from birth or, in the case of a newly adopted child, from the date that the birth parent or appropriate legal authority grants the subscriber or his or her spouse, in writing, the right to control the child's health care.

Only newborns or adopted children who are eligible for enrollment under the Health Net plan, and who are enrolled within 60 days of the date of birth or, from the date the right to control health care is acquired, will continue to be covered after the initial 30-day automatic coverage period. The subscriber must enroll the child through the employer by completing and submitting a New Enrollment/Change form to receive coverage beyond the initial 30-day coverage period. The assigned effective date is the first of the month following the qualifying event.

How are dependents enrolled?
To enroll eligible dependents, the employee/ subscriber must submit a fully completed New Enrollment/Change form. The Add Dependent option must be checked, all the dependents the subscriber wishes to add must be indicated on the form, and it must be signed and dated by the subscriber.

Remember that, except in the case of a loss or change in other coverage or family status (marriage, birth or adoption), existing dependents may only be enrolled at initial enrollment or subsequent open enrollment periods.

[6]For those groups and plans that are subject to the Affordable Care Act.

[7]Health Net is required by California law to treat domestic partners in the same manner as spouses.

Enrolling newly acquired dependents

What is the definition of a newly acquired dependent?

A newly acquired dependent is a spouse or child who joins the family as an eligible dependent (through marriage, birth or adoption) after the date the subscriber's coverage becomes effective. **Note:** When a subscriber's covered dependent child gives birth to a child, the newborn grandchild of the subscriber is not eligible for coverage. See the section "Enrolling dependents" (page 18) for additional information.

When may newly acquired dependents be enrolled in a Health Net plan?

- Newly acquired dependents may enroll in Health Net up to 60 days from the date of birth, or the date that the legal right to control health care is granted for adoption, the date of the court order granting guardianship, the date of marriage, or of domestic partnership.
- If a newly acquired dependent is not enrolled within 60 days from the date of acquisition, the newly acquired dependent is not eligible for membership until the next open enrollment period.

When does coverage become effective for a newly acquired dependent?

Spouses: A new spouse must be enrolled within 60 days of marriage. Coverage will begin on the date of marriage or the first of the month following the date of marriage, according to the rules established by the group.

Newborns: Newborns of the subscriber or spouse are covered from the moment of birth. However, that coverage is automatically provided for only the first 30 days following birth. In order for coverage to continue, the child must be enrolled before the 31st day of life.

For HMO and POS, the child will be enrolled under the mother's PPG if the mother is an enrolled Health Net member. The child will be enrolled with the subscriber's PPG if the mother is not an enrolled Health Net member. The dependent child can then be enrolled with another PPG after the first day of the following month.

Adoptees: A dependent child who is being adopted will be covered automatically for the first 30 days following the date the birth parent or appropriate legal authority grants the employee or his or her spouse, in writing, the right to control the child's health care. After 30 days, the newly adopted child who is eligible to be enrolled (i.e., adoptee of the subscriber or spouse) must be enrolled by the subscriber as a family member to continue coverage without a lapse. The subscriber must enroll the adopted child through the employer within 60 days following the date the legal right to control health care is acquired. Copies of the signed consent form will be required.

Wards or subjects to guardianship: A dependent who is within the age limit and who is a legally acquired dependent (ward) of the subscriber or covered spouse must be enrolled within 40 days of the commencement date of legal guardianship. Coverage will begin as of the first of the calendar month following Health Net's receipt of the enrollment request. Proof that the subscriber or covered spouse is a court-appointed legal guardian will be required.

How are billing charges affected by adding newly acquired dependents?

There will be additional billing charges for the newly acquired dependent if his or her enrollment causes the subscriber's contract

to become a two-party (employee + spouse [no child(ren)] or employee + child(ren) [no spouse]) or family (employee + spouse + child[ren]) contract type. The billing charges will start on the dependent's effective date. If enrollment is completed within 60 days of this date, the effective date will be the first of the month following the month in which the dependent was acquired. If the subscriber is already on a family or employee + child contract, there will be no additional billing charge. Some groups may not be impacted by adding dependents and should contact their account manager to verify.

How are newly acquired eligible dependents enrolled?

To enroll newly acquired eligible dependents, you must submit a completed, signed and dated New Enrollment/Change form for each employee who wishes to enroll newly acquired dependents.

Important: Newborns and adopted children will be covered for the first 30 days, but enrollment of acquired dependents is never automatic. Completion/submission of a New Enrollment/Change form is required.

Health Net will require that enrollment requests for children who have been placed in the subscriber's or spouse's custody for adoption be accompanied by a copy of the signed consent form.

Enrollment requests for children who have become wards must be accompanied by a copy of the court order establishing the guardianship.

Health Net ID card

Soon after enrollment, members will receive their Health Net ID card. This card should be carried by the member at all times to be used when obtaining medical or hospital care and when purchasing covered prescription drugs. The ID card will identify the individual as a Health Net member.

For HMO, Elect and POS, it includes the name, address and telephone number of the member's PPG. In addition, the card has printed instructions that remind the member that all medical and hospital services must be rendered or authorized by the selected PPG in order to be covered by Health Net. Elect Open Access, POS, PPO, and Flex Net ID cards also have a list of the services that require certification.

ID cards will be issued under the following conditions:

- Enrollment in Health Net
- Change of PPG or PCP (HMO and POS only)
- Change in medical plans
- Transfer to COBRA coverage
- Member name change
- As requested by the member

As dependents are added to an existing subscriber's contract or as replacement cards are ordered, a card will be issued for that member only.

Summary of Benefits and Coverage

Employer Instructions

Section 5

Health Net®

An Affordable Care Act (ACA)[1] *requirement for employers that sponsor group health plans*

As required by the ACA, health plans and employer groups must provide the *Summary of Benefits and Coverage (SBC)* to eligible employees and family members, who are:

- currently enrolled in the group health plan, or
- eligible to enroll in the plan, but not yet enrolled, or
- covered under COBRA continuation coverage.

Health Net is committed to ensuring compliance with all timing and content requirements with regard to the distribution of the SBC. To meet this goal, you are required to provide the SBC in the **exact and unmodified form**, including appearance and content, as provided to you by Health Net.

Please follow the instructions below so you will know how to distribute the SBC.

SBC form and manner

You may provide the SBC to eligible or covered individuals in paper or electronic form (i.e., email or Internet posting).

- If you provide a paper copy, the SBC must be in the exact format and font provided by Health Net, and, as required under the ACA, must be copied on *four double-sided pages*.
- If you mail a paper copy, you may provide a single SBC to the employee's last known address, unless you know that a family member resides at a different address. In that case, you must provide a separate SBC to that family member at the last known address.
- For covered individuals, you may provide the SBC electronically if certain requirements from the U.S. Department of Labor are met.[2]
- If you email the SBC, you must send the SBC in the exact electronic PDF format provided to you by Health Net.
- If you post the SBC on the Internet, you must advise your employees by email or paper that the SBC is available on the Internet, and provide the Internet address. You must also inform your employees that the SBC is available in paper form, free of charge, upon request. You may use the model language below for an e-card or postcard in connection with a website posting of an SBC:

Availability of Summary Health Information

As an employee, the health benefits available to you represent a significant component of your compensation package. They also provide important protection for you and your family in case of illness or injury.

Your plan offers a series of health coverage options. Choosing a health coverage option is an important decision. To help you make an informed choice, your plan makes available a Summary of Benefits and Coverage (SBC). The SBC summarizes important information about any health coverage option in a standard format to help you compare across options.

The SBC is available online at: <[group's website.com]>. A paper copy is also available, free of charge, by calling the toll-free number on your ID card.

[1]26 C.F.R. § 54.9815-2715; 29 C.F.R. § 2590.715-2715; and 45 C.F.R. § 147.200.
[2]Such requirements can be found at 29 C.F.R. § 2520.104-1(b).

This document is provided to you as a customer courtesy and is not intended to be legal advice. Please consult with your own legal counsel to determine your responsibilities under the SBC regulations of the Affordable Care Act.

Timing of SBC distribution

For plan years with open enrollment beginning on or after September 23, 2012, you must provide the SBC as follows:

- **Upon application.** If you distribute written application materials, you must include the SBC with those materials. If you do not distribute written application materials for enrollment, you must provide the SBC by *the first day the employee is eligible to enroll in the plan*.
- **Special enrollees.** For special enrollees[3], you must provide the SBCs *within 90 days following enrollment.*
- **Upon renewal.** If open enrollment materials are required for renewal, you must provide the SBC *no later than the date on which the open enrollment materials are distributed*. If renewal is automatic, you must provide the SBC *no later than 30 days prior to the first day of the new plan year*. If your group health plan is renewed less than 30 days prior to the effective date, you must provide the SBC *as soon as practicable, but no later than 7 business days after issuance of new policy or the receipt of written confirmation of intent to renew your group health plan*.

At the time your plan renews, you are not required to provide the Health Net SBC to an employee who is not currently enrolled in a Health Net plan. However, if an employee requests a Health Net SBC, you must provide the SBC as soon as you can, but no later than 7 business days following your receipt of the request.

Notice of SBC modification

Occasionally, there will be a material change(s) to the SBCs other than in connection with a renewal, such as changes in coverage. You must provide notice of the material changes to employees *no later than 60 days prior to the date on which change(s) become effective*. You must provide this notice in the same number, form and manner as described above. When such changes are initiated by Health Net, Health Net will provide you with modified SBCs for distribution.

Uniform glossary

Employees and family members can access a glossary by visiting www.cciio.cms.gov, or by calling Health Net at the number on the ID card to request a copy. Health Net shall provide a written copy of the glossary to callers within 7 business days after Health Net receives their request.

If you have any questions, please contact your Health Net account manager.

[3]Special enrollees are individuals who request coverage through special enrollment. Regulations regarding special enrollment are found in the U.S. Code of Federal Regulations, at 45 C.F.R. 146.117 and 26 C.F.R. 54.9801-6, and 29 C.F.R. 2590.701-6.

This document is provided to you as a customer courtesy and is not intended to be legal advice. Please consult with your own legal counsel to determine your responsibilities under the SBC regulations of the Affordable Care Act.

Out-of-Area Dependents

Section 6

All individuals (i.e., your employees and their eligible dependents) enrolling in a Health Net HMO, Elect Open Access, Point-of-Service (POS), or Elect plan must choose a primary care physician in order to be covered. If an employee knows that he or she has a dependent child outside the Health Net HMO service area, the employee must still choose a Health Net primary care physician for that child.

For members with HMO or EPO plans, Health Net will cover an out-of-area dependent for the cost of emergency and urgent care, minus any applicable copayment. Health Net will not pay for routine care such as Pap tests, physical exams or elective surgery when a dependent is away from the service area. A Health Net network physician may render these services once the dependent returns to the Health Net service area.

If your employees and their dependents are enrolled in one of the Health Net Point-of-Service (POS) plans, out-of-area dependents always have the option of using the out-of-network portion of their plan to access care. A detailed description is provided in the *Certificate of Insurance* or *Evidence of Coverage.*

Routine care/follow-up care

If a dependent requires routine or follow-up care while out-of-area:

- HMO member: Claims will be denied unless Health Net has given prior authorization.
- POS member: Claims will be paid at the in-network level if provided in-state by a Health Net California PPO or out-of-state by a Health Net national network (First Health) provider. Claims will be paid at the out-of-network benefit level for other providers. Members should obtain prior authorization from Health Net for those services requiring authorization as identified in the member's plan documents.
- PPO member: Claims will be paid at the in-network level if provided in-state by Health Net's California PPO network or out-of-state by a Health Net national network (First Health) provider. Claims will be paid at the out-of-network benefit level for other providers. Members should obtain prior authorization from Health Net for those services requiring authorization as identified in the member's plan documents.

The normal guidelines/criteria still apply for services that require prior authorization.

Out-of-area emergency care

If an out-of-area dependent has a medical emergency, as defined in the plan documents, he or she should seek care at a local emergency room. The hospital or a family member need only notify Health Net if the dependent is admitted to the hospital so that Health Net may follow the course of his or her treatment. Under a Point-of-Service (POS) plan, care following an emergency requires prior authorization in order to be covered as an in-network service. If a POS member obtains follow-up care without prior authorization, the services are paid as out-of-network.

HMO members require prior authorization from their medical group for out-of-area services following the emergency.

Out-of-area urgent care – See plan document for definition

When an out-of-area dependent needs to see a doctor urgently but the situation is not an emergency, he or she should first contact his or her primary care physician or Health Net treating physician for advice.

For urgent care

In considering coverage for urgent care outside the service area, Health Net will review the situation to confirm that the signs and symptoms at the time of treatment required urgent care.

Bills from nonparticipating providers

Submitting bills to Health Net

To be reimbursed for medical bills from nonparticipating physicians or providers, members must send the bills to Health Net in an envelope addressed as follows:

Health Net of California, Inc.
PO Box 9103
Van Nuys, CA 91409-9103

Members must be sure to include the following information:

- A completed Health Net Medical Claim form. Members may obtain copies from the Health Net Customer Contact Center or online at www.healthnet.com.
- The itemized bill with the date(s) of service, diagnosis and complete treatment information.
- Health Net ID number and two-digit suffix listed on the ID card of the member who received services.
- A brief explanation of why services were needed and could not be obtained from a Health Net plan physician or provider.
- An *Explanation of Benefits (EOB)* from the primary insurance carrier if the member has other health coverage that is primary.
- A statement of payment if the member has paid the provider.

For emergency care

After receiving all of the information listed above, if services were rendered due to an emergency, Health Net may send a questionnaire.

Payment of claims

When Health Net approves a non-plan claim, payment is generally made directly to the provider. However, if the information Health Net receives indicates that the provider was already paid, the plan will reimburse the member directly with proof of payment.

