Health Net®
MEDICARE PROGRAMS

January 1 – December 31, 2017

Evidence of Coverage:

Your Medicare Health Benefits and Services as a Member of Health Net Aqua (PPO)

This booklet gives you the details about your Medicare health care coverage from January 1 – December 31, 2017. It explains how to get coverage for the health care services you need.
This is an important legal document. Please keep it in a safe place.

This plan, Health Net Aqua (PPO), is offered by Health Net Life Insurance Company. (When this *Evidence of Coverage* says "we," "us," or "our," it means Health Net Life Insurance Company. When it says "plan" or "our plan," it means Health Net Aqua (PPO).)

Health Net Life Insurance Company is a Medicare Advantage organization with a Medicare contract to offer this PPO plan. Enrollment in a Health Net Medicare Advantage plan depends on contract renewal.

Member Services has free language interpreter services available for non-English speakers (phone numbers are printed on the back cover of this booklet).

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

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2018.

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

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2017 Evidence of Coverage

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CHAPTER 1

Getting started as a member

Chapter 1. Getting started as a member

SECTION 1 Introduction

Section 1.1 You are enrolled in Health Net Aqua (PPO), which is a Medicare PPO

You are covered by Medicare, and you have chosen to get your Medicare health care coverage through our plan, Health Net Aqua (PPO).

There are different types of Medicare health plans. Our Plan is a Medicare Advantage PPO Plan (PPO stands for Preferred Provider Organization). This plan does not include Part D prescription drug coverage. Like all Medicare health plans, this Medicare PPO is approved by Medicare and run by a private company.

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

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

The words "coverage" and "covered services" refer to the medical care and services available to you as a member of Health Net Aqua (PPO).

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

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

Section 1.3 Legal information about the *Evidence of Coverage*

It's part of our contract with you

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

The contract is in effect for months in which you are enrolled in Health Net Aqua (PPO) between January 1, 2017 and December 31, 2017.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of Health Net Aqua (PPO) after December 31, 2017. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2017.

Medicare must approve our plan each year

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

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

Section 2.1 Your eligibility requirements

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

- You have both Medicare Part A and Medicare Part B (Section 2.2 tells you about Medicare Part A and Medicare Part B)
- -- *and* -- you live in our geographic service area (Section 2.3 below describes our service area)
- -- *and* -- you are a United States citizen or are lawfully present in the United States
- -- *and* -- you do *not* have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different Medicare Advantage plan that was terminated.

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

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

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

Section 2.3 Here is the plan service area for our plan

Although Medicare is a Federal program, Health Net Aqua (PPO) is available only to individuals who live in our plan service area. To remain a member of our plan, you must continue to reside in the plan service area. The service area is described below.

Our service area includes these counties in Oregon: Douglas, Jackson, Josephine.

If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment

Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

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

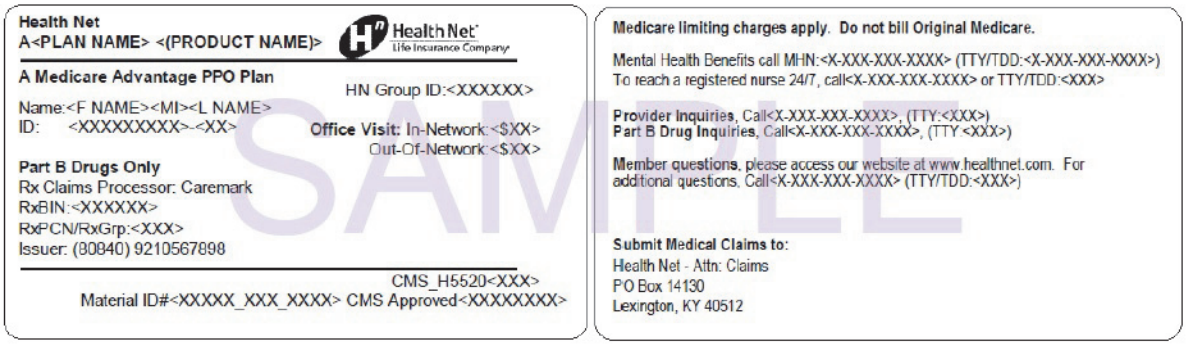
Section 2.4 U.S. Citizen or Lawful Presence

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

SECTION 3 What other materials will you get from us?

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

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



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

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

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. (Phone numbers for Member Services are printed on the back cover of this booklet.)

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

The *Provider Directory* lists our network providers.

What are "network providers"?

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

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

As a member of our plan, you can choose to receive care from out-of-network providers. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and medically necessary. However, if you use an out-of-network provider, your share of the costs for your covered services may be higher. See Chapter 3 (*Using the plan's coverage for your medical services*) for more specific information.

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

SECTION 4 Your monthly premium for Health Net Aqua (PPO)

Section 4.1 How much is your plan premium?

As a member of our plan, you pay a monthly plan premium. For 2017, the monthly premium for our plan is $49. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

In some situations, your plan premium could be <u>more</u>

In some situations, your plan premium could be more than the amount listed above in Section 4.1. If you signed up for extra benefits, also called "optional supplemental benefits", then you pay an additional premium each month for these extra benefits. If you have any questions about

your plan premiums, please call Member Services (phone numbers are printed on the back cover of this booklet).

- If you enroll in Comprehensive Dental Optional Supplemental Benefits, you pay an additional monthly premium of $39.
- If you enroll in Preventive Dental Optional Supplemental Benefits, you pay an additional monthly premium of $15.

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

Many members are required to pay other Medicare premiums

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

Your copy of *Medicare & You 2017* gives information about these premiums in the section called "2017 Medicare Costs." This explains how the Medicare Part B premium differs for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2017* from the Medicare website (http://www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

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

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

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

Option 1: You can pay by check or money order

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

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

Health Net Medicare Programs
P.O. Box 894702
Los Angeles, CA 90189-4702

Checks and money orders should be made payable to Health Net, Inc., and not to the Centers for Medicare & Medicaid Services (CMS) nor the United States Department of Health and Human Services (HHS). Premium payments may not be dropped off at the Health Net office. A $15 fee will be charged for all returned checks due to nonsufficient funds (NSF).

Option 2: You can have your premium automatically withdrawn from your bank account

Instead of paying by check or money order, you can have your monthly plan premium payment automatically withdrawn from your bank account. If you are interested in this option, call Member Services at the phone number listed on the back cover of this booklet to ask for the appropriate form. Once Automatic Bank Draft is set up by your bank, we will send you a confirmation letter telling you when the first payment will be deducted from your bank account. Until you receive the confirmation from us, please continue to pay as you are billed.

On or about the 6th of each month (or the next business day if the 6th falls on a holiday or weekend), we will communicate directly with your bank to deduct the premium amount due for that month. Your monthly bank statement will reflect the amount debited for your Health Net premium. You will not receive a bill for your monthly premium from us while this service is in effect. If you receive a bill for your premium payments while this service is in effect, please disregard it.

Option 3: You can have the plan premium taken out of your monthly Social Security check

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

Option 4: You can have the plan premium taken out of your monthly Railroad Retirement Board (RRB) check

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

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

Your plan premium is due in our office by the 1st of each month. If we have not received your premium payment by the 7th business day of the month, we will send you a notice telling you that your plan membership will end if we do not receive your plan premium within two months. If you are having trouble paying your premium on time, please contact Member Services to see if we can direct you to programs that will help with your plan premium. (Phone numbers for Member Services are printed on the back cover of this booklet.)

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

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

If you think we have wrongfully ended your membership, you have a right to ask us to reconsider this decision by making a complaint. Chapter 7, Section 9 of this booklet tells how to make a complaint. If you had an emergency circumstance that was out of your control and it caused you to not be able to pay your premiums within our grace period, you can ask us to reconsider this decision by calling 1-888-445-8913 between 8:00 a.m. to 8:00 p.m., Pacific Time, seven days a week. TTY users should call 711. You must make your request no later than 60 days after the date your membership ends.

Section 4.3 Can we change your monthly plan premium during the year?

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

SECTION 5 Please keep your plan membership record up to date

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

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage.

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

Let us know about these changes:

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

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

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

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

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

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

SECTION 6 We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

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

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

SECTION 7 How other insurance works with our plan

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

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

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

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

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

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

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

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

CHAPTER 2

Important phone numbers and resources

Chapter 2. Important phone numbers and resources

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

How to contact our plan's Member Services

For assistance with claims, billing or member card questions, please call or write to Health Net Aqua (PPO) Member Services. We will be happy to help you.

Method	Member Services – Contact Information
CALL	1-888-445-8913 Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. From October 1 through February 14, our plan operates a toll-free call center for both current and prospective members that is staffed seven days a week from 8:00 a.m. to 8:00 p.m. Pacific time. During this time period, current and prospective members are able to speak with a Member Service representative. However, after February 14, our office hours are 8:00 a.m. to 8:00 p.m., Monday through Friday. On weekends and certain holidays, your call will be handled by our automated phone system. When leaving a message, please include your name, phone number and the time that you called, and a representative will return your call no later than one business day after you leave a message. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 (National Relay Services) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	1-866-214-1992

Method	Member Services – Contact Information
WRITE	Health Net Medicare Programs P.O. Box 10420 Van Nuys, CA 91410-0420
WEBSITE	www.healthnet.com

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

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

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

Method	Coverage Decisions For Medical Care – Contact Information
CALL	1-888-445-8913 Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
TTY	711 (National Relay Service) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	1-866-295-8562
WRITE	Health Net Medicare Advantage Health Services Department 13221 SW 68th Parkway, Suite 200 Tigard, OR 97223
WEBSITE	www.healthnet.com

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

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

Method	Appeals For Medical Care – Contact Information
CALL	1-888-445-8913 Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
TTY	711 (National Relay Service) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	1-877-713-6189
WRITE	Health Net Medicare Programs Appeals and Grievances Department P.O. Box 10343 Van Nuys, CA 91410-0343
WEBSITE	www.healthnet.com

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

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

Method	Complaints About Medical Care – Contact Information
CALL	1-888-445-8913 Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
TTY	711 (National Relay Service) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	1-877-713-6189
WRITE	Health Net Medicare Programs Appeals and Grievances Department P.O. Box 10343 Van Nuys, CA 91410-0343
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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

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

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

Method	Payment Requests – Contact Information
CALL	1-888-445-8913 Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
TTY	711 (National Relay Service) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
WRITE	Health Net Life Insurance Company P.O. Box 14130 Lexington, KY 40512
WEBSITE	www.healthnet.com

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

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

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

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

Method	Medicare – Contact Information
WEBSITE	http://www.medicare.gov This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state. The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about our plan: • **Tell Medicare about your complaint:** You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.) • **Minimum essential coverage (MEC):** Coverage under this Plan qualifies as minimum essential coverage (MEC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families,for more information on the individual requirement for MEC.

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

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

In Oregon, the SHIP is called Senior Health Insurance Benefits Assistance Program (SHIBA).

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

SHIBA counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your medical care or treatment, and help you straighten out problems with your Medicare bills. SHIBA counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Method	Senior Health Insurance Benefits Assistance Program (SHIBA) (Oregon SHIP) - Contact Information
CALL	1-800-722-4134
TTY	711 (National Relay Service) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Senior Health Insurance Benefits Assistance Program (SHIBA) P.O. Box 14480 Salem, OR 97309-0405
WEBSITE	www.oregonshiba.org

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

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

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

You should contact Livanta in any of these situations:

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

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

SECTION 5 Social Security

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

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

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

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

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

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

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

To find out more about Medicaid and its programs, contact Oregon Health Plan.

Method	Oregon Health Plan (Oregon's Medicaid program) – Contact Information
CALL	General/Applications: 1-800-699-9075 Member: 1-800-273-0557
TTY	711 (National Relay Service) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Health Systems Division 500 Summer Street NE, Salem, OR 97301
WEBSITE	www.oregon.gov/oha/healthplan/Pages/splash.aspx

SECTION 7 How to contact the Railroad Retirement Board

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

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

Method	Railroad Retirement Board – Contact Information
CALL	1-877-772-5772 Calls to this number are free. Available 9:00 a.m. to 3:30 p.m. Monday, Tuesday, Thursday, and Friday (Central Time). Available 9:00 a.m. to 12:00 p.m. on Wednesday (Central Time). Please note, any calls after 3:15 p.m. Central Time will be automatically routed to voicemail. If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.

Method	Railroad Retirement Board – Contact Information
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	http://www.rrb.gov

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

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this booklet.) You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

CHAPTER 3

Using the plan's coverage for your medical services

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

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

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

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

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

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

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

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

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

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

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in Chapter 4 of this booklet).
- **The care you receive is considered medically necessary**. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You receive your care from a provider who is eligible to provide services under Original Medicare.** As a member of our plan, you can receive your care from either a

network provider or an out-of-network provider (for more about this, see Section 2 in this chapter).