Coverage upon reaching maximum age

When coverage ends

A dependent child covered under the extended age limit will terminate according to criteria agreed upon in advance by your company and Health Net.

Notification requirements

It is your employee's responsibility to notify Health Net and your company's benefits office of changes in dependent eligibility status. Health Net will remind your employee about dependent eligibility status 90 days prior to the time that, according to our records, a child will reach the maximum age for dependent coverage.

Other coverage options

When the dependent child is ineligible for coverage, see the "Continuation of Coverage" section for information on plan options.

Billing

Procedures

Section 7

Health Net®

Billing and payments

The following section explains the billing and payment method we utilize and includes information on our online billing services.

Billing method: Members added or terminated within a specific month

Groups with 51–100 employees have two available billing options. Your account manager will discuss with you the best option for your specific group. Below is a brief overview of the two options available.

Option 1

This billing option allows a member's coverage to begin on the first day of the month following the designated waiting period that is determined by your company and agreed to by Health Net. The premium is charged for the full monthly premium.

All terminations of coverage will be effective the last day of the coverage month; the full monthly premium is charged.

Option 2

If a member is added during the 1st through the 15th of the coverage month, premium is charged for the full monthly premium. If a member is added during the 16th through the last day of the coverage month, there is no premium charged for the coverage month.

If a member is terminated during the period that includes the 1st through the 15th of the coverage month, there is no premium charged for the coverage month. If a member is terminated during the 16th through the last day of the coverage month, the full monthly premium is charged.

Age-banded rate increases outside of open enrollment

For groups that are age-rated, which are groups whose subscription charges are based on the age of the subscriber, if a subscriber changes an age-band during the course of the year, the new rate is effective the first of the month after the subscriber's birthday. However, if the subscriber's birthday is the first day of the month, then the new rate will be effective the first day of the month of the subscriber's birthday.

Health Net invoice

Health Net will send your invoice between the 4th and 28th of the month prior to the coverage month (this date is customizable). This invoice will list the active subscribers in effect on your plan(s). This information will be based on the Health Net enrollment forms and change and cancellation forms received from you and processed by Health Net before the bill run date for the month during which the invoice is generated (i.e., the month prior to the coverage month).

Health Net requests that you pay the dollar amount noted on the invoice under the heading "Please Pay This Amount." If there are any questions or concerns about paying this amount, please call the Accounting representative assigned to your account at 1-800-909-6362. Any adjustments to credit or debit your account will be reflected on the next invoice.

When payment is due

Payment of an invoice is due to Health Net by the first day of every month for coverage that month; for example, Health Net will send the April invoice between March 4 and March 28. Your group should then remit payment by April 1. There are two advantages for you to pay as early as possible: (1) to increase the accuracy of the following month's invoice, and (2) to avoid any interruption of health care coverage to your employees.

Employer groups should call the Membership Accounting & Eligibility Department at 1-800-909-6362 with any billing problems and questions which may arise.

Manual billing and payment process

Manual payment process

Premiums are payable monthly – Just include the invoice and payment. If adjusting from Health Net's billed amount, please indicate what charge line is being adjusted on the front page of the invoice premiums. Please also include all names, bill periods, and dollar amounts for any premium adjustments that are made from Health Net's original billed amount. If there are any questions about this process, please call the assigned Accounting representative at 1-800-909-6362 for assistance in determining the appropriate information to include.

- Indicate the group number on the check.
- Make sure payment is submitted on or before the due date. Health Net of California will not accept postdated checks.
- Checks must be made payable to Health Net of California.
- Health Net may terminate coverage for any group that does not remit full payment by the end of the grace period on which payment is due. If payment is not received after the grace period is over, Health Net will terminate the group at the end of the month.

Health Net enrollment and billing
Direct addresses
Health Net Enrollment Phone: 1-800-909-6362 Fax: (818) 676-7411 Address: PO Box 9103 Van Nuys, CA 91409-9103
Health Net Billing (Payments) Phone: 1-800-909-6362 Fax: (818) 676-7411 Health Net File #52617 Los Angeles, CA 90074-2617

- Health Net will not pay claims incurred after the termination date.
- Health Net will not reinstate groups that have been terminated due to a negligent payment history.

Employer groups need to include their group plan number on all correspondence that is sent to our office. This provides prompt identification and processing.

Electronic billing and payment process

Online billing and enrollment

Billing and enrollment can be conducted online at www.healthnet.com. Eligible employers are able to:

- View and pay bills online.
- Research prior billing and payment history.
- Enroll, terminate and modify employee and dependent enrollment.
- Communicate with billing and enrollment specialists through a secure online message center.

Access to all these tools is managed by your respective client administrator, ensuring security and administrative ease in the management of delegated users.

Electronic Funds Transfer (EFT) Process

Electronic Funds Transfer (EFT) is the process by which Health Net debits the customer's account electronically upon their request. After the customer calculates the amount of payment to be submitted on the Health Net Billing and Enrollment website for the invoice being reviewed, your pre-registered account is debited. For more information about how to register and/or use the online Billing and Enrollment website, please contact your Enrollment or

Accounting representative, and they can connect you with Health Net's online billing services team.

Notifying Health Net of enrollment changes

How to notify Health Net

For prompt, accurate processing of all enrollment transactions, you need to complete the Health Net Enrollment Form and/or Change and Cancellation Form. On the form, you need to include the appropriate group number that corresponds to the product (HMO, PPO, etc.) and population (active, COBRA, retiree, etc.) the subscriber has chosen, and send it to Health Net. Copies of these forms can be obtained through your Health Net representative or by logging in to www.healthnet.com.

The forms serve as enrollment/disenrollment notification. When completing the Health Net enrollment form, please include the name and access code of the primary care physician(s) being selected and coordination of benefits and dependent information, if applicable. Cancellations can also be reported on the Health Net invoice using the "Membership Changes" section of the invoice. Please see the Billing Statement Pamphlet for additional information.

When forms are due to Health Net

All Health Net Enrollment forms and Change and Cancellation forms must be submitted to the plan by the 10th of the month prior to the effective date of the enrollment and within 60 days of the qualifying event. Meeting this deadline will allow Health Net to reflect these changes and all appropriate premium adjustments on the invoice for the month in which the enrollment, change and/or cancellation is effective.

Late reports of enrollments, changes or cancellations

All eligibility transactions not reported to Health Net in enough time to be processed prior to the bill run date for your account will automatically be reflected on the company's Health Net invoice for the following month. The amount due will be adjusted accordingly to conform to the Health Net retroactivity policy.

Retroactivity policy

Health Net's standard retroactivity permits premium adjustments to be made for the current month (based on date of receipt by Health Net) plus 2 months prior to the current month (credit or debit) for all enrollment transactions. Since a COBRA situation may require more flexibility regarding the reinstatement of members, special provisions will be allowed for COBRA members upon prior approval from Health Net.

Mailing enrollment transactions

Health Net provides Enrollment and Change and Cancellation forms. If you must use a different envelope, you should send it to:

Health Net
PO Box 9103
Van Nuys, CA 91409-9103

To obtain additional forms, please call the Account Services Unit at the number located in the "Customer Service" section of the manual.

COBRA groups

All COBRA groups administered by a third-party administrator will be set up with a separate group number.

Claims

Information

Section 8

Health Net®

Claims

The following section will help you understand the process that members should follow when submitting and filing claims.

Claim submission

Although members usually do not have to complete claim forms when obtaining care from an in-network provider, there may be certain situations when they may be required to complete claim forms to receive reimbursement, such as in the following situations:

- When obtaining services from a nonparticipating laboratory.
- When obtaining care from an out-of-network provider and they have out-of-network coverage.
- When Health Net is the secondary insurance carrier.

Members should submit claim forms and claim resubmission forms to the addresses located on their Health Net ID card.

Claim filing deadlines

- Members and participating providers must submit a claim to Health Net within 120 days of the claim's date of service.
- Members should check their *Evidence of Coverage/Certificate of Coverage* to determine how much time from the date of service they have to submit an out-of-network claim. If the nonparticipating provider will submit the claim, members should advise the provider how much time they have.

Claims that provide all necessary information are processed within 30–45 business days. Necessary information includes all of the following:

- patient name and Health Net member ID #
- Health Net provider ID #
- provider information, including Federal Tax ID Number (FTIN)
- date of service
- place of service
- diagnosis code
- procedure code
- individual charge for each service
- provider signature

Explanation of Benefits (EOB)

Health Net will send an EOB once it processes a claim for a service provided to the member. This form explains the action taken by Health Net on that claim. Depending on the claim, the EOB may include the amount paid by Health Net, the patient's responsibility, allowed charges and, if applicable, the reason Health Net denied coverage and its corresponding explanation. The EOB will explain the member's rights to appeal our decision. Members may contact the Customer Contact Center at 1-800-289-2818 if help is needed to understand their EOB.

If you have any questions regarding a particular claim submission, please contact the Account Services Unit or your Health Net account manager. Members can check claims online at www.healthnet.com or by calling Health Net's Customer Contact Center at 1-800-522-0088.

Coordination *of* Benefits *(COB)*

Section 9

Health Net®

Coordination of Benefits (COB)

The following is a summary of information, benefits and services which are fully described in the member's EOC/COI, which is subject to change. It is possible for employees to be enrolled in Health Net as well as another group health plan that offers some of the same benefits. In such instances, Health Net will coordinate benefits with the other carrier to provide members with the maximum amount of allowable coverage, while avoiding duplicate payment for the same benefits. This coordination is meant to protect both you as the employer and Health Net members from higher premiums that could otherwise result from such duplicate payment.

Health Net collects information about other coverages through information provided on the Health Net enrollment application and questionnaires mailed directly to members. This section explains how Health Net uses that information to make sure members receive the maximum amount of allowable coverage.

Determining who pays first

Employees, spouses and dependents
The plan that covers the member as a subscriber or through the member's place of work is the "Primary Plan," the plan that pays first. The plan that covers the member as a spouse or dependent is the "Secondary Plan," the plan that pays second.

Active employees with retiree coverage
A plan that covers a person as an active employee is primary over a plan that covers that person as a retiree.

Dependents covered under both parents' plans
The parent whose birthday occurs first in the year has the primary plan; the other parent's plan is the secondary plan for the children's claims. The actual year of birth does not matter, only the month and day. This is known as the "birthday rule" and it applies to children of unwed, as well as married, parents.

In rare instances where the other plan follows the gender rule rather than the birthday rule, the gender rules apply.

When parents are divorced or separated
If the divorce decree or separation agreement specifies that one parent has responsibility for the children's medical expenses, that parent's plan pays first if it has been informed of the decree or agreement. If the children are covered as dependents under the other parent's health plan, that plan pays second.

In the absence of an agreement or decree that specifies which parent has responsibility for the children's medical expenses, or if the decree or agreement has not been made known to the appropriate plan, the plan of the parent with physical custody pays first, the plan of that parent's spouse (the stepparent) pays second, and the plan of the natural parent without physical custody pays third.

None of the above
If the above rules do not establish which plan should pay first, the plan that has covered the member for the longer period of time is primary.

When Health Net is primary

Accessing care from a Health Net participating provider
If a member receives services from a network provider and pays a copayment, he or she may ask the physician/provider for a "bill" to submit to the secondary carrier. By filing a claim with the other insurance company, the member may be able to be reimbursed for the copayment or at least obtain credit toward that plan's deductible.

Accessing care from a non-Health Net participating provider
Members who access out-of-network services in accordance with their plan design must submit a claim form to Health Net. Health Net will render payment in accordance with the member's plan design. The member may then submit the balance of the claim to the secondary carrier for consideration.

Members who do not have out-of-network benefits as part of their plan design are not eligible for benefits from Health Net when they receive services from a nonparticipating provider, unless Health Net has, as an exception, approved those services in advance, or the services were for urgent or emergent situations. However, members may be eligible for benefits from their other carrier and should therefore submit claims to that carrier.

When Health Net is secondary

Accessing care from any provider (Health Net participating or nonparticipating)
Members should present their Health Net ID card at the physician/provider's office. If the member has primary coverage through another carrier, it is his or her responsibility to inform the provider of which carrier should be billed first.

When a provider requires payment at the time services are rendered
When Health Net is secondary, physicians/providers are advised that they should not request payment from members at the time services are rendered, except for copayments. If members do pay more than a copayment at the time services are rendered, they may be reimbursed by Health Net after the physician has been paid. There is an 18-month deadline for submitting claims involving coordination of benefits.

Billing the primary carrier
Members should request a copy of the bill and submit a claim to their primary carrier. If appropriate, members should indicate on the claim form that payment be mailed directly to the physician/provider. Usually benefits can be assigned to the physician/provider via the member's signature in a specific spot on the claim form.

Explanation of Benefits

The primary carrier will then send the member an Explanation of Benefits (EOB) form, which tells how much of the bill, if any, the carrier paid. A sample of a Health Net EOB form can be found at the end of the "Claims Information" section.

Billing Health Net

The physician/provider should submit a photocopy of the primary carrier's EOB form and a corresponding claim form to Health Net. These items must come to Health Net in one package. To ensure this happens, members should:

1. Send a photocopy of the EOB form from the primary carrier, along with their Health Net ID number, to the physician/provider who rendered the services.
2. If appropriate, send the physician/provider the full amount of any checks received for their services from the primary carrier, along with the photocopy of the EOB form.
3. Instruct the physician/provider to forward the photocopy of the EOB form and the corresponding claim to Health Net.

When Health Net receives this information, the plan will pay on the balance of the claim, up to the Health Net contracted amount. If the primary carrier already paid the contracted amount, Health Net will not make any further payments, and the provider may not "balance bill" the member.

If the primary carrier applies all or part of its payment toward that plan's deductible, Health Net will pay on the balance of covered services, up to the plan's allowed amount. Any balance due cannot be charged to the member.

If the service involves a copayment, the member's liability for the copayment will be determined by the coordination of benefits process.