- The providers in our network are listed in the *Provider Directory*.
- If you use an out-of-network provider, your share of the costs for your covered services may be higher.
- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you go to a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.

SECTION 2 Using network and out-of-network providers to get your medical care

Section 2.1 You may choose a Physician of Choice (POC) to provide and oversee your medical care

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

When you become a member of our plan, you may choose a plan provider to be your Physician of Choice (POC). (Some people may call a POC a "Primary Care Provider" or "PCP"). Choosing a POC is optional and not a requirement of this plan. Your POC is a health care professional who meets state requirements and is trained to give you basic medical care. Providers that can act as your POC are those that provide a basic level of care. These include doctors specializing in family practice, general practice, internal medicine, and gynecologists who provide care for women. A Nurse Practitioner (NP), a State licensed registered nurse with special training providing a basic level of health care, or a Physician Assistant (PA), credentialed as a POC, providing services within a primary care setting can also act as your POC.

You may choose to get your routine or basic care from your POC. Your POC can also help arrange or coordinate the rest of the covered services you get as a member of our plan. Since your POC can provide and coordinate your medical care, you may want to have all of your past medical records sent to your POC's office.

You may choose to see your POC first for most of your routine health care needs. However, you can still obtain services on your own without contacting your POC first. Some types of services may require approval in advance from our plan (this is called getting prior authorization). If the service you need requires prior authorization, your POC (if you have chosen one) or other network provider will request the authorization from our plan. Please see Chapter 4 for the specific benefits that require prior authorization.

How do you choose your POC?

When you enroll in our plan, you may choose a contracting provider to serve as your POC from our network. To select a POC, you will indicate your choice of POC on your enrollment form and submit it to our plan. You can find a list of contracting providers in the *Provider Directory* or you may visit our website at www.healthnet.com. To confirm the availability of a provider, or to ask about a specific provider, please contact Member Services at the phone number on the back cover of this booklet.

Changing your POC

You may change your POC for any reason, at any time. Also, it's possible that your POC might leave our plan's network of providers and you would have to find a new POC in our plan or you will pay more for covered services.

You may choose another network provider to serve as your Physician of Choice. If you continue seeing the provider after the provider leaves our network, you will be subject to the out-of-network level of cost sharing for services provided by your POC.

To change your POC, call Member Services at the phone number on the back cover of this booklet. This change will take effect immediately. Choosing a POC is optional and not a requirement of this plan.

Section 2.2 How to get care from specialists and other network providers

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

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

You do not need a referral to see a specialist. Some in-network services may require prior authorization (approval in advance) from our plan. Prior authorization is an approval process that happens before you get certain services. If the service you need requires prior authorization, your POC (if you have chosen one) or other network provider will request it from our plan. Our plan will review the request and will send a decision (organization determination) to you and your provider. See the Medical Benefits Chart in Chapter 4, Section 2.1 of this booklet for the specific services that require prior authorization.

Prior authorization for out-of-network services is not required, although it is recommended. We recommend that your out-of-network provider requests prior authorization from our plan for out-of-network services to confirm that the out-of-network service is medically necessary. If our plan determines that the out-of-network service was not medically necessary after you receive the service, you will have to pay for the service yourself.

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

It is important that you know that we may make changes to the hospitals, doctors and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan but if your doctor or specialist does leave your plan you have certain rights and protections summarized below:

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

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

Section 2.3 How to get care from out-of-network providers

As a member of our plan, you can choose to receive care from out-of-network providers. However, please note providers that do not contract with us are under no obligation to treat you, except in emergency situations. Our plan will cover services from either in-network or out-of-network providers, as long as the services are covered benefits and are medically necessary. However, **if you use an out-of-network provider, your share of the costs for your covered services may be higher.** Here are other important things to know about using out-of-network providers:

- You can get your care from an out-of-network provider, however, in most cases that provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If you receive care from a provider who is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive. Check with your provider before receiving services to confirm that they are eligible to participate in Medicare.
- You don't need to get a referral or prior authorization when you get care from out-of-network providers. However, before getting services from out-of-network providers you

may want to ask for a pre-visit coverage decision to confirm that the services you are getting are covered and are medically necessary. (See Chapter 7, Section 4 for information about asking for coverage decisions.) This is important because:

- Without a pre-visit coverage decision, if we later determine that the services are not covered or were not medically necessary, we may deny coverage and you will be responsible for the entire cost. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. See Chapter 7 *(What to do if you have a problem or complaint (coverage decisions, appeals, complaints))* to learn how to make an appeal.

- It is best to ask an out-of-network provider to bill the plan first. But, if you have already paid for the covered services, we will reimburse you for our share of the cost for covered services. Or if an out-of-network provider sends you a bill that you think we should pay, you can send it to us for payment. See Chapter 5 (*Asking us to pay our share of a bill you have received for covered medical services*) for information about what to do if you receive a bill or if you need to ask for reimbursement.
- If you are using an out-of-network provider for emergency care, urgently needed services, or out-of-area dialysis, you may not have to pay a higher cost-sharing amount. See Section 3 for more information about these situations.

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

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

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

What is covered if you have a medical emergency?

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

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

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

After the emergency is over you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be covered by our plan. If you get your follow-up care from out-of-network providers, you will pay the higher out-of-network cost-sharing.

What if it wasn't a medical emergency?

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

However, after the doctor has said that it was *not* an emergency, the amount of cost-sharing that you pay will depend on whether you get the care from network providers or out-of-network providers. If you get the care from network providers, your share of the costs will usually be lower than if you get the care from out-of-network providers.

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

What are "urgently needed services"?

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

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

In most situations, if you are in the plan's service area and you use an out-of-network provider, you will pay a higher share of the costs for your care. However, if the circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, we will allow you to get covered services from an out-of-network provider at the lower in-network cost-sharing amount.

What to do when you need medical care immediately

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

If your situation is not so severe: Call your Physician of Choice (POC). If you don't have a POC or can't call your POC, or if you need medical care right away, go to the nearest medical center, urgent care center, or hospital.

If you are unsure of whether an emergency medical condition exists, you may call your POC for help.

Your POC, on-call physician or answering service is available 24 hours a day, seven days a week, to respond to your phone calls regarding medical care that you believe is needed immediately. They will evaluate your situation and give you direction about where to go for the care you need.

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

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

When you are outside the service area and cannot get care from a network provider, our plan will cover urgently needed services that you get from any provider at the lower in-network cost-sharing amount.

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

Section 3.3 Getting care during a disaster

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

Please visit the following website: www.healthnet.com for information on how to obtain needed care during a disaster.

Generally, during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing.

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

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

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

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

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

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

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

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

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

Section 5.1 What is a "clinical research study"?

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

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

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

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

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

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

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

If you plan on participating in a clinical research study, contact Member Services (phone numbers are printed on the back cover of this booklet).

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

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

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

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

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

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

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

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

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (www.medicare.gov). You

can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

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

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

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

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

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

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

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

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

SECTION 7 Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of durable medical equipment own the equipment after paying copayments for the item for 13 months. As a member of our plan, there are also certain types of durable medical equipment you will own after paying copayments or coinsurance for the item for a specified number of months. Your previous payments towards a durable medical equipment item when you had Original Medicare do not count towards payments you make while a member of our plan. If you acquire ownership of a durable medical equipment item while you are a member of our plan, the provider may bill the plan for a maintenance fee every six months. There are also certain types of durable medical equipment you will not acquire ownership no matter how many payments you make for the item while a member of our plan. Call Member Services (phone numbers are printed on the back cover of this booklet) to find out about the rental or ownership requirements of durable medical equipment and the documentation you need to provide.

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

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

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

CHAPTER 4

Medical Benefits Chart (what is covered and what you pay)

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

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

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

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

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

- The **"deductible"** is the amount you must pay for medical services before our plan begins to pay its share. (Section 1.2 tells you more about your plan deductible.)
- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

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

Section 1.2 What is your plan deductible?

Your deductible is $150. This is the amount you have to pay out-of-pocket before we will pay our share for your covered medical services. Until you have paid the deductible amount, you must pay the full cost for most of your covered services. (The deductible does not apply to the services that are listed below.) Once you have paid your deductible, we will begin to pay our share of the costs for covered medical services and you will pay your share (your copayment or coinsurance amount) for the rest of the calendar year.

The deductible does not apply to some services, including certain in-network preventive services. This means that we will pay our share of the costs for these services even if you haven't paid your deductible yet.

The deductible does not apply to the following services received IN-NETWORK:

- Acupuncture and naturopathy from the "Complementary/Alternative health care" benefit category
- Additional online and telephonic smoking cessation counseling from the “Smoking and tobacco use cessation” benefit category
- Annual physical exam (routine non-Medicare covered)
- Chiropractic services (Medicare-covered)
- Chiropractic services (routine non-Medicare covered) from the "Complementary/Alternative health care" benefit category
- Dental services (Medicare-covered)
- Diabetes self-management training from the "Diabetes self-management training, diabetic services and supplies" benefit category
- Diabetic supplies from the "Diabetes self-management training, diabetic services and supplies" benefit category
- Digital rectal exam from the "Prostate cancer screening exams" benefit category
- Emergency care
- Eye exam (Medicare-covered) from the "Vision care" benefit category
- Eye exam (routine non-Medicare covered) from the "Vision care" benefit category
- Eyewear (Medicare-covered) from the "Vision care" benefit category
- Eyewear (routine non-Medicare covered) from the "Vision care" benefit category
- Fitness Benefit
- Glaucoma screening from the "Vision care" benefit category
- Health education from the "Health and wellness education programs" benefit category
- Hearing tests (Medicare-covered) from the "Hearing services" benefit category
- Home health agency care
- Hospice care (Medicare-covered services) and the one-time only hospice consultation
- Kidney disease education services from the "Services to treat kidney disease and conditions" benefit category
- Lab services from the "Outpatient diagnostic tests and therapeutic services and supplies" benefit category
- Nurse Advice Line from the "Health and wellness education programs" benefit category
- Outpatient mental health care
- Outpatient substance abuse services
- Podiatry services (Medicare-covered)
- Preventive services (those indicated in the Medical Benefits Chart with an apple, unless otherwise noted)
- Primary care doctor office visits from the "Physician/Practitioner services, including doctor's office visits" benefit category
- Screening barium enema from the "Colorectal cancer screening" benefit category

- Specialist office visits from the "Physician/Practitioner services, including doctor's office visits" benefit category
- Therapeutic shoes and inserts from the "Diabetes self-management training, diabetic services and supplies" benefit category
- Urgently needed services
- Worldwide Emergency/Urgent coverage
- X-rays from the "Outpatient diagnostic tests and therapeutic services and supplies" benefit category

The deductible does not apply to the following services received OUT-OF-NETWORK:

- Acupuncture and naturopathy from the "Complementary/Alternative health care" benefit category
- Additional online and telephonic smoking cessation counseling from the "Smoking and tobacco use cessation" benefit category
- Annual physical exam (routine non-Medicare covered)
- Chiropractic services (routine non-Medicare covered) from the "Complementary/Alternative health care" benefit category
- Emergency care
- Eye exam (routine non-Medicare covered) from the "Vision care" benefit category
- Eyewear (routine non-Medicare covered) from the "Vision care" benefit category
- Health education from the "Health and wellness education programs" benefit category
- Nurse Advice Line from the "Health and wellness education programs" benefit category
- Preventive services (those indicated in the Medical Benefits Chart with an apple, unless otherwise noted) 🍎
- Urgently needed services
- Worldwide Emergency/Urgent coverage

Section 1.3 What is the most you will pay for covered medical services?

Under our plan, there are two different limits on what you have to pay out-of-pocket for covered medical services:

- Your **in-network maximum out-of-pocket amount** is $2,500. This is the most you pay during the calendar year for covered plan services received from network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services from network providers count toward this in-network maximum out-of-pocket amount. (The amounts you pay for plan premiums and services from out-of-network providers do not count toward your in-network maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your in-network maximum out-of-pocket amount. These services are marked with an asterisk (*) in the Medical Benefits Chart.) If you have paid $2,500 for covered services from network providers, you will not have any

out-of-pocket costs for the rest of the year when you see our network providers. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

- Your **combined maximum out-of-pocket amount** is $5,100. This is the most you pay during the calendar year for covered plan services received from both in-network and out-of-network providers. The amounts you pay for deductibles, copayments, and coinsurance for covered services count toward this combined maximum out-of-pocket amount. (The amounts you pay for your plan premiums do not count toward your combined maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your combined maximum out-of-pocket amount. These services are marked with a diamond (◈) in the Medical Benefits Chart.) If you have paid $5,100 for covered services, you will have 100% coverage and will not have any out-of-pocket costs for the rest of the year for covered services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.4 Our plan does not allow providers to "balance bill" you

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

Here is how this protection works.