When Health Net is primary

Health Net will pay benefits in accordance with the member's EOC. This decision affects all dependents as long as the dependent does not carry his or her own automobile insurance that states the primary carrier as anything other than Health Net.

- Claims from $0 to $5,000 – No-fault will pay 80 percent; Health Net will pay 20 percent.
- Claims over $5,000 – No-fault will pay 100 percent after member pays the deductible.

When Health Net is secondary

When Health Net is secondary, the plan will pay the lesser amount of the allowable expense left after the primary insurance has paid the equivalent value of services if Health Net was primary.

Coordination with non-insurance carriers: workers' compensation

All claims related to a work-related injury or illness should be submitted to your company's workers' compensation carrier for consideration, not to Health Net. If the workers' compensation carrier contests that the claim is work-related, Health Net will provide benefits upon receipt of the denial and will pursue the matter with the workers' compensation carrier.

Coordination with non-insurance carriers: accidents/other party liability

Upon notification that a member has been injured, Health Net sends a questionnaire to the member. The questionnaire asks for complete details of how, when and where the accident occurred and if the member has hired an attorney. The COB Department researches all aspects of the situation. Health Net then provides benefits according to the coverage provided. If the member is successful in his or her lawsuit, Health Net may be reimbursed a portion of the amount it paid toward the claim(s).

A Health Net participating physician/provider cannot recover any money from a third-party settlement for charges related to medical services provided to Health Net members. However, physicians/providers are not prohibited from billing the member's attorney for copies of medical records, preparation of medical-legal reports, and providing expert medical testimony. Participating physicians/providers cannot require a Health Net member to:

- Sign an agreement that indicates the physician/provider does not have to look to Health Net for payment of medical services; or
- Sign an agreement that requires payment of any of the member's settlement amounts by the attorney, or by the member, to the physician/provider for medical services.

Member Appeal *and* Grievance *Process*

Section 10

Health Net®

Member appeals and grievances

The following is a summary of information, benefits and services which are fully described in the member's EOC/ COI. Health Net has implemented a medical necessity appeal process and an administrative grievance process for use when a member does not agree with a decision that we have made. Requests may be submitted by phone, fax or by mail.

Medical necessity appeal process

If a member disagrees with a Health Net decision that a health care service is not medically necessary and appropriate, the member (or someone he or she designates with specific written consent of the member) may initiate an appeal process. Upon receipt of the request for appeal, the issue will be investigated and reviewed by Health Net clinical staff. Under certain circumstances, the member may request an expedited appeal. If Health Net denies the appeal at Stage 1, the member can proceed to Stage 2, which entails a hearing with a Health Net Clinical Appeals Panel. The member, or his or her designee, may attend the panel meeting in person or via telephone conference to discuss the case. Health Net's written final adverse determination will advise the complainant of their state's external review process, the third stage in the medical necessity appeals process.

Non-medical necessity grievance

If a member disagrees with a Health Net decision that is not based on medical necessity, the member (or someone he or she designates with specific written consent of the member) may use the Health Net grievance process to resolve the issue. The member may initiate a grievance via phone by calling the Customer Contact Center at 1-800-522-0088 (TTY users should call 1-800-977-6757). If the member prefers to submit a grievance via fax or by mail, the Customer Contact Center representative will provide the fax number. To submit a grievance in writing, please mail to:

Health Net, Appeals & Grievances
PO Box 10348
Van Nuys, CA 91410

The grievance determination letter will advise the member of available options should the member disagree with the outcome of the grievance. Prior to filing a grievance, the member always has the option of contacting the Customer Contact Center for assistance in resolving his or her issue. Please note that a member may file a complaint with the appropriate state regulator at any time.

Continuity of Care *and* *Case* Management *Programs*

Section 11

Health Net®

Continuity of care

This section is included to help you understand the Health Net Continuity of Care Program for the HMO plan. Continuity of care is when a new member is allowed to continue seeing a nonparticipating provider at an in-network level of benefits. Health Net covers health care services provided under continuity of care with the same terms and conditions as applicable for participating health care providers. To be eligible for payment by the plan, providers must agree to Health Net terms and conditions prior to providing service under the continuity of care provisions.

To be eligible for COC services, California commercial group HMO members must be receiving care for one of the six medical conditions listed in Health and Safety Code Section 1373.96 (AB1286), which are as follows:

- Acute condition – sudden onset of symptom due to illness/injury.
- Serious chronic condition – disease/illness/disorder continues without cure and/or requires ongoing treatment; continue until safe to transfer care, up to 12 months.
- Pregnancy – three trimesters through postpartum.
- Terminal illness – incurable/irreversible, high probability of causing death.
- Care of newborn child – birth through 36 months, with care not to exceed 12 months.
- Scheduled surgery – must be plan-authorized and scheduled within 180 days from the provider contract termination date or Health Net effective date of coverage.

Please note that in addition to having a qualifying medical condition, a member or his or her authorized representative must submit a Continuity of Care Assistance Request Form within time frames and conditions outlined in his or her EOC/COI.

Current Health Net members and new enrollees are eligible for COC services in any of the following instances:

- The employer has a new member join Health Net from another health plan or insurer.
- A specific benefit plan change resulting in a different provider network.
- A participating physician group (PPG) change due to PPG closure, or involuntary transfer of the member to another PPG.
- A primary care physician (PCP) change when the PCP changes affiliation with a PPG, or the Health Net contract terminated.
- Continuity of care with a noncontracted mental health provider for a new member when they change to Health Net.

Initiating a request for the COC services process is quite simple:

- The member (or employer) advises Health Net of any transitional care needs within 60 days of the effective date of the member's Health Net coverage, or within 30 days of the provider contract termination.
- A Health Net Continuity Assistance Request Form is submitted. The member will be asked to select a PPG and PCP for any services not directly related to the condition for which continuity of care services are approved.

Care management programs

Health Net's Care Management Program targets members at risk or who are experiencing a significant medical event. The program serves as a means for achieving wellness and autonomy through support, coordination of services, communication, education, and identification of health care resources.

Comprehensive Case Management Program
Targets members with care needs that require an intensive level of service. The case manager arranges for the delivery of care and monitors the member's condition on an ongoing basis.

Complex care support

Members with care needs that require an intensive level of service are referred to the Complex Case Management (CCM) Program. Patients may have multiple co-morbidities, terminal diagnoses, several providers of care, and be experiencing psychological, social and financial upheaval.

The CCM Program's collaborative approach facilitates communication among patients, their families, treating physicians, and other providers of care. The goal is to support the treating physician's care plan and complement case management.

The program provides consistent, regular, psychosocial, and environmental support to patients and their families through a single community-based nurse care manager who is supported by a clinical team of nurses and physicians.

Patients indicate significantly better pain and symptom management compared to usual care, and a significantly higher percentage of patients pass away at home (patient preference). Survey results also indicate 95 percent of patients (and families) are satisfied with the program and would recommend it to others, and 80 percent report improved quality of life.

High Risk Obstetrics Program
The primary focus is to reduce the occurrence of preterm births utilizing a three-tier approach.

Oncology Case Management Program
Targets members with newly diagnosed or recurrent disease to educate the member and coordinate necessary referral services.

Post Discharge Program
An outreach call after hospital discharge assures that the member has an understanding of discharge instructions, medication knowledge and adherence, and to confirm the ordered home care services have been initiated.

Renal Care Program
Targets members who have been diagnosed with end-stage renal disease and are currently being treated with dialysis to provide ongoing health status monitoring and interventions.

Transplant Case Management Program
Supports members through the evaluation, transplant and recovery processes.

Continuation *of* Coverage

Section 12

Coverage options following termination, including continuation of coverage

In this section, you will find information about:

- Individual plans
- Federal COBRA
- Cal-COBRA
- Extension of benefits (due to total disability)
- Leave of absence
- Medicare Plus/Plan J coverage

Can former Health Net members continue coverage following termination?

Most former Health Net group members are able to continue to be covered under one of the continuation options outlined in this chapter.

Who is not eligible to continue coverage under Health Net plans?

Continuing coverage is not available to members who have had group coverage terminated by Health Net for any of the following reasons:

- The member knowingly omitted or misrepresented a material fact on the Member Enrollment and Change form.
- The member utilized fraud or deception in the use of Health Net or the PPG services or facilities or knowingly permitted such fraud or deception by another.
- The member moved out of the Health Net service area.

Coverage options following termination

Federal COBRA Continuation Coverage: Federal law says that many employers who had 20 or more employees on at least 50% of their working days during the preceding calendar year must offer continuation coverage. This law is known as the Consolidated Omnibus Budget Reconciliation Act (COBRA) of 1985.

IRS Section 125

Under the IRS Section 125 rules, individuals may not change their enrollment or benefits elections in mid-year. The only time an individual may make a mid-year election change on a pre-tax basis is upon a change in family status if the plan allows mid-year election changes due to changes in family status. **Please note:** The Section 125 rule only applies if deductions for the employee's health insurance are taken out on a pre-tax basis. Even then, employees may not make changes at will except for cancelling coverage. They must still wait until open enrollment unless they experience a qualified family status change as defined by HIPAA.

Under IRS regulations, changes in family status include:

- Marriage, divorce, legal separation, or annulment of the employee.
- Death of the employee's spouse or dependent.
- Birth or adoption of the employee's child or placement for adoption.
- Commencement or termination of employment of the employee's spouse.
- A switch from part-time to full-time status, or vice versa, by the employee or the employee's spouse or other qualified dependent.
- An unpaid leave of absence taken by the employee or employee's spouse.
- A significant change in the health coverage of the employee or spouse attributable to the spouse's employment.
- Changes in work schedule for employee or any qualified dependent including strike or lockout or return from an unpaid leave of absence.
- The dependent satisfies or ceases to satisfy the requirements for unmarried dependents. An event that causes an employee's dependent to satisfy or cease to satisfy the requirements for coverage due to attainment of age, student status or any similar circumstances as provided under

the accident or health plan under which the employee receives coverage.

- A change in the place of residence or worksite of the employee, spouse or dependent.

The temporary regulations also add the following three new events upon which a change in election can occur under an accident and health plan or group-term life insurance component of a flex plan:

- If a change in status occurs that results in entitlement to COBRA continuation coverage by the employee, spouse or dependent, the employee may increase his or her flex plan election amount to pay for the COBRA coverage on a pre-tax basis.
- If the employee, spouse or dependent becomes entitled to Medicare or Medicaid (other than pediatric vaccines), the employee may elect to cancel the coverage of the employee, spouse or dependent.
- If the plan receives a qualified medical child support order (QMED) pertaining to an employee's dependent, the employee may elect to add the child to the plan (if the QMED requires coverage) or drop the child from the plan (if the QMED requires the ex-spouse to provide coverage).

Section 125 dictates that members may not necessarily be allowed to cancel their membership at any time. The determination of when they can and can't cancel is the responsibility of the employer group.

Cal-COBRA continuation coverage: For employers with fewer than 20 employees on 50% of the employer's business days in the preceding year, Health Net is required by state law to offer continuation coverage.

Additional continuation coverage for ages 60–65: For employers who must provide federal COBRA or Cal-COBRA continuation coverage, Health Net is required by state law to offer additional coverage after the COBRA or Cal-COBRA continuation coverage ends, but only under the following circumstances:

- If the subscriber or spouse was 60 years of age or older on the date of the subscriber's termination of employment; and
- If the subscriber had worked for the employer for the previous five years, the subscriber and his or her spouse may be eligible for additional coverage when the COBRA or Cal-COBRA coverage expires.

This coverage can continue until the beneficiary becomes eligible for Medicare, up to a maximum of 5 years from the date federal COBRA or Cal-COBRA was scheduled to end.

To purchase this additional COBRA-like coverage, the member must notify Health Net of his or her wish to do so within 30 calendar days before COBRA or Cal-COBRA coverage is scheduled to end.

Cal-COBRA extension for former federal COBRA beneficiaries: For employers who must provide federal COBRA continuation coverage for a period of less than 36 months, Health Net is required by California law to offer a Cal-COBRA extension for a maximum combined period of 36 months.

Health Net Individual & Family plans

Health Net is now an option for enrolling over-age dependents and employees leaving your company wishing to explore options other than COBRA or Cal-COBRA coverage.

Should employees wish to apply for coverage under our individual plan for any reason, they may contact an agent or broker, or call 1-800-909-3447. Individuals who purchase an IFP plan forfeit their rights to COBRA and Cal-COBRA continuation rights. Application for an individual policy may also be made at our website at www.healthnet.com.

Spotlight on

Medicare

Section 13

Health Net®

Overview

Health Net is contracted with the Centers for Medicare & Medicaid Services (CMS) to offer various Medicare plans:

1. Medicare Advantage (MA) / "Seniority Plus"

- Medical benefits only.
- Members must go to a doctor within the Health Net network of physicians.

2. Medicare Advantage Prescription Drug (MAPD) / "Seniority Plus"

- Medical and Part D (prescription) benefits.
- Members must go to a doctor within the Health Net network of physicians.

3. Medicare Coordination of Benefits (Medicare COB) and Medicare Part D Prescription Drug Plans (PDP) also known as COB/PDP

- Medical and prescription benefits.
- Medicare is primary; therefore, members can go to any Medicare-accepting physician.
- Members must be enrolled in both COB and PDP plans at the same time (with the same effective dates).

4. Health Net Life Group Medicare Supplement AKA MedSupp

- Medical benefits.
- Medicare is primary; therefore, members can go to any Medicare-accepting physician.

We offer these types of plans to individual Medicare eligible beneficiaries and employer group health plan employees/retirees and their dependents that are Medicare-eligible. CMS regulations for employer group Seniority Plus and COB/PDP plans have additional requirements and regulations.