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

- If you believe a provider has "balance billed" you, call Member Services (phone numbers are printed on the back cover of this booklet).

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

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

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

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- Some of the services listed in the Medical Benefits Chart are covered as in-network services *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from our plan.
    - Covered services that need approval in advance to be covered as in-network services are marked in *italics* in the Medical Benefits Chart.
    - You never need approval in advance for out-of-network services from out-of-network providers.
    - While you don't need approval in advance for out-of-network services, you or your doctor can ask us to make a coverage decision in advance.

Other important things to know about our coverage:

- For benefits where your cost-sharing is a coinsurance percentage, the amount you pay depends on what type of provider you receive the services from:
    - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
    - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers.
    - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers.

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2017* Handbook. View it online at www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.).
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2017, either Medicare or our plan will cover those services.

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

Medical Benefits Chart

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for this preventive screening.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for this preventive screening.
Ambulance services *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required, for out-of-network services.* • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by the plan. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. You pay $100 per one-way trip for Medicare-covered ambulance services. No charge for more than one trip in a single day.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. You pay $100 per one-way trip for Medicare-covered ambulance services. No charge for more than one trip in a single day.

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

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39. • One screening mammogram every 12 months for women age 40 and older. • Clinical breast exams once every 24 months. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for covered screening mammograms.	There is no coinsurance, copayment, or deductible for covered screening mammograms
Cardiac rehabilitation services *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required, for out-of-network services.*	You pay the amounts shown below after the one-time combined in-network and out-of-network	You pay the amounts shown below after the one-time combined in-network and out-of-network

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	yearly plan deductible of $150 has been satisfied. You pay $25 for each Medicare-covered cardiac rehabilitation services visit.	yearly plan deductible of $150 has been satisfied. You pay $40 for each Medicare-covered cardiac rehabilitation services visit.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months). For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
copayment or coinsurance will apply for the care received for the existing medical condition.		
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months. • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services *In-network services may require prior authorization (approval in advance) to be covered except in an emergency. Prior authorization is recommended, although not required, for out-of-network services.* Covered services include: • We cover Manual manipulation of the spine to correct subluxation	You pay $15 for each Medicare-covered visit for the manual manipulation of the spine to correct subluxation.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. You pay $15 for each Medicare-covered visit for the manual manipulation of the spine to correct subluxation.

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
Colorectal cancer screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. One of the following every 12 months: • Guaiac-based fecal occult blood test (gFOBT) • Fecal immunochemical test (FIT) DNA based colorectal screening every 3 years For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.
Complementary/Alternative health care*◈ *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required, for out-of-network services.* You are not held liable for any charges for services determined to be "not medically necessary" when you see an in-network provider unless you agreed in writing to such liability before the services were	You pay $15 for each routine (Non-Medicare covered) chiropractic, acupuncture, or naturopathy visit.*◈ There is a combined in-	You pay $15 for each routine (Non-Medicare covered) chiropractic, acupuncture, or naturopathy visit.*◈ There is a combined in-

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
rendered. If you see an out-of-network provider you may be responsible for services determined to be "not medically necessary" • Routine (Non-Medicare covered) chiropractic services • Acupuncture • Naturopathy *The amounts you pay for these services do not count towards your in-network maximum out-of-pocket amount of $2,500. ◈The amounts you pay for these services do not count toward your combined maximum out-of-pocket amount of $5,100. Refer to "Additional Benefit Information" later in this chapter for more information on Complementary/Alternative health care services.	network and out-of-network $500 annual coverage limit for Complementary/ Alternative health care services.	network and out-of-network $500 annual coverage limit for Complementary/ Alternative health care services.
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. We cover: Medicare-covered dental services include the following: • Otherwise non-covered procedures or services, such as tooth removal, when performed by a dentist incident to and as an integral part of an otherwise Medicare-covered procedure. • Extractions of teeth to prepare jaw for radiation treatment of neoplastic disease. • Dental exams prior to kidney transplantation.	You pay $25 for Medicare-covered dental services. Routine (Non-Medicare covered) preventive and comprehensive dental services are not covered. However, this plan covers routine preventive and comprehensive dental services for an extra cost.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied, ***excluding routine preventive and comprehensive dental services.*** You pay $40 for Medicare-

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
	Refer to Section 2.2, "*Extra 'optional supplemental' benefits you can buy*", later in this chapter for more information on optional supplemental dental services, including limitations.	covered dental services. Routine (Non-Medicare covered) preventive and comprehensive dental services are not covered. However, this plan covers routine preventive and comprehensive dental services for an extra cost. Refer to Section 2.2, "*Extra 'optional supplemental' benefits you can buy*", later in this chapter for more information on optional supplemental dental services, including limitations.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a	There is no coinsurance, copayment, or deductible for an annual depression screening visit.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
copayment or coinsurance will apply for the care received for the existing medical condition.		
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. There is no coinsurance, copayment, or deductible for each Medicare-covered fasting plasma glucose tests for persons at risk of diabetes.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests. There is no coinsurance, copayment, or deductible for each Medicare-covered fasting plasma glucose tests for persons at risk of diabetes.
Diabetes self-management training, diabetic services and supplies *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required, for out-of-network services. No prior authorization is required for the diabetes self-management training preventive benefit.* For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions	There is no copayment for Medicare-covered diabetes supplies. You pay 15% coinsurance for Medicare-covered therapeutic shoes for people with diabetes who have severe	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. There is no copayment for Medicare-

Services that are covered for you	What you must pay when you get these services	
	In-Network	**Out-of-Network**
for checking the accuracy of test strips and monitors. o Supplies to monitor your blood glucose may be obtained through a pharmacy and may be limited to supplies from select manufacturers. Please contact Member Services for additional information. Phone numbers are listed on the back cover of this booklet. • For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • Diabetes self-management training is covered under certain conditions.	diabetic foot disease. There is no coinsurance, copayment, or deductible for beneficiaries eligible for the diabetes self-management training preventive benefit.	covered diabetes supplies. You pay 20% coinsurance for Medicare-covered therapeutic shoes for people with diabetes who have severe diabetic foot disease. There is no coinsurance or, copayment for beneficiaries eligible for the diabetes self-management training preventive benefit.
Durable medical equipment and related supplies *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required, for out-of-network services.* (For a definition of "Durable Medical Equipment," see Chapter 10 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. We cover all medically necessary durable medical equipment covered by Original Medicare. If our	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. You pay 15% coinsurance for Medicare-covered durable medical	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. You pay 20% coinsurance for Medicare-covered durable medical

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you.	equipment and related supplies.	equipment and related supplies.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. • Coverage in the United States[1] For coverage outside of the United States[1], please see "Worldwide Emergency/Urgent Coverage" below in this Medical Benefits Chart. [1]United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.	You pay $75 for each Medicare-covered emergency room visit. You do not pay this amount if you are admitted to the hospital within 24 hours. If you receive emergency care at an out-of-network hospital and get inpatient care after your emergency condition is stabilized, your cost is the cost sharing you would pay at an in-network hospital.	You pay $75 for each Medicare-covered emergency room visit. You do not pay this amount if you are admitted to the hospital within 24 hours. If you receive emergency care at an out-of-network hospital and get inpatient care after your emergency condition is stabilized, your cost is the cost sharing you would pay at an in-network hospital.
Fitness Benefit	There is no coinsurance, copayment, or deductible for Fitness Benefit.	Fitness Benefit is not covered out of network

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
	Refer to "Additional Benefit Information" later in this chapter for more information on Fitness benefits.	
Health and wellness education programs **Health Education** Trained clinicians promote healthy behaviors and help build skills to enhance self-care capabilities. Provides support/education on treatment choices to assist in making health care decisions. Clinicians also send educational materials and advise of educational modules on Health Net's website. **Nurse Advice Line** Toll-free telephonic coaching and nurse advice from trained clinicians are available 24 hours a day, 7 days a week. Health Net's Nurse Advice Line provides real time health care assessments to help the member determine the level of care needed at the moment. Nurses provide 1:1 consultation, answers to health questions and symptom management support that empower members to make confident and appropriate decisions about their care and treatment. Members can access the nurse advice line by calling 1-800-893-5597, TTY (711).	There is no copayment, coinsurance or deductible for health and wellness education programs. Refer to "Decision Power®: Health and Wellness" under "Additional Benefit Information" later in this chapter for more information on these benefits.	There is no copayment, coinsurance or deductible for health and wellness education programs. Refer to "Decision Power®: Health and Wellness" under "Additional Benefit Information" later in this chapter for more information on these benefits.
Hearing services Covered services include: Diagnostic hearing and balance evaluations performed	You pay $25 for each Medicare-covered hearing test.	You pay the amounts shown below after the one-time combined in-

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.		network and out-of-network yearly plan deductible of $150 has been satisfied. You pay $40 for each Medicare-covered hearing test.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months. For women who are pregnant, we cover: • Up to three screening exams during a pregnancy. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered preventive HIV screening.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered preventive HIV screening.
Home health agency care *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required, for out-of-network services.* Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means	There is no coinsurance, copayment or deductible for Medicare-covered home health visits.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied.

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week). • Physical therapy, occupational therapy, and speech therapy. • Medical and social services. • Medical equipment and supplies.		You pay 30% coinsurance for Medicare-covered home health visits.
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief. • Short-term respite care. • Home care. <u>For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis</u>: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. <u>For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:</u> If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network:	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan. You pay $25 for the one-time only hospice consultation.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan. You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied.

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
• If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services. • If you obtain the covered services from an out-of-network provider, you pay the plan cost-sharing for out-of-network services. For services that are covered by our plan but are not covered by Medicare Part A or B: Our plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services. **Note:** If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services. Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.		You pay $40 for the one-time only hospice consultation.
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine. • Flu shots, once a year in the fall or winter. • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B. • Other vaccines if you are at risk and they meet Medicare Part B coverage rules. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for the Medicare-covered pneumonia, influenza, and Hepatitis B vaccines. For other Medicare-covered vaccines (if you are at risk and they meet Medicare Part B coverage rules), please refer to the Medicare Part B	There is no coinsurance, copayment, or deductible for the Medicare-covered pneumonia, influenza, and Hepatitis B vaccines. For other Medicare-covered vaccines (if you are at risk and they meet Medicare Part B coverage rules), please refer to the Medicare

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
	prescription drugs section of this chart for applicable cost-sharing.	Part B prescription drugs section of this chart for applicable cost-sharing.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required, for out-of-network services.* You are covered for unlimited days per benefit period for Medicare-covered stays. No hospital stay required prior to admission for Medicare-covered stays. Covered services include but are not limited to: • Semi-private room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive care or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Physical, occupational, and speech language therapy. • Inpatient substance abuse services.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. You pay $175 each day from days 1 through 8 per benefit period, for Medicare-covered inpatient hospital care. There is no coinsurance or copayment from days 9 and beyond per benefit period, for Medicare-covered inpatient hospital care. Your inpatient benefits are based upon the	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. You pay $200 each day from days 1 through 8 per benefit period, for Medicare-covered inpatient hospital care. There is no coinsurance or copayment from days 9 and beyond per benefit period, for Medicare-covered inpatient hospital care. Your inpatient benefits are based upon the

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are at a distant location, you may choose to go locally or distant as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a distant location (farther away than the normal community patterns of care) and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Physician services. **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at https://www.medicare.gov/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	date of admission. If you are admitted to the hospital in 2017 and are not discharged until 2018, the 2017 copayments will apply until you are discharged from the hospital or transferred to a skilled nursing facility. If you get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital. A benefit period begins the first day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days	date of admission. If you are admitted to the hospital in 2017 and are not discharged until 2018, the 2017 copayments will apply until you are discharged from the hospital or transferred to a skilled nursing facility. If you get inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost sharing you would pay at a network hospital. A benefit period begins the first day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
	in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.	in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.
Inpatient mental health care *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required, for out-of-network services.* Covered services include mental health care services that require a hospital stay. You are covered for 90 days per benefit period for Medicare-covered stays. • There is a 190-day lifetime limit for inpatient mental health services provided in a psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital. • If the member has used part of the 190-day Medicare lifetime benefit prior to enrolling in our Plan, then the member is only entitled to receive the difference between the number of lifetime days already used and the Plan benefit. Refer to "Additional Benefit Information" later in this chapter for more information on mental health	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. You pay $175 each day from days 1 through 8 per benefit period, for Medicare-covered inpatient mental health care. There is no coinsurance or copayment from days 9 through 90 per benefit	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. You pay $200 each day from days 1 through 8 per benefit period, for Medicare-covered inpatient mental health care. There is no coinsurance or copayment from days 9 through 90 per benefit