This guide should assist group administrators in understanding the regulations that CMS requires Health Net to follow for enrollment, disenrollment and plan changes. A Medicare beneficiary may only have one (1) type of Medicare managed prescription drug coverage at once. If a Medicare-eligible retiree is enrolled in one type of Medicare managed prescription drug plan (i.e., Retiree Subsidy Discount (RDS), Seniority Plus or COB/PDP) and submits an enrollment for another type of Medicare managed prescription drug plan (i.e., RDS, Seniority Plus or COB/PDP), then they will be automatically disenrolled by CMS from the previous prescription plan and enrolled into the new prescription plan.

Employer group contacts

Each employer group has an account manager and may also obtain assistance with membership and billing issues by calling our Membership Accounting Department at 1-800-224-8808.

Medicare Department

The Medicare Department is responsible for all Medicare eligibility issues. The Medicare representatives handle the enrollment, disenrollment and group transfers for all members enrolled in a Seniority Plus, MedSupp, or MedCOB and PDP product.

Commercial Department

The Commercial Department is in charge of all Early Retiree, COBRA and Commercial Individual products. The Commercial representatives handle the enrollment, disenrollment and group transfers for the above products. In addition, the department handles Case Install, which is the implementation of the new groups.

My contacts:			
Title	Name	Phone number	Fax number
Account manager			
Accounting Department			
Commercial eligibility rep			
Medicare eligibility rep			

Finance Department

The Finance Department is in control of all billing-related issues. They handle the billing and accounting for the COB/PDP, Seniority Plus, Early Retiree, and COBRA products.

Enrollment materials

CMS-approved Health Net materials

Health Net has employer group-specific Medicare enrollment materials that have been approved by CMS to use and distribute to members and potential members. These include enrollment forms, letters/notices, provider directories, and various pre- and post-enrollment marketing materials. Health Net or the employer group cannot alter these materials after CMS has approved them.

Employer group-specific materials

Employers are encouraged to develop their own materials describing employer contributions, special benefits and their enrollment procedures (i.e., letters, pre-enrollment packets, etc.). These materials do not require CMS approval. If review or CMS approval of employer group-specific materials is desired, please contact your Health Net account manager. Should you be interested in custom pre-enrollment materials or assistance in mailing group specific materials, please contact your Health Net account manager.

Please note: Any materials mailed or developed (whether entirely or in part) by Health Net require CMS approval.

Eligibility requirements

Seniority Plus requirements

In order to be eligible for a Health Net Seniority Plus plan, potential members must:

- Be eligible for Medicare Part A and enrolled in Medicare Part B as of the enrollment effective date of the plan.
- Comply with CMS enrollment guidance regarding end-stage renal disease (ESRD).
- Permanently reside in one of Health Net's Seniority Plus service areas.

Per the Medicare Managed Care Manual section 20.2.2, individuals that develop ESRD while enrolled in a health plan (e.g., a commercial or group health plan, or a Medicaid plan) offered by the MA organization are eligible to elect an MA plan offered by that organization within the same state. In order to be eligible, there must be no break in coverage between enrollment in the health plan offered by an MA organization (Health Net), and the start of coverage in the MA plan (Health Net) offered by the same

organization. If an employer or union group beneficiary with ESRD ages into Medicare, he or she may enroll in an employer- or union-sponsored MA plan (Health Net) regardless of prior commercial coverage.

Medicare COB plan eligibility

In order to be eligible for Health Net's COB Plan, potential members must:

- Be eligible for Medicare Part A and enrolled in Medicare Part B as of the enrollment effective date of the COB plan.
- Permanently reside in one of Health Net's COB service areas.
- Be concurrently enrolled in a Medicare Part D PDP plan.

Medicare Part D (PDP) plan eligibility requirements

In order to be eligible for Health Net's PDP plan, potential members must:

- Be eligible for Medicare Part A and/or enrolled in Medicare Part B as of the enrollment effective date of the PDP plan.
- Permanently reside in one of Health Net's COB service areas.
- Be concurrently enrolled in a Medicare Coordination of Benefits (COB) plan.

Health Net Life Group Medicare Supplement eligibility requirements

- Be eligible for Medicare Part A and/or enrolled in Medicare Part B as of the enrollment effective date of the MedSupp plan.
- Reside in California upon enrollment.

Obtaining Medicare Part A or Part B

Potential members who need to purchase Part A or enroll in Part B need to contact their local Social Security office, visit www.socialsecurity.gov on the Web or call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. If they receive benefits from the Railroad Retirement Board (RRB), they should call their local RRB office or 1-877-772-5772. TTY users should call 1-312-751-4701.

Plan coverage structures

All retirees and their dependents must qualify for these plans individually under their own Medicare claim number (found on their red, blue and white Medicare identification card). Each member will receive his or her personal Health Net ID card and reference number. COB/PDP members will receive their PDP ID card from SilverScript.)

Ways to enroll in Seniority Plus or COB/PDP plans

Seniority Plus

Non-Medicare eligible dependents

If the employee/retiree is eligible to enroll in Health Net's Seniority Plus plan but their dependent(s) is not Medicare-eligible, the dependent may only enroll in a non-Medicare plan. **Please note:** The processing for non-Medicare plan enrollments or changes may differ from Medicare plan enrollments or changes.

Employer group-specific enrollment forms

Group employees/retirees and their dependents requesting enrollment into our Employer Group Seniority Plus plans need to use the current calendar year's versions of employer group-specific enrollment forms. If they complete an "individual" enrollment form, they will be enrolled into an individual plan, which does not include your group's enhanced benefits. The employee/retiree and their Medicare-eligible dependent (if applicable and eligible to receive group benefits) need to complete separate Health Net employer group-specific enrollment forms.

In order to enroll in a Group Seniority Plus plan, all applicants must completely fill out a group enrollment form.

The following data must be filled out on the enrollment form in order for the form to be considered "complete":

- Employer name
- Group number (if known)
- Name (as stated on the Medicare ID card)
- Date of birth
- Gender
- Home phone number
- Permanent address
- Medicare claim number (as stated on the Medicare ID card)
- Requested primary care physician (PCP) and participating physician group (PPG) (**Note:** If a PCP or PPG is not requested, one will be assigned.)
- All enrollment questions answered
- Signature of applicant
- Date application was filled out (The effective date of coverage cannot be prior to the date the application was filled out/signed.) **Please note:** If there is no signature date on the application, Health Net will contact the member to verify intent to enroll.

If the applicant has an authorized representative sign or assist with filling out the application, they are advised to include a copy of the documentation that designates them as the beneficiary's representative. This documentation includes but is not limited to Durable Powers of Attorney (DPOA), Power of Attorney for Healthcare (POA-H), or Healthcare Conservator.

All Health Net enrollment forms are in triplicate. The white copy should be sent to Health Net for processing, the yellow copy can be kept by the employer group administrator, and the pink copy should remain with the enrollee/applicant.

For Seniority Plus Enrollment forms being sent via fax, the fax number is 1-866-214-1992. Please include a coversheet indicating the following:

- group name
- sender information (phone and email address)
- number of enrollment forms attached
- request for fax receipt confirmation via email (email address needed)

Non-Medicare eligible dependents

If the employee/retiree is eligible to enroll in Health Net's MA or MAPD plan but their dependent(s) is not Medicare-eligible, the dependent may only enroll in a non-Medicare plan. **Please note:** The processing for non-Medicare plan enrollments or changes may differ from Medicare plan enrollments or changes.

COB/PDP Plans

Employer group-specific election forms

For a January 1, 2013, effective date, two separate forms will be required for COB/PDP enrollment: the Health Net COB and the SilverScript PDP. Both forms must be completed and submitted together at the time of enrollment. Currently, Health Net cannot support, and therefore does not accept, electronic enrollments for COB/PDP plans.

The following data must be filled out on the enrollment form in order for the form to be considered "complete":

- Employer name
- Group number (if known)
- Name (as stated on the Medicare ID card)

- Date of birth
- Gender
- Home phone number
- Permanent address
- Medicare claim number (as stated on the Medicare ID card)
- Requested primary care physician (PCP) and participating physician group (PPG)
- All enrollment questions answered
- Signature of applicant
- Date application was filled out (The effective date of coverage cannot be prior to the date the application was filled out/signed.) **Please note:** If there is no signature date on the application, Health Net will contact the member to verify intent to enroll.

If the applicant has an authorized representative sign or assist with filling out the application, they are advised to include a copy of the documentation that designates them as the beneficiary's representative. This documentation includes but is not limited to Durable Powers of Attorney (DPOA), Power of Attorney for Healthcare (POA-H), or Healthcare Conservator.

For COB/PDP enrollment forms being sent via fax, the fax number is 1-866-214-1992. Please include a coversheet indicating the following:

- group name
- sender information (phone and email address)
- number of enrollment forms attached
- request for fax receipt confirmation via email (email address needed)

Health Net Life Group Medicare Supplement eligibility requirements

Non-Medicare eligible dependents
If the employee/retiree is eligible to enroll in Health Net's MA or MAPD plan but their dependent(s) is not Medicare-eligible, the dependent may only enroll in a non-Medicare plan. **Please note:** The processing for non-Medicare plan enrollments or changes may differ from Medicare plan enrollments or changes.

Employer group-specific election forms
Group employees/retirees and their dependents requesting enrollment into our Employer Group Medicare Supplement plan need to use our employer group-specific enrollment forms.

The employee/retiree and their Medicare-eligible dependent (if applicable and eligible to receive group benefits) need to complete separate Health Net Employer group-specific enrollment forms.

The following data must be filled out on the enrollment form in order for the form to be considered complete:

- Employer name
- Plan choice
- Name (as stated on the Medicare ID card)
- Date of birth
- Gender
- Home phone number
- Permanent address
- Medicare claim number (as stated on the Medicare ID card)
- Signature of applicant
- Date application was filled out. (The effective date of coverage cannot be prior to the date the application was filled out/signed.) **Please note:** If there is no signature date on the application, Health Net will contact the member to verify intent to enroll.

If the applicant has an authorized

representative sign or assist with filling out the application, they are advised, but not required, to include a copy of the documentation that designates them as the beneficiary's representative. This documentation includes but is not limited to Durable Powers of Attorney (DPOA), Power of Attorney for Healthcare (POA-H), or Healthcare Conservator.

All Health Net enrollment forms are in triplicate. The white copy should be sent to Health Net for processing, the yellow copy can be kept by the employer group administrator, and the pink copy should remain with the enrollee/applicant.

For Medicare Supplement enrollment forms being sent via fax, the fax number is 1-866-214-1992. Please include a coversheet indicating the following:

- group name
- sender information (phone and email address)
- number of enrollment forms attached
- request for fax receipt confirmation via email (email address needed)

All enrollments can also be mailed via USPS:

Health Net
Attn: Medicare Enrollment Services (SP)
PO BOX 10420
Van Nuys, CA 91410-0420

Scan/PDF:

eghp_enrollment_online@healthnet.com

Enrollment effective dates

Seniority Plus enrollment effective dates

The requested enrollment effective date cannot be prior to the date the employer group-specific enrollment form was completed/signed by the enrollee. If the enrollment form is received by Health Net, signed by the enrollee but not dated, Health Net will use the earliest received date as the signature date. If there is a delay between Health Net receiving the application, and the beneficiary signing the application, Health Net will provide feedback to the group. In addition, Health Net will contact the member to verify intent to enroll. If an enrollment form is received with a signature date older than 30 days, Health Net will also contact the enrollee to verify intent to enroll. If Health Net is unable to contact the member, then the enrollment will be processed using the earliest received date. In addition, if there is a delay between Health Net receiving the application and the beneficiary signing the application, Health Net will provide feedback to the group.

For all employer groups, Seniority Plus enrollments are "verified" with the employer group within two (2) days of receipt. The Medicare Eligibility representative reaches out to the employer group administrator/contact to confirm requested effective date and group number. If direct contact cannot be made, the effective date will be assumed as the first of the month following Health Net's earliest received date.

Example:

Scenario 1: For an employer group-specific enrollment form received by Health Net on July 12 and signed July 5, the enrollment will be processed for an effective date of August 1.

Scenario 2: If an enrollment form is signed by the enrollee June 2, received by Health Net July 20, and the group requests an effective date prior to July 1, Health Net can only process the enrollment for a July 1 effective date (due to the signature date).

Scenario 3: Health Net receives a signed enrollment form on June 2 but it is not dated; the signature date will be considered June 2; therefore, the effective date cannot be prior to July 1.

Enrollment forms received after requested effective date

Health Net can process an enrollment form with an effective date up to 90 days prior to the Health Net received date. **Please note:** The enrollment form must be signed prior to the requested effective date.

Example: For an employer group-specific enrollment form received on July 12 with a signature date of May 3, the group can request an effective date of June 1, July 1 or August 1.

Enrollment form received more than 30 days in advance of requested effective date

Employer group-specific enrollment forms may also be processed for an effective date up to 90 days after the month in which the enrollment form is received if a future date is requested.

Example: For an employer group-specific enrollment form received on July 12, the group can request an effective date of August 1, or September 1 or October 1.

Acknowledgment receipt of enrollment (by Health Net) and CMS confirmation of enrollment (for Seniority Plus plans)

Once Health Net receives an employer group-specific enrollment form and eligibility is verified (within 7 calendar days of receipt), the enrollee's data is entered into the enrollment/membership system. An acknowledgment letter is mailed to the enrollee advising the applicant that Health Net has received the enrollment application and will notify them of their proposed effective date. Within 7–10 business days, an ID card will be created and mailed to the enrollee. Enrollment information is electronically transmitted to CMS on a daily basis.

If the enrollment form is not complete or eligibility cannot be verified, an "Enrollment Pending" letter will be generated and mailed to the enrollee requesting additional information. CMS requires that Health Net receive the additional information within 21 calendar days from the date of the "Enrollment Pending" letter. If the information is received and the enrollment can be deemed "complete and eligible," please refer to the paragraph above. If the information is not received within the 21 calendar days and/or the applicant is determined to be ineligible for the plan based on information received, the enrollment will be denied. An "Enrollment Denial" letter will be generated and mailed to the enrollee. Currently, Health Net is not able to send copies of member letters to the employer group.