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
services.	period, for Medicare-covered inpatient mental health care. Your inpatient benefits are based upon the date of admission. If you are admitted to the hospital in 2017 and are not discharged until 2018, the 2017 copayments will apply until you are discharged from the hospital or transferred to a skilled nursing facility. A benefit period begins the first day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a	period, for Medicare-covered inpatient mental health care. Your inpatient benefits are based upon the date of admission. If you are admitted to the hospital in 2017 and are not discharged until 2018, the 2017 copayments will apply until you are discharged from the hospital or transferred to a skilled nursing facility. A benefit period begins the first day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
	skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.	skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.
Inpatient services covered during a non-covered inpatient stay *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Refer to the Medical Benefits Chart for the specific service. Prior authorization is recommended, although not required, for out-of-network services.* If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the hospital or the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services. • Diagnostic tests (like lab tests). • X-ray, radium, and isotope therapy including technician materials and services. • Surgical dressings. • Splints, casts and other devices used to reduce fractures and dislocations. • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including	The listed services will continue to be covered at the cost-sharing amounts shown in the Medical Benefits Chart for the specific service. For Medicare-covered medical supplies, including cast and splints, you pay the applicable cost-sharing amount where the specific service is provided. For example, if these medical supplies were used during a visit to an emergency room, then they would be included as part of the emergency room	The listed services will continue to be covered at the cost-sharing amounts shown in the Medical Benefits Chart for the specific service. For Medicare-covered medical supplies, including cast and splints, you pay the applicable cost-sharing amount where the specific service is provided. For example, if these medical supplies were used during a visit to an emergency room, then they would be included as part of the emergency room

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition. • Physical therapy, speech therapy, and occupational therapy.	visit copayment.	visit copayment.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services.	There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services.
Medicare Part B prescription drugs *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required, for out-of-network services.*	You pay the amounts shown below after the one-time combined in-network and out-of-network	You pay the amounts shown below after the one-time combined in-network and out-of-network

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services. • Drugs you take using durable medical equipment (such as nebulizers) that were authorized by the plan. • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant. • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Antigens. • Certain oral anti-cancer drugs and anti-nausea drugs. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa). • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases.	yearly plan deductible of $150 has been satisfied. You pay 15% coinsurance for Medicare-covered Part B drugs. You pay 15% coinsurance for Medicare-covered Part B chemotherapy drugs.	yearly plan deductible of $150 has been satisfied. You pay 20% coinsurance for Medicare-covered Part B drugs. You pay 20% coinsurance for Medicare-covered Part B chemotherapy drugs.

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Outpatient diagnostic tests and therapeutic services and supplies *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required, for out-of-network services.* Covered services include, but are not limited to: • X-rays. • Therapeutic radiological services (radiation therapy, radium and isotope), including technician materials and supplies • Surgical supplies, such as dressings. • Splints, casts and other devices used to reduce fractures and dislocations. • Laboratory services (includes blood tests, urinalysis, and some screening tests) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied, ***excluding the following services: x-ray and laboratory services.*** You pay $12 per visit for Medicare-covered x-rays.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. You pay $20 per visit for Medicare-covered x-rays. There is no

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
need. All other components of blood are covered beginning with the first pint used. • Other diagnostic tests. • Diagnostic radiological services (includes complex tests such as CT, MRI, MRA, SPECT) • EKG tests	There is no copayment for Medicare-covered laboratory services. There is no coinsurance or copayment for Medicare-covered blood and blood services. You pay 15% coinsurance for Medicare-covered complex diagnostic imaging services. You pay 15% coinsurance for Medicare-covered radiation therapy and Medicare-covered diagnostic procedures and tests (complex diagnostic radiology services). There is no coinsurance or copayment for Medicare-covered EKG	copayment for Medicare-covered laboratory services. There is no coinsurance or copayment for Medicare-covered blood and blood services. You pay 20% coinsurance for Medicare-covered complex diagnostic imaging services. You pay 20% coinsurance for Medicare-covered radiation therapy and Medicare-covered diagnostic procedures and tests (complex diagnostic radiology services). There is no coinsurance or copayment for Medicare-covered EKG

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
	tests. For Medicare-covered medical supplies, including cast and splints, you pay the applicable cost-sharing amount where the specific service is provided. For example, if these medical supplies were used during a visit to an emergency room, then they would be included as part of the emergency room visit copayment. If the doctor provides you services in addition to outpatient diagnostic procedures, tests, and lab services, separate cost sharing may apply.	tests. For Medicare-covered medical supplies, including cast and splints, you pay the applicable cost-sharing amount where the specific service is provided. For example, if these medical supplies were used during a visit to an emergency room, then they would be included as part of the emergency room visit copayment. If the doctor provides you services in addition to outpatient diagnostic procedures, tests, and lab services, separate cost sharing may apply.
Outpatient hospital services *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Refer to the Medical Benefits Chart for the*	You pay the applicable cost-sharing amounts shown in this Medical Benefits	You pay the applicable cost-sharing amounts shown in this Medical Benefits

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

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
Outpatient mental health care *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required, for out-of-network services.* Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	You pay $25 for each Medicare-covered individual or group therapy visit. Refer to "Additional Benefit Information" later in this chapter for more information on outpatient mental health services, including the outpatient registration process.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. You pay $40 for each Medicare-covered individual or group therapy visit. Refer to "Additional Benefit Information" later in this chapter for more information on outpatient mental health services, including the outpatient registration process.
Outpatient rehabilitation services *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required, for out-of-network services.* Covered services include: physical therapy,	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	deductible of $150 has been satisfied. You pay $25 for each Medicare-covered outpatient rehabilitation therapy visit.	deductible of $150 has been satisfied. You pay $40 for each Medicare-covered outpatient rehabilitation therapy visit.
Outpatient substance abuse services *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required, for out-of-network services.* Covered services include: Substance Use Disorder services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional or program as allowed under applicable state laws.	You pay $25 for each Medicare-covered individual or group therapy visit. Refer to "Additional Benefit Information" later in this chapter for more information on outpatient mental health services.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. You pay $40 for each Medicare-covered individual or group therapy visit. Refer to "Additional Benefit Information" later in this chapter for more information on outpatient mental health services.