Official confirmation/acceptance of enrollment into one of Health Net's Seniority Plus plans can only be granted by CMS through an electronic transaction reply reporting process. Once Health Net receives the confirmation, a confirmation of enrollment letter is generated and mailed to the member. The process of transmission to CMS and response from CMS is approximately 7–14 calendar days.

If CMS denies the enrollment, the enrollee will receive a letter explaining the reason for denial. If there were any services used, the enrollee will be held responsible for the cost of those services.

The response from CMS can vary up to 30 calendar days. This is dependent on the time of year, the total volume of enrollments and plan changes CMS is processing (not just from Health Net, but from every health insurance carrier who offers Medicare plans).

COB/PDP enrollment effective dates

For enrollments submitted via hard copy enrollment form

The enrollment requested effective date cannot be prior to the date the employer group-

specific enrollment form was completed/signed by the enrollee. If the enrollment form is received by Health Net, signed by the enrollee but not dated, Health Net will use the earliest received date as the signature date. In addition, Health Net will contact the member to verify intent to enroll. If Health Net is unable to contact the member, then the enrollment will be processed using the earliest received date. In addition, if there is a delay between Health Net receiving the application and the beneficiary signing the application, Health Net will provide feedback to the group.

Scenario 1: For an employer group-specific enrollment form received on July 12 and signed July 5, the enrollment will be processed for an effective date of August 1.

Scenario 2: If an enrollment form is signed by the enrollee June 12, and the group requests an effective date prior to July 1, Health Net can only process the enrollment for a July 1 effective date (due to the signature date).

Scenario 3: Health Net receives a signed enrollment form on June 2 but it is not dated; the signature date will be considered June 2; therefore, the effective date cannot be prior to July 1.

Enrollment forms received after requested effective date

Health Net can process an enrollment form with an effective date up to 90 days prior to the Health Net received date. **Please note:** The enrollment form must be signed prior to the requested effective date.

Example: For an employer group-specific enrollment form received on July 12 with a signature date of May 3, the group can request an effective date of June 1, July 1 or August 1.

Enrollment form received more than 30 days in advance of requested effective date

Employer group-specific enrollment forms may also be processed for an effective date up to 90 days after the month in which the enrollment form is received, if a future date is requested.

Example: For an employer group-specific enrollment form received by Health Net on July 12, the group can request an effective date of August 1, September 1 or October 1.

Medicare Supplement enrollment effective dates

For enrollments submitted via hard copy enrollment form

If the enrollment form is received by Health Net, signed by the enrollee but not dated, Health Net will use the earliest received date as the signature date.

Enrollment forms received after the requested effective date

Health Net can process an enrollment for the first of the previous month if the application is received by the 7th day of the current month.

Scenario 1: Application is received on April 5 and the applicant is requesting an April 1 effective date. The application will be processed with the April 1 effective date since the application is received within the first 7 days of the month.

Scenario 2: Application is received on April 12 and the applicant is requesting an April 1 effective date. The application will be processed with the May 1 effective date since the application is received after the first 7 days of the month.

Enrollment form received more than 30 days in advance of the requested effective date

Health Net can process an enrollment for an effective date up to 90 days after the month in which the enrollment form is received, if a future date is requested.

Scenario 1: Application is received on May 5 and the applicant is requesting an August 1 effective date. The application will be processed with the August 1 effective date since the effective date is within the 90-day time frame.

Confirmation of enrollment

Once Health Net receives an employer group-specific enrollment form and eligibility is verified, the enrollee's data is entered into the enrollment system. A confirmation of enrollment letter is generated and mailed to the member. If enrollment is denied, the enrollee will receive a letter advising of the reason for denial. If there were any services used, the enrollee will be held responsible for the cost of those services.

If the enrollment form is not complete or eligibility cannot be verified, an "Enrollment Pending" letter will be generated and mailed to the enrollee requesting additional information. Health Net requires the additional information be received within 30 calendar days from the date of the "Enrollment Pending" letter. If the information is received and the enrollment can be deemed "complete and eligible," please refer to the paragraph above. If the information is not received within the 30 calendar days and/or the applicant is determined to be ineligible for the plan based on information received, the enrollment will be denied. An "Enrollment Denial" letter will be generated and mailed to the enrollee.

Post-enrollment activities/processes

Identification (ID) cards

Each MAPD enrollee will receive one (1) ID card. Each new COB/PDP enrollee will receive two (2) ID cards.

- One (1) for the COB plan
- One (1) for the PDP plan

Cards are created and mailed out to new enrollees within 7–10 business days of member's enrollment. Other triggers of ID cards include physician or medical group changes, reinstatements and effective date changes. Members are encouraged to present their most current ID card at every point of service including pharmacy visits. The current ID card will have the most accurate data, which will allow the pharmacy to process the claim successfully.

Enrollee/member access to services (medical and prescription)

Upon processing a completed and verified eligible employer group-specific enrollment, the enrollee will be added to our membership system. By being added to the membership system, the enrollees will be able to access medical care and prescription benefits as of their effective date of coverage. If urgent/medically necessary prescriptions are needed and the pharmacy indicates the enrollee/member is not yet active with Health Net, please bring this issue to your Medicare Eligibility representative's attention.
Please note: Enrollees are notified of their proposed effective date of coverage with Health Net via an Acknowledgement Letter.

Address changes

Address changes should be communicated by the member to the Health Net Customer Contact Center using the toll-free phone number listed on their Health Net ID card. If a member permanently moves outside any Health Net covered service area, they will no longer meet eligibility requirements for the MA or MAPD plan and must be disenrolled from the plan. Address change notification can also be by a member's legally authorized representative. These representatives include but are not limited to Durable Powers of Attorney (DPOA), Power of Attorney for Healthcare (POA-H), or Healthcare Conservator. These representatives need to

be able to provide the documentation, which grants them this authority, to Health Net or CMS upon request.

Discrepancy resolution and reporting eligibility reconciliation

Some groups communicate changes via electronic tape files weekly/bi-weekly/monthly/quarterly. Others use emailed Excel files. The Commercial and Medicare Eligibility representatives process these adds/terms/changes within five (5) business days of receipt and will notify the group of any discrepancy and the action needed to resolve the discrepancy.

Accounting reconciliation

Accounting representatives, Commercial Eligibility representatives and Medicare Eligibility representatives work together monthly to address any eligibility issues which are identified during the account reconciliation process. Commercial and Medicare Eligibility representatives research these discrepancies within seven (7) business days of receipt and will notify the group of any discrepancy and the action needed to resolve the discrepancy.

Urgent/escalated eligibility issues

Each employer group has a specific Medicare Group Eligibility representative. These representatives can assist with all urgent eligibility-related issues including pharmacy access problems. They are available Monday through Friday, 7:00 a.m. to 4:30 p.m.

MA, MAPD and MedSupp disenrollment process

There are four different ways that Health Net can receive MA, MAPD or MedSupp disenrollments:

- A voluntary disenrollment request by the member.
- An involuntary request to disenroll the member by employer group.
- A group terminating their entire contract with Health Net.
- CMS sends Health Net a request to disenroll the member (excludes MedSupp).

Involuntary disenrollments are any disenrollment requests not initiated and signed by the member.

Voluntary disenrollment request initiated by the member

Health Net receives a disenrollment request signed by the member that was submitted either directly from the member or through the employer group. Health Net will disenroll the member the first of the following month after Health Net's earliest received date and will submit the transaction to Medicare.

Involuntary disenrollment request by the group to disenroll the member

Employer group is requesting disenrollment of the member due to non-payment or for internal group reasons and there is no signed disenrollment request from the member. CMS requires that Health Net provide the member a notice that the employer group intends to disenroll them a minimum of 21 days prior to processing the disenrollment. This means that the requested disenrollment will be processed 21 days from the date of the letter with a disenrollment effective date of the first of the following month. Once CMS accepts the involuntary disenrollment request, they are hestiant to accept any reinstatment requests. (Health Net will process all group-requested disenrollments within seven (7) calendar days of receipt). Due to CMS compliance, Health Net strongly encourages employer groups to submit disenrollment requests at least **45** days prior to the disenrollment date. If Health Net receives written notice from an employer group to disenroll less than **30** days prior to the requested disenrollment date,

Health Net will extend the disenrollment date for the member in order to meet the required time frame for the member notification stated above.

Examples:
Scenario 1: Group requests disenrollment of member John Smith on June 15 for an effective date of August 1. Health Net sends the member the notification letter on June 17. On July 17, the disenrollment will be processed for an effective date of August 1.

Scenario 2: Group requests disenrollment of member Jane Doe on July 16 for an effective date of August 1. Health Net sends the member the notification letter on July 20. On August 20, the disenrollment will be processed for an effective date of September 1. The only way for the member to be disenrolled effective August 1, would be for the member to submit a signed disenrollment request (requesting 8/1 disenrollment). Notice will include an Abbreviated Election Form (AEF) should the member choose to enroll in a Health Net individual MA or MAPD plan.

Employer group termination from Health Net

When an employer group is terminating their contract with Health Net, CMS requires that Health Net notify employer group members at least 21 days prior to the effective date of an employer group plan termination. Employer group plan members are notified of the option to enroll in an Individual Medicare Advantage plan offered by Health Net. Health Net will provide the affected employer group members with this notice 21 days prior to the plan termination. Due to CMS compliance, Health Net strongly encourages employer groups to submit termination requests at least 45 days prior to the termination date. This will also avoid extension of the employer group plan contract. If Health Net receives written notice from an employer group to terminate their contract 21 days or less prior to the requested termination date, Health Net will extend the termination date for such an employer group contract by one month in order to meet the required time frame for the member notification stated above.

Examples:
Scenario 1: Group requests contract termination on June 15 for an effective date of August 1. Health Net sends the affected members the notification letter on June 17. On July 17, the member's disenrollments will be processed for an effective date of August 1.

Scenario 2: Group requests contract termination on July 16 for an effective date of August 1. Health Net sends the affected members the notification letter on July 20. On August 20, the disenrollment will be processed for an effective date of September 1 causing the group's contract to be extended for one (1) month. The only way for the member to be disenrolled effective August 1 would be for the member to submit a signed disenrollment request (requesting 8/1 disenrollment).

These beneficiary protections are required by CMS for any employer group Medicare Advantage disenrollment, whether the employer group chooses to disenroll the entire contract or only certain service areas or counties within the contract.

Voluntary retroactive disenrollment request

If a voluntary disenrollment request is not received by Health Net prior to the requested disenrollment effective date (as specified on the request), Health Net will process the disenrollment for the first of the following month after the actual date received. In addition, the request will be forwarded to the

Health Net Reconciliation Team so that they can process the retroactive disenrollment request with CMS. In anticipation of CMS approval, Health Net will update our membership system to reflect the requested disenrollment date (providing the member's request meets the eligibility requirements for the retroactive disenrollment). The member will be advised via letter that their retroactive disenrollment request is being processed. CMS guarantees review of all retroactive requests within 45 days of receipt. Health Net will notify the member of CMS's acceptance or rejection of their retroactive request. If there is no specific disenrollment effective date requested, the effective date will be based upon the earliest Health Net received date and will be processed for the first of the month following receipt.

Disenrollment

All disenrollment requests must come directly to Health Net. Health Net will notify the SilverScript account manager via secure/encrypted email of any involuntary termination or disenrollment provided by the Employer Group or their administrator.

SilverScript is responsible for processing all disenrollment transactions with CMS.

PDP disenrollment requests

Voluntary disenrollments: Enrollees who request to disenroll from their employer group health plan must disenroll in writing. Written requests from enrollees can be accepted via mail or facsimile and must be dated and signed. Health Net must notify SilverScript of all voluntary disenrollments via secure/encrypted email on a daily basis. The SilverScript account manager must notify the Health Net membership representative of all voluntary disenrollments from the transaction reply report via secure FTP each Monday and Thursday. The Health Net membership representative will update Health Net's system and the respective membership representative will send a follow-up email to their counterpart confirming receipt of the disenrollment request.

Involuntary disenrollments: Employer groups must proactively notify their enrollees of the prospective disenrollment. SilverScript must notify all enrollees no less than 21 calendar days prior to the effective date of the enrollee's disenrollment from the EGHP contract. Such notices are prospective, not retroactive. Health Net must provide SilverScript all required disenrollment data no less than 45 days in advance of the disenrollment effective date.

Group termination

An employer group may voluntarily disenroll its entire group from the employer group health plan contract. Employer groups who are disenrolling their entire group must provide Health Net all required disenrollment data no less than 45 days in advance of the disenrollment effective date.

In the event that an EGHP contract is terminated or a class of eligible persons is terminated, Health Net will notify SilverScript of the action and, if deemed appropriate and necessary, the reason. Notice will be provided within 5 days of Health Net's knowledge of the termination and at least 90 days prior to the actual effective date of termination. Notice will be verbal and will then be followed up by written documentation via secure/encrypted email.

Additional information

Group billing statements

Questions about your statement? Please call: Groups 2–50, 1-800-224-8808; Groups 51–100 and Groups 101+, 1-800-909-6362. Billing options:

- Separate physical bills for each group ID.
- Consolidated physical bill that organizes by group ID (for multiple group IDs).
- "Positive Listing" billing: Based on internal records, groups send Health Net listings of all the subscribers they wish to pay for. This listing is considered to be a positive indication of the subscribers they intend to be active in the Health Net system. Normally this occurs when groups prefer not to utilize Health Net's bill.

Low Income Subsidy (LIS) for MAPD and PDP members

LIS is a program to help people with limited income and resources pay their prescription drug costs. Once a Medicare beneficiary has been deemed eligible to receive this help and they join a Medicare prescription drug plan, Medicare will contribute toward their Medicare prescription drug plan premium by paying the health plan directly. If any of your employees/retirees have received this type of assistance from Medicare, you will be notified either via the billing statement or by your accounting representative during the monthly account reconciliation process. LIS credits will show on the billing statement on the "Adjustments to Membership" page. The member who received the LIS credit will be listed and the reason for the credit will be "LIS."

If your group does not use the physical billing statement and uses a monthly membership "positive listing," you will be notified to take a credit after the monthly account reconciliation has been completed.

Late Enrollment Penalty (LEP) for MAPD and PDP members

If a Medicare beneficiary does not join a Medicare drug plan when they are first eligible for Medicare Part A and/or B and they go without creditable prescription drug coverage for 63 continuous days or more, they may have to pay a late-enrollment penalty (LEP) to join a plan later. This penalty amount changes every year, and will be accessed as long as they are enrolled in Medicare prescription drug coverage. A late-enrollment penalty is calculated when you join a Medicare drug plan. To estimate the penalty amount, multiply 1% of the national base beneficiary premium ($27.93 x 1%= $.28 in 2008) by the number of full months you were eligible to join a Medicare drug plan but didn't. Round this amount to the nearest ten cents to get the LEP amount. This penalty amount is added each month to the Medicare drug plan's premium for as long as the plan is active.

Creditable prescription drug coverage

Prescription drug coverage (for example, from an employer or union) that is equal to or better than Medicare's standard prescription drug coverage is considered to be "creditable" by CMS. If an employer or union stops offering prescription drug coverage that is creditable, the beneficiaries affected won't have to pay a late-enrollment penalty if they join a Medicare drug plan and their coverage begins before they go 63 days without coverage. During the enrollment process, these beneficiaries may be asked to provide proof of their prior creditable coverage and when it ended. Health Net attempts to verify any and all uncovered months of Medicare prescription drug coverage prior to transmitting the information to Medicare.

Retiree drug subsidy (RDS)

Retiree drug subsidy (RDS) programs were designed to encourage employers and unions to continue providing high quality prescription drug coverage to their retirees. The retiree drug subsidy is flexible enough to enable employers and unions to obtain the subsidy without disrupting their current coverage. RDS prescription plans require employer groups to apply and maintain direct ongoing communication and reporting with CMS regarding the employees/retirees participating in the program. For more information, please visit http://rds.cms.hhs.gov/default.htm. A Medicare beneficiary may only have one (1) type of Medicare managed prescription drug coverage. Therefore, if an enrollee is enrolled in an employer group RDS plan and they apply for a Health Net MAPD (medical and prescription benefits) plan, they will need to confirm that they understand enrollment into the Health Net MAPD will result in the automatic cancellation of the RDS prescription plan. This confirmation will be requested of them after they complete their enrollment form or CMS rejects the enrollment transaction. Once CMS rejects the enrollment transaction, Health Net will call the member to obtain verification. If no contact is made, then a notice is sent to the beneficiary to provide confirmation of enrollment into the MAPD plan. The beneficiary has 30 calendar days to respond with their confirmation. If no response is received by the end of the 30th day, Health Net will cancel the MAPD enrollment request per CMS guidelines. In addition, Health Net will send a notice of enrollment cancellation to the beneficary. If an enrollee has an RDS prescription plan and is applying for an MA-only (medical benefits only) plan, the RDS prescription plan is not affected and the enrollee will not be contacted. The national base beneficiary premium changes each year and is determined by CMS.

If you want more information regarding your Medicare benefits, please call 1-800-596-6565, 8:00 a.m. to 8:00 p.m., 7 days a week. Health Net of California, Inc. is a Medicare Advantage (MA) organization with a Medicare contract. Anyone with Medicare Parts A and B may apply.

Health *Promotion* and Wellness

Section 14

Decision Power®

Getting people to engage in their health is the most important step to reversing the patterns that can lead to higher costs and lower economic output. Taking that step is the hardest thing for many people.

Decision Power is the bridge to action
Grounded in science and reinforced by experience, Decision Power addresses the health needs of the whole person through integrated resources and support that span the entire spectrum of health – from wellness to wellness coaching, chronic condition management to end-stage disease support.

The Decision Power cornerstones
Doctor-patient principle
Working with doctors, not around them, is the linchpin that distinguishes Decision Power from typical health and wellness programs. Our clinicians work in respectful partnership with the physicians closest to the patient, creating an environment of professional collaboration versus one of contention.

Information sharing
Decision Power functions as a data hub with multiple channels for bringing in and sending out information. Risk stratification and predictive modeling of the incoming data enable Health Net to identify and reach out to members identified as high-risk.

Beyond data, Decision Power uses technology in combination with open-ended questions to build the big picture. The integrated database used by the clinicians and support staff reflects claims, eligibility, pharmacy, lab tests, lab results, and prior authorization data so they can quickly identify and address other health or life issues that may aggravate a condition or influence a decision.

Informed consumerism
Decision Power gives members the power to choose and the knowledge to choose wisely. Among the highlights:

- The Health Risk Questionnaire (HRQ) is the gateway to ongoing recommendations and resources based on each member's unique health profile and goals. Among the highlights: Members receive email alerts on information and action steps to take based on their HRQ results.
- One-on-one consultations – Members enrolled in a condition management program can talk to the same wellness coach every time they call. Conversations are not time-limited or scripted so that our health management staff has the flexibility to help with the member's primary concern while exploring and addressing the range of issues that may be related to and complicated by it.
- Step-by-step plans for losing weight, tobacco cessation and nutrition are provided with a combination of online self-help tools. Coaching support is included to facilitate lasting, healthy changes.
- Personal Health Record – captures the self-reported data from a member's HRQ, claims data (when members set up the record to do so), and any immunization and test records they enter, so they can manage and track their health.
- Medication Center – tracks prescription drug history and provides important education about drug interactions.
- Mental health support – resources for depression, excessive alcohol use, eating disorders, etc.
- Techniques to help patients feel comfortable about talking with their doctor and expressing their values and preferences.

- Ongoing guidance for people living with chronic conditions such as diabetes, asthma, depression, and heart disease.
- Education about preference-sensitive conditions such as chronic back pain, breast cancer, and arthritis of the hip and knee, as well as conditions where there are multiple treatment approaches, and the right one depends on the individual's specific condition, personal preferences and values.
- Specialized support from nurse case managers to help both patients and family members deal with the complexity of complicated conditions or treatments, and end-stage illnesses.

CareAlerts for members and providers

The Decision Power CareAlerts Program is a data-driven program that applies predictive modeling algorithms to identify clinical gaps in care, drug interactions and dangerous drug side effects across an entire client population. This results in the identification of actionable opportunities to improve quality of care and address medication safety for specific individuals. CareAlerts integrates both participant and provider clinical care gap messaging into Health Net's case and disease management programs. Timely, prioritized communications allow treating health providers to be informed about a participant's progress, medication adherence and potential risk management issues. Health Net's multi-modal communication strategy with tailored communications addresses the unique set of gaps in care for individual participants. Messages are personalized to the individual and delivered at the optimal time or teachable moment. Decision Power provides care gap notifications to both participants and health providers to promote more collaborative efforts to close gaps before they escalate into high-risk or high-cost events.

Early identification of care gaps increases the opportunity to influence healthier behaviors and reduce risks. The Decision Power CareAlerts Program provides Health Net providers and members with directed alerts based on care gaps identified through multiple data sources on a batch mode basis, including:

- Pharmacy, medical and lab claims
- Participant eligibility files
- Participant benefit information
- Provider information

CareAlerts can identify a broad range of patient-specific care gaps within the following four categories. These care gap categories were developed based on national guidelines, HEDIS measures, and evidence-based health management and prevention recommendations:

- **Prevention** – Preventive screening tests, immunizations and provider follow-up visits.
- **Care gaps** – Gaps in care that result in sub-optimal therapy for chronic conditions, such as pharmacological therapies or biometric monitoring goals.
- **Medication therapy** – Age-inappropriate therapy, as some medications have a higher risk for the elderly.
- **Medication adherence and safety**
  - Medication adherence for maintenance drugs
  - Early discontinuation of maintenance drugs
  - Duplicate therapy, when the same condition is treated with different medications
  - Drug interactions
  - Drug-disease interactions

Find out more!
Call your broker or Health Net sales representative, or visit us online at www.healthnet.com today!

Good for people, good for business. Fully informed consumers. Evidence-based care. Active collaboration and decision-making between doctors and patients.

Decision Power from Health Net is our long-term investment in the health of your organization.

The Decision Power care gap messages are relevant to the individual member and delivered at the optimal time or teachable moment. The CareAlert process uses sophisticated technology and content management, along with a suite of proprietary business rules to determine the following for each patient-specific care gap result:

- Message recipient
- Communication mode
- Message content
- Optimal time for communication using message prioritization rules
- Message frequency

The Decision Power programs can receive care alert feedback from physicians and participants that allows for improved messaging based on information not available in claims data. A standard toll-free number will be established for members to submit feedback while physicians will have phone and fax feedback options available. The CareAlert Program utilizes Healthwise™ to create consistent and appropriate messages for the different recipients. Healthwise is a not-for-profit organization that is considered the industry standard for health content and messaging.

Healthy Pregnancy Program

Health Net has expanded our Healthy Pregnancy Program to include new features, functions and focus. For 2013, Health Net has added a full service OB program that includes the following elements that are integrated with the current NICU program, 17P initiative, Healthy Baby and text4baby programs.

- **OB Risk Assessment and Education:** The Decision Power OB Risk Assessment and Education Program has proven to be successful in early identification of risk, as are our periodic assessments and educational programs that improve overall outcomes. Components of this program include initial assessment to identify participants with high-risk obstetrical conditions; follow-up assessment completed at approximately 28 weeks; BabyLine access to Health Net's Healthy Pregnancy 24/7 phone line staffed with experienced perinatal nurses; and Personal Health Record (PHR) access for participants to the Decision Power maternity website.
- **OB Case Management:** A core component of the Decision Power OB Case Management Program is the expertise and experience of our high-risk OB nurse case managers who are available 24/7. Health Net's case management has been shown to prolong pregnancies, improve birth weights and minimize hospitalizations. Through our CM program, we identify participants with high-risk obstetrical conditions, and high-risk OB nurses case manage these participants, creating unique care plans with goals, support, target dates, and periodic assessments; and maintain regular contact with participants through our high-risk nurse outreach.[1]

[1]This program applies to the shared risk medical group.

Additional Medicare Advantage member benefits

In-home biometric monitoring (Medicare Advantage members only)

An exciting advancement of the disease management program offers qualified, high-acuity beneficiaries a variety of in-home monitoring units. Real-time data is reviewed by clinically trained nurses, giving beneficiaries and their families valuable peace of mind.

DayLink® Monitors collect program condition data in tandem with other peripheral devices, including electronic scales, glucometers and blood pressure monitors. Depending on a beneficiary's symptoms or change in status, program nurses are well-positioned to identify and manage a gap in care, and if needed, coordinate timely intervention in the beneficiary's home.

Musculoskeletal Pain Program (Medicare Advantage members only)

The Decision Power Musculoskeletal Pain Program (MSP) is designed to identify individuals who may be at high risk of developing a pain condition that could result in high costs either through direct medical utilization or lost productivity. The enhanced interventions encourage optimal participant functionality and early return to work. This comprehensive integrated program addresses both core pain conditions and major musculoskeletal disorders, including:

- Back pain (neck, upper and lower back)
- Rheumatoid arthritis
- Osteoarthritis
- Migraine headaches
- Tension headaches
- Regional musculoskeletal disorders (RMD):
- Frozen shoulder
- Tendinitis/Bursitis
- Elbow disorders (tennis/golf elbow)
- Rotator cuff disorder
- Carpal tunnel syndrome
- Fibromyalgia

By giving participating members and providers the programs, tools, connectivity, and information to make better health care decisions, the Decision Power MSP helps increase the efficiency and effectiveness of care, leading to more timely actions, and more personalized and actionable solutions that ultimately lead to improved outcomes.

Urgent and Emergency Care

Section 15

Urgent and emergency care

What is the difference between emergency and urgent care?

The following is a summary of information, benefits and services which are fully described in the member's EOC/COI. Health Net members are covered for emergency and urgent care when illness or injury strikes them or their covered family members. However, to ensure they take care of themselves and their family the best way possible, and to maximize their health care benefits, it's important that they know the difference between emergency and urgent care. If members use the emergency room when the situation is not an emergency, they may be responsible for the costs of the visit. Health Net applies the "prudent layperson" standard in order to determine whether services for emergency conditions are covered. As always, members should review their plan documents for benefit and coverage information pertaining to emergency services and the prudent layperson standard.

The following represents a compilation of definitions found in our most common documents. Please refer to your *Evidence of Coverage (EOC)/Certificate of Insurance (COI)* for language specific to your plan.

If members use the emergency room when the situation is not deemed an emergency, as defined by the prudent layperson standard, they will be responsible for the costs of the visit. The following is the definition of urgently needed care: Urgently needed care is any otherwise covered medical service that a reasonable person with an average knowledge of health and medicine would seek for treatment of an injury, unexpected illness or complication of an existing condition, including pregnancy, to prevent the serious deterioration of his or her health but which does not qualify as emergency care, as defined in the member's EOC/COI. This may include services for which a person should reasonably have known an emergency did not exist.

Before going to an emergency room, members should determine if the situation is a true emergency under the prudent layperson standard. If it's not a critical situation, they should call their physician. **If the problem is an emergency, they should not hesitate to call 911 or go to the hospital.** If members are faced with an urgent condition, they should:

- Call their PCP or treating physician. Their doctor may give them advice on where they should go to obtain care.
- If the doctor does not return a call within a reasonable amount of time, and the member believes their health is at risk, they should seek care in an urgent care center.
- Call Decision Power, toll-free, at 1-800-893-5597. A nurse is available to respond to health-related questions 24 hours a day, 7 days a week, and can assist members in determining the appropriate level of care.

Out-of-area care

If a member has an urgent medical problem while traveling outside the Health Net service area, the member should first contact his or her primary care physician or participating treating physician for advice. If this is not possible, the member should seek the services of a private physician or urgent care center.

Emergency care is any otherwise covered service for an acute illness, a new injury or an unforseen deterioration or complication of an existing illness, injury or condition already known to the person or, if a minor, the minor's parent or guardian, that a reasonable person with an average knowledge of health and medicine (a prudent layperson) would seek if he or she was having serious symptoms (including symptoms of severe mental illness and Serious Emotional Disturbances of a Child) and believed that without immediate treatment, any of the following would occur:

- His or her health would be put in serious danger (and in the case of a pregnant woman, would put her or her unborn child in serious danger).
- His or her bodily functions, organs or parts would become seriously damaged.
- His or her bodily organs or parts would seriously malfunction.

If a dependent child will be attending school away from home but still within the Health Net service area, that child may choose a participating primary care physician located close to where he or she will be attending school rather than close to home. Health Net will cover an out-of-area student for the cost of emergency and urgent care, minus any applicable copayment.

As always, members should consult their Plan documents for specific benefit and coverage information pertaining to out-of-area emergency services and the prudent layperson standard.

Preventive *Care*

Section 16

Health Net®

As of August 1, 2012, nongrandfathered group (and individual) health benefit plans must cover additional services for females as preventive care without member cost-sharing. For a complete list of covered preventive services, including the expanded listing of women's preventive services, go to http://www.hrsa.gov/womensguidelines/.

Since September 23, 2010, all nongrandfathered plans are required to cover in-network preventive services without cost-sharing to participants. Specifically, such plans cannot require enrollees to pay copayments, coinsurance or deductibles on preventive services such as those evidence-based items or services with a rating of A or B in the current recommendations of the United States Preventive Services Task Force; immunizations for routine use in children, adolescents and adults; evidence-informed preventive care and screenings supported by the Health Resources Services Administration (HRSA) for infants, children and adolescents; and evidence-informed preventive screening and care for women based on guidelines supported by HRSA. A complete list of the required recommendations, services and guidelines is available at: www.healthcare.gov/law/provisions/preventive/index.html. Per subsequent rules released by HRSA, which expands women's preventive health services, as of August 1, 2012, nongrandfathered group (and individual) health benefit plans must cover additional services for females as preventive care without member cost-sharing.

These additional services include, but are not limited to, FDA-approved contraception methods,[1] contraceptive counseling and breastfeeding support, supplies, and counseling.

A complete list of covered preventive services, including the expanded listing of women's preventive services, is available at http://www.hrsa.gov/womensguidelines/.

[1]**Note**: Health Net may impose cost-sharing on brand-name drugs when a generic version is available. Health Net will not impose cost-sharing on a brand-name drug when a generic version is not available.

Pharmacy *Program*

Section 17

Health Net®

The Health Net pharmacy plan

Overview

Health Net pharmacy plan benefits are divided into three tiers. These tiers are designed to give members maximum flexibility in choosing the drug that fits their personal needs and budget, particularly when alternatives are available.

Some prescription drug benefits include a deductible that must be paid before the plan begins to cover prescriptions.

- Prescription drug benefits include different generic substitution programs.
- MAC A plan: If a member or the physician chooses a brand-name drug when it has a generic equivalent, they are required to pay the difference in cost between the generic and the brand-name drug plus their applicable copayment. (Members should check their benefits for details.)
- MAC B plans: If a member chooses a brand-name drug when it has a generic equivalent, they are required to pay the difference in cost between the generic and the brand-name drug plus their applicable copayment. If the physician states "do not substitute," the specified drug will be dispensed at the applicable copayment.

	Mac A plan	*Mac B plan*
Physician-requested brand	Ancillary charge plus applicable copayment	Applicable copayment with no ancillary charge
Member-requested brand	Ancillary charge plus applicable copayment	Ancillary charge plus applicable copayment

Specialty tier

Some plans may also have a specialty tier which is covered under the pharmacy benefit. Specialty tier drugs will usually be provided by a specialty pharmacy identified by Health Net. Most of these drugs require prior authorization. Please consult your plan documents[1] to determine whether your pharmacy benefit includes the specialty tier and the EDL[2] or RDL[3] for coverage.

Prescription is for	*You pay*
Specialty drugs (primarily injectable drugs either brand name or generic)	In most cases, a coinsurance or the tier specified in the Specialty Drug List of the EDL or RDL

How members can ensure prescription coverage

- Ask their doctor to prescribe from the Health Net Essential Rx Drug List (EDL) for nongrandfathered members, or Recommended Drug List (RDL) for grandfathered members whenever possible.
- Work with their doctor to determine if the drug requires prior authorization or has other limitations or restrictions in accordance with their prescription drug benefit.
- View their prescription coverage online by logging in to www.healthnet.com.

Health Net's Essential Rx Drug List and Recommended Drug List

The Health Net Essential Rx Drug List (EDL) for nongrandfathered members, and the Recommended Drug List (RDL) for grandfathered members each contain a list of prescription drugs approved for these Health Net members. The lists are regularly reviewed and updated by our Pharmacy and Therapeutics (P&T) Committee. The P&T Committee is a panel of clinicians and practicing doctors who represent a broad spectrum of medical specialties, including

[1]*Evidence of Coverage (EOC)* or *Certificate of Insurance (COI).*

[2]Health Net's Essential Rx Drug List (EDL) for nongrandfathered members.

[3]Drug List (RDL) for grandfathered members.

cardiology, infectious disease, internal medicine, behavioral health, and pediatrics. The committee considers questions like:

How well does the medicine treat the illness? How safe is it? Compared to similar, less expensive medicines, does it work better, the same or worse?

To find out what medications are on the EDL and RDL, go to www.healthnet.com > *Employers* > *View Our Pharmacy Plan*.

Health Net pharmacy network

We contract with pharmacies throughout California and nationwide – over 63,000 locations – to ensure that when a member needs medication, they won't have to go far. Pharmacies that belong to our network include local and national chains, such as CVS Caremark, Walgreens, Sav-on, Walmart, Target and Rite Aid. To find a Health Net pharmacy, go to www.healthnet.com > *Employers* > *View Our Pharmacy Plan*.

How members can transition medications

Members can transition select maintenance medications – those taken every day – to Health Net pharmacy coverage. This is done by filling out a Prescription Transition form, included in the member enrollment packet or available for download at www.healthnet.com > *Employers* > *View Our Pharmacy Plan*. Members should follow the following guidelines:

- The form(s) must be completed and submitted within the first three months (90 days) of eligibility with Health Net.
- A separate form is required for each family member transitioning medications.
- Medications that require prior authorization should be listed on the form.
- Medication not listed on the form may require a call from the prescribing doctor to Health Net for prior authorization to ensure coverage.
- The completed form(s) should be faxed or mailed to the fax number or address shown on the form.

When Health Net receives the form(s), authorization for each eligible medication is entered into the pharmacy claims processing system, so members can obtain their medications with their new Health Net pharmacy coverage.

The pharmacy will contact the prescribing doctor if a medication requires prior authorization and is not on the Prescription Transition form or Health Net's EDL or RDL. The pharmacy will either suggest an alternative medication covered by Health Net and/or will ask the doctor to contact Health Net to request coverage for the medication they prescribed. This is common practice followed by all pharmacies and doctors.

Prior authorization

Prior authorization is the process of obtaining approval from Health Net for certain prescriptions before they are eligible for coverage. Among the reasons a medication may require prior authorization:

- high potential for abuse
- requires laboratory tests/monitoring for safety reasons
- part of a step care guideline
- high potential for off-label/experimental use
- excluded from coverage for certain uses (e.g., nail fungus)
- duration or quantity exceeds approved guidelines

As part of this prior authorization process, members may be required to try one or more prerequisite medicines first before another medication will be covered. Prerequisite and prior authorization drugs are FDA-approved to treat the same condition. Prior authorization helps ensure the appropriate use of medications and may even lower a member's copayment.

Our P&T Committee determines which drugs are subject to our prior authorization program. To obtain the most up-to-date listing, go to the Employer section of www.healthnet.com > *Employers* > *View Our Pharmacy Plan*.

The prior authorization process works like this:

1. Members should ask the prescribing physician to complete a Prior Authorization Request Form and send it along with any relevant documentation to Health Net Pharmaceutical Services for review. The doctor must provide medical evidence that:
   - the requested drug is medically necessary for the member's condition,
   - a preferred drug has failed to be an effective treatment for the member,
   - the member has experienced adverse effects from the preferred drug, or
   - changing therapy to a covered medication would be medically inappropriate.

   Medical necessity is determined based on the physician's chart records, previous drug therapy, and other pertinent medical data, such as laboratory results.

   Physicians may obtain prior authorization forms by contacting the Pharmacy Prior Authorization Unit or through Health Net's provider website.

2. After comparing the information given in the request to the established prior authorization criteria, a decision is made. Decisions will be made once all information required has been submitted with the request. If the request is urgent, the review can be completed quicker depending upon the information provided in the fax. Most decisions are made within 24–48 hours.

New members may complete a Transition of Care Form for some medications that require a prior pharmacy authorization in order to waive an additional authorization by Health Net.

- If the prior authorization request is approved, the pharmacy will be able to bill Health Net directly and the member will be required to pay the applicable copayment based on their specific plan as defined in their *Evidence of Coverage (EOC)* or *Certificate of Insurance (COI)*.
- If the prior authorization request is denied, the member and the prescribing physician will be notified in writing of the decision and informed of the appeal process.
- If the member obtains a drug that requires prior authorization without getting one first, he or she may be responsible for the entire cost of the drug.

Members can call the doctor's office or the Customer Contact Center at the number on the back of their Health Net ID card with questions.

Money-saving tips

Members can save money and still get the medication they need.

- Ask if the medication is on our Essential Drug List or Recommended Drug List. If it isn't, the member should ask if there's a preferred alternative.
- Go generic. Many name brand medications have generic alternatives that work just as well and cost less. Each member should talk to his or her doctor to see if he or she can take advantage of generic substitutes for current brand-name medications. All generics are FDA-approved and equivalent to their brand-name counterparts in safety, strength, quality, and performance.
- Use the Health Net mail order pharmacy program (CVS Caremark) for maintenance medications, if available, depending on their prescription drug benefit.

For most plans, members pay only two retail copayments for each three-month supply through mail order. For example, if a medication requires a $15 copayment per month under the retail prescription drug benefits, a three-month mail order supply would require $30, rather than $45 at retail. (Members should refer to their EOC/COI for benefit plan terms and conditions.)

Health Net mail order pharmacy details

Health Net's mail order pharmacy program offers:

- **Convenience:** Home delivery for most maintenance prescription needs. Maintenance medications are drugs needed for chronic or long-term conditions, such as high blood pressure or high cholesterol.
- **Savings:** For most plans, this means a three-month supply of a drug for the copayment of only two months.

Eligibility

Most members with prescription drug benefits are eligible. Members should refer to their EOC or COI for benefit plan terms and conditions.

Coverage

Most maintenance medications that, by law, require a doctor's prescription and are covered under the member's prescription drug benefit are available via mail order. Certain controlled substances and all drugs that require prior authorization may be subject to dispensing limitations according to the pharmacy prescription plan and/or the professional judgment of the pharmacist and/or state laws and regulations.

Members with questions should call the toll-free Customer Contact Center number listed on their Health Net ID card, or go to www.healthnet.com. **Note:** The mail order pharmacy program is designed to complement, not replace, the existing Health Net pharmacy network.

Using mail order

Members should:

1. Ask their doctor for a prescription. By law, CVS Caremark can only fill a prescription with the quantity indicated. Generally, the maximum mail order benefit is up to a ninety-day supply at a time.

Example
1 tablet/capsule a day = 90 tablets/capsules
2 tablets/capsules a day = 180 tablets/capsules
3 tablets/capsules a day = 270 tablets/capsules

2. Examine the prescription for the proper dosage, as well as the doctor's signature, state license number and DEA number. Members need to make sure that their full name is on the prescription.
3. Complete a mail order form with their Health Net ID number included on the order form. Members can obtain an order form by calling the Customer Contact

Center at 1-800-522-0088 or from www.healthnet.com > *Employers* > *View Our Pharmacy Plan*.

For the first order, members also complete and include a patient profile where they list all allergies, drug sensitivities and health conditions. Members should answer "none" if none applies.

4. Mail the completed order forms, original prescriptions (no photocopies) and their copayment(s) to CVS Caremark Mail Order.
5. Allow at least 14 days from the day they mail the order for the prescription to arrive. Prescriptions will be delivered at no charge to the members, most by first-class mail directly to their home. There is a charge, however, if overnight mail service is selected. Medication(s) will arrive in a plain, weather-resistant package, ensuring safety, security and privacy.
6. Place refill orders at least 14 days prior to the time their current supply of medication runs out. This can be done via Internet, phone or mail-in refill form included with the first order. Only refills authorized by their physician can be filled.

   Members can also determine when their prescription is refillable from their prescription bottle, which displays the date that they can order their next refill, or at www.healthnet.com > *Member (login)* > *My Health Plan* > *My Prescriptions* > *Order by mail*. Mail order gives members access to a pharmacist 24 hours a day for any questions they may have. They can also check on the status of a prescription 24 hours a day via the Internet or by speaking to a mail order representative.

For questions about mail orders, members can contact CVS Caremark customer service at 1-888-624-1139 or 1-866-236-1069 (TTY).

Pharmacy online

Online, anytime at www.healthnet.com, members can:

- Instantly locate any of over 63,000 participating pharmacies throughout the United States.
- Compare drugs according to drug price and plan-related copayments.
- Enroll in the mail order program, as well as refill orders and check on an order status.
- Research drugs for uses, side effects and potential drug-to-drug interactions.
- Download forms or complete copies of the Health Net Essential Drug List, Recommended Drug List and Prior Authorization List.
- Access a host of health and wellness resources.
- Get up-to-date information about prescription drugs, over-the-counter medications and supplements, as well as prescription history monitoring, drug interactions and more from the Medication Center.

Our prescription drug benefits and pharmacy programs have been designed to empower members to make decisions based on their health needs and finances. Members should ask their doctor or pharmacist any questions about side effects, proper usage and alternative drugs for a prescription. For questions about their prescription drug benefits, members should call Customer Service at the number on their Health Net ID card.

Diabetic Equipment, Medications, Services, *and* Supplies

Section 18

Diabetic equipment, medications, services, and supplies

The following is a summary of information, benefits and services which are fully described in the member's EOC/COI. A variety of state mandates dictate how Health Net must cover diabetic equipment, medication, services, and supplies.

This section is included to help you understand the benefits available to your employees and their dependents for diabetic equipment, medication, services, and supplies. For more detailed information, please consult the EOC/COI or call your Health Net representative.

Covered items

Equipment

Covered equipment includes insulin pumps and appurtenances, insulin infusion devices, injection aids, blood glucose monitors, and data management systems.

Please note: Insulin pumps require prior authorization from Health Net.

Medication

Covered medications include insulin, oral agents for controlling blood sugar and glucose-elevating agents.

Services

Covered services include education provided in the physician's office or in a participating hospital as to the proper diet and self-management that is necessary to properly treat the member's diabetic condition.

Supplies

Covered supplies include syringes for the injection of insulin or glucose-elevating agents, test strips for glucose monitors and visual readings, lancets, and urine testing strips.

How coverage is provided

Coverage of medical equipment is provided under the member's Health Net medical benefits. Diabetic medication and supplies are covered under the member's Health Net prescription benefits, unless the member does not have prescription coverage through Health Net.

How/where to obtain equipment, medication, supplies, and services

Equipment

Members may obtain diabetic equipment from a durable medical equipment vendor or a Health Net participating pharmacy, if the pharmacy carries diabetic equipment. For the most up-to-date list of participating durable medical equipment suppliers, please visit us online at www.healthnet.com for our online search or the Health Net Directory of Physicians and Providers.

Insulin pumps

- Must be purchased by the member through a durable medical equipment vendor or directly from the manufacturer.
- Prior authorization is required.

Blood glucose meter

- May be purchased by the member through a durable medical equipment vendor, or a preferred blood glucose meter may be obtained through a participating pharmacy.
- Prior authorization is not required, except when a replacement is purchased prior to the expiration of the average life span of the equipment (approximately three years).

Medication

Diabetic medication is available at Health Net participating pharmacies or through the mail order prescription drug program. For the most up-to-date list of participating pharmacies, please visit us online at www.healthnet.com.

Supplies
Preferred blood glucose meters are available at Health Net participating pharmacies, which are available online at www.healthnet.com.

Services
Diabetic services, such as education to help a member manage his or her diabetes, are covered subject to the member's office visit copayment. For specific details about coverage, refer to the member EOC/COI. Members should discuss their needs with their Health Net primary care physician or attending physician. Members can also contact the Health Net Customer Contact Center for more information about how to access diabetic services. It is in the member's best interest to obtain prior authorization.

Costs

At a participating Health Net pharmacy
Whether or not the member has a prescription drug rider, diabetic medications and supplies may be subject to a copayment as set forth in the plan documents, if applicable. However, diabetic purchases are not applied toward any prescription benefit maximum that may be on the plan.

Through the Health Net mail order pharmacy program
For many plans, members can receive up to a 90-day supply of diabetic medication for two copayments, if applicable.

Mental Health *and* Substance Abuse *Benefits*

Section 19

Mental health/substance use disorder benefits

The following is a summary of information, benefits and services which are fully described in the member's EOC/COI. Managed Health Network (MHN),[1] Health Net's behavioral health subsidiary, administers all mental health and substance use disorder benefits (except for PPO and Flex Net commercial and Medicare members).

To determine which mental health and substance use disorder benefits are available to your company's employees and to determine in which state your contract is written, please consult your benefit documents or contact your Health Net account manager.

Basic coverage

Mental health: Mental health care includes evaluative and crisis intervention services for the treatment of emotional disorders and mental illness. Health Net covers treatment of the acute phase of mental illness or emotional disorders. "Acute" is defined as reaching a crisis rapidly, but with the potential to get well. Coverage includes evaluation, crisis intervention and short-term treatment.

Substance use disorder: Substance use disorder is the misuse or excessive use of alcohol and/or drugs or use of a drug without medical justification. Substance use disorder coverage usually includes detoxification, treatment and aftercare. Treatment can take place in an inpatient or outpatient setting.

Detoxification: Detoxification is a medically safe process to remove or free a user from the intoxicating or addictive substance in the body (e.g., heroin or alcohol). The detoxification process can take from three to seven days depending on the type of substance the detoxification is treating.

Please note: Health Net complies with all applicable Mental Health Parity legislation.

[1]Managed Health Network, Inc. (MHN) is a subsidiary of Health Net, Inc. The MHN family of companies includes Managed Health Network, MHN Services and MHN Government Services. Health Net and Managed Health Network are registered service marks of Health Net, Inc. All rights reserved.

Health Net Dental *and* Vision

Section 20

Health Net®

Dental coverage

Dental coverage may be purchased in conjunction with a Health Net medical plan or on a standalone basis. Members of groups that have purchased dental coverage will find benefit coverage, terms and conditions in their EOC/COI.

A quick summary of the options we offer:

Dental HMO

Health Net Dental HMO plans are available to California employees and family members who live or work within the Health Net Dental HMO service area.

As part of the enrollment process, each employee enrolling in the dental HMO plan chooses a primary care dentist within 30 miles of where he or she lives or works, and includes that information on the enrollment form. Each covered family member may select a different Dental HMO provider. If the employee does not select a primary care dentist at the time of enrollment, Health Net will assign a primary care dentist for the employee (and all enrolled family members).

All dental care must be provided by the member's DHMO provider – (exceptions are emergencies and referrals authorized by Dental Benefit Providers of California, Inc. (DBP).

Health Net Dental Member Services at 1-866-249-2382 is here to answer questions, relay the most up-to-date DHMO provider information, help select a new DHMO provider, order ID cards, and more. Members may also visit us online at www.healthnet.com > *Employers > View Small Group Plans > Dental plan overview > Go to the Health Net Dental Website.*

Dental PPO

Health Net Dental PPO plans offer members flexibility and the choice of using any licensed dentist. Using a Health Net network dental provider generally saves members out-of-pocket expenses.

To learn about dental plan coverage and locate participating providers, members may call Health Net Dental Member Services at 1-866-249-2382, or visit www.healthnet.com > *Employers > View Small Group Plans > Dental plan overview > Go to the Health Net Dental Website.*

For services obtained out-of-network, members submit claims to:

Health Net Dental
Attn: Claims Unit
PO Box 30567
Salt Lake City, UT 84130-0567

Health Net Dental HMO products are provided by DBP and Health Net Dental PPO, and indemnity products are underwritten by Unimerica Insurance Company (together, "the DBP Entities").

Vision coverage

PPO vision coverage may be purchased in conjunction with a Health Net medical plan or on a standalone basis.

Health Net Vision PPO plans offer employees and family members a choice of any licensed vision provider and access to a large network of independent providers for greater cost savings.

The Health Net Vision network includes optical retailers such as LensCrafters, Pearle Vision, Sears Optical, Target Optical, and JCPenney Optical, giving members:

- More provider choices.
- Added convenience – vision care in the same place they shop.
- Flexible appointments – Health Net's exclusive vision network features evening and weekend appointments to fit every schedule.

Members should refer to their *Certificate of Insurance* for terms and conditions of coverage, including which services are limited or excluded from coverage.

For services obtained out-of-network, members submit claims to:

Health Net Vision
Attn: OON Claims
PO Box 8504
Mason, OH 45040-711

Health Net Vision plans are underwritten by Fidelity Security Life Insurance Company and administered by EyeMed Vision Care, LLC.

Employee Communication *Materials*

Section 21

Health Net®

Employee communication materials

We believe it is very important to communicate with members about their benefits as well as other helpful information. Read below to learn more about the type of communications your employees can expect to receive from us throughout the year.

Enrollment packets: an employee's guide to enrollment

Enrollment packets educate prospective members about Health Net and the benefits available to them through your company. This information can be distributed during your company's open enrollment period, during your plan year when a new hire becomes eligible for benefits, or when a current employee becomes eligible for benefits due to a qualifying event.

Enrollment packets typically include the following:

- enrollment form
- health plan product and Health Net company overview
- company-specific benefit summary
- information about some of our value-added wellness programs

To make arrangements to receive enrollment packets, please call your account manager.

Member newsletter: plan news and programs to keep members healthy

Our member newsletter is written by experienced staff members and mailed directly to members' homes once a year. It informs members about plan news and provides key information about how to stay healthy and take advantage of all the programs Health Net has to offer.

Special targeted mailings: wellness and disease management information

Targeted mailings quickly disseminate important information to a specific population of Health Net members.

Examples of special targeted mailings in the past include:

- Mammogram reminders to women of targeted age groups.
- Cervical cancer screening reminders to women of targeted age groups.
- Immunization reminders and suggested schedules for children.

Legal *Information/* Miscellaneous *Items*

Section 22

Health Net®

Legal information and other miscellaneous items

The following will provide you with additional legal information and miscellaneous items that will help you in managing your Health Net business.

Applicant/client responsibility

Health Net requires all applicants age 18 and older to personally read, complete and assume accountability for the "Conditions of Enrollment" by signing and dating the application. All applications must be completed and signed in blue or black ink by the applicant and the applicant's spouse. The applicant or payor is held accountable for the accuracy of all health information, including omitted alcohol/drug use. All plan change requests must be completed by the applicant/insured member.

Effective dates

Health Net offers the 1st of the month as the effective date. Insurance brokers have no authority to bind coverage or assign effective dates. Effective dates for applications will not be backdated.

Discrimination

Health Net does not discriminate among applicants by race, religion, gender, color, national origin, or other conditions, or criteria that are related to the applicant's health status.

Quality assurance (HEDIS)

The quality of care provided to our members is also evidenced in routinely high scores received on the Health Plan Employer Data Information Set (HEDIS). The report is defined by the National Committee for Quality Assurance (NCQA) and produced annually by health plans. Health Net has developed treatment protocols and guidelines for preventive services such as physical exams and immunizations as well as disease- and procedure-specific guidelines for treating heart attacks, and using and monitoring drugs.

Health Insurance Portability and Accountability Act (HIPAA)

Health Net is pleased to acknowledge that we are HIPAA compliant with the Privacy provision, Transactions and Code Sets provision, and the security requirements of HIPAA. We have developed policies and procedures to ensure that our members' information is protected and safeguarded according to the law. A Notice of Privacy Policy (NOPP) is sent to members annually outlining their individual rights.

Health Net's confidentiality policy

For the Account Services Unit to release confidential medical information regarding a member's claims, Health Net requires that the member complete and sign the Member Authorization Form. The completed authorization form provides Health Net with a signed, written release from the member (or from a legal guardian/power of attorney, with appropriate documentation) authorizing us to release the confidential information to the benefits administrator or broker. A member's claim cannot be released to a broker without the member's signed, written authorization.

Need answers? Find them here:

- Call your broker or your Health Net account manager.
- Visit us online at www.healthnet.com/employer.
- See ACA-related information at www.healthnet.com/employer/reformguide.

Save time online.

Everything Health Net – from materials to the latest news – is available to you around the clock at www.healthnet.com/employer.

It's also the destination that makes health coverage administration easy for you. And for employees, our easy-to-use website connects them with essential information, wellness resources and more to help them achieve an overall sense of good health. It's all part of the Health Net experience!

Health Net Seniority Plus

PO Box 10198
Van Nuys, CA 91410-0198
1-800-275-4737

Customer Contact Center

1-800-522-0088

Assistance for the hearing and speech impaired

1-800-995-0852

www.healthnet.com/employer

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

Decision Power is not part of Health Net's commercial medical benefit plans. It is not affiliated with Health Net's provider network, and it may be revised or withdrawn without notice. Decision Power is part of Health Net's Medicare Advantage benefit plans. It is not affiliated with Health Net's provider network. Decision Power services, including clinicians, are additional resources that Health Net makes available to enrollees of the above listed Health Net companies.

PPO and Life insurance plans are underwritten by Health Net Life Insurance Company, a subsidiary of Health Net, Inc. Health Net Dental HMO plans are underwritten by Dental Benefit Providers of California, Inc. ("DBP"). Obligations of DBP are not the obligations of or guaranteed by Health Net, Inc. or its affiliates. Health Net Dental PPO and indemnity plans are underwritten by Unimerica Life Insurance Company. Obligations of Unimerica Life Insurance Company are not the obligations of or guaranteed by Health Net, Inc. Health Net Vision plans are underwritten by Fidelity Security Life Insurance Company and administered by EyeMed Vision Care, LLC (together, the "Fidelity Entities"). Discounts on vision care services and products are made available by EyeMed. The Fidelity Entities are not affiliated with Health Net of California, Inc. or Health Net Life Insurance Company (together, the "Health Net Entities"). Obligations of the Fidelity Entities are neither the obligations of nor guaranteed by the Health Net Entities.Health Net of California, Inc. has a contract with Medicare to offer HMO plans. Enrollment in a Health Net Medicare Advantage plan depends on contract renewal. Anyone with Medicare Parts A and B may apply.

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