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers Includes outpatient observation services. *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required, for out-of-network services.* **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient."	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. You pay $175 for each Medicare-covered visit to an outpatient hospital facility. You pay $150 for each Medicare-covered visit to an ambulatory surgical center.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. You pay $200 for each Medicare-covered visit to an outpatient hospital facility. You pay $175 for each Medicare-covered visit to an ambulatory surgical center.
Partial hospitalization services *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required, for out-of-network services.* "Partial hospitalization" is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. There is no coinsurance or copayment for	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. There is no coinsurance or copayment for

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
	the Medicare-covered partial hospitalization program. Refer to "Additional Benefit Information" later in this chapter for more information on outpatient mental health services.	the Medicare-covered partial hospitalization program. Refer to "Additional Benefit Information" later in this chapter for more information on outpatient mental health services.
Physician/Practitioner services, including doctor's office visits Covered services include: • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location. • Consultation, diagnosis, and treatment by a specialist. • Basic hearing and balance exams performed by your POC or specialist, if your doctor orders it to see if you need medical treatment. • Second opinion prior to surgery. • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician). Separate cost-sharing may apply depending on services rendered.	You pay $12 for each Medicare-covered primary care doctor office visit or medically-necessary surgery services furnished in a physician's office. You pay $25 for each Medicare-covered specialist visit or medically-necessary surgery services furnished in a specialist's office. For medically-necessary surgery services	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. You pay $20 for each Medicare-covered primary care doctor office visit or medically-necessary surgery services furnished in a physician's office. You pay $40 for each Medicare-

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
	furnished in a certified ambulatory surgical center, hospital outpatient department, or any other location, you pay the applicable cost-sharing amount for where the specific service is provided.	covered specialist visit or medically-necessary surgery services furnished in a specialist's office. For medically-necessary surgery services furnished in a certified ambulatory surgical center, hospital outpatient department, or any other location, you pay the applicable cost-sharing amount for where the specific service is provided.
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	You pay $25 for each Medicare-covered visit (medically necessary foot care).	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. You pay $40 for

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
		each Medicare-covered visit (medically necessary foot care).
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam. • Prostate Specific Antigen (PSA) test. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for an annual PSA test.	There is no coinsurance, copayment, or deductible for an annual PSA test.
Prosthetic devices and related supplies *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required, for out-of-network services.* Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision care" later in this section for more detail. • Medicare-covered parenteral and enteral	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. You pay 15% coinsurance for Medicare-covered prosthetic devices and related supplies.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. You pay 20% coinsurance for Medicare-covered prosthetic devices and

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
nutrition (PEN): Covers related supplies and nutrients. Does not cover baby food and other regular grocery products that can be blenderized and used with the enteral system or any additional nutritional supplementation (such as those for daily protein or caloric intake).	You pay 15% coinsurance for Medicare-covered parenteral and enteral nutrition supplies and nutrients.	related supplies. You pay 20% coinsurance for Medicare-covered parenteral and enteral nutrition supplies and nutrients.
Pulmonary rehabilitation services *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required, for out-of-network services.* Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. You pay $25 for each Medicare-covered pulmonary rehabilitation services visit.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. You pay $40 for each Medicare-covered pulmonary rehabilitation services visit.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol

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

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.		
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling to prevent STIs preventive benefit.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling to prevent STIs preventive benefit.
Services to treat kidney disease and conditions **Covered services include:** • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3). • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care). • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply). Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the section, "Medicare Part B prescription drugs."	$150 has been satisfied***, excluding Medicare-covered kidney disease education services.*** You pay 20% coinsurance for Medicare-covered renal dialysis (kidney) services. There is no coinsurance, copayment or deductible for Medicare-covered kidney disease education services, up to 6 sessions per lifetime.	$150 has been satisfied. You pay 20% coinsurance for Medicare-covered renal dialysis (kidney) services. There is no coinsurance or copayment for Medicare-covered kidney disease education services, up to 6 sessions per lifetime.
Skilled Nursing Facility (SNF) Care *In-network services may require prior authorization (approval in advance) to be covered, except in an emergency. Prior authorization is recommended, although not required, for out-of-network services.* (For a definition of "Skilled Nursing Facility (SNF) Care," see Chapter 10 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") You are covered for 100 days each benefit period. No hospital stay required prior to admission. Covered services include but are not limited to:	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. There is no	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied. There is no

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
• Semi-private room (or a private room if medically necessary). • Meals, including special diets. • Skilled nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors). • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs. • Laboratory tests ordinarily provided by SNFs. • X-rays and other radiology services ordinarily provided by SNFs. • Use of appliances such as wheelchairs ordinarily provided by SNFs. • Physician/Practitioner services. Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital.	coinsurance or copayment each day from days 1 through 20 per benefit period, for Medicare-covered skilled nursing facility care. You pay $100 each day from days 21 through 100 per benefit period, for Medicare-covered skilled nursing facility care. You pay all costs for each day after day 100 in the benefit period. Your inpatient benefits are based upon the date of admission. If you are admitted to the hospital in 2017 and are not discharged until 2018, the 2017 copayments will apply until you are discharged from the hospital or transferred to a skilled nursing	coinsurance or copayment each day from days 1 through 20 per benefit period, for Medicare-covered skilled nursing facility care. You pay $150 each day from days 21 through 100 per benefit period, for Medicare-covered skilled nursing facility care. You pay all costs for each day after day 100 in the benefit period. Your inpatient benefits are based upon the date of admission. If you are admitted to the hospital in 2017 and are not discharged until 2018, the 2017 copayments will apply until you are discharged from the hospital or transferred to a skilled nursing

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
	facility. A benefit period begins the first day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.	facility. A benefit period begins the first day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit	If you haven't been diagnosed with an illness caused or complicated by tobacco use: There is no coinsurance, copayment, or deductible for the Medicare-	If you haven't been diagnosed with an illness caused or complicated by tobacco use: There is no coinsurance, copayment, or deductible for the Medicare-

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
attempts within a 12-month period, however, you will pay the applicable inpatient or outpatient cost-sharing. Each counseling attempt includes up to four face-to-face visits. Additional online and telephonic smoking cessation counseling is available from trained clinicians which includes guidance on steps of change, planning, counseling and education. Refer to "Decision Power®: Health and Wellness" under "Additional Benefit Information" later in this chapter for more information on this benefit. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	covered smoking and tobacco use cessation preventive benefits. If you have been diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that is affected by tobacco: You pay the applicable cost sharing for Medicare-covered smoking cessation counseling sessions where services are received. For example, if your counseling session is received as part of an outpatient mental health visit, you pay the applicable outpatient mental health cost sharing.	covered smoking and tobacco use cessation preventive benefits. If you have been diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that is affected by tobacco: You pay the applicable cost sharing for Medicare-covered smoking cessation counseling sessions where services are received. For example, if your counseling session is received as part of an outpatient mental health visit, you pay the applicable outpatient mental health cost sharing.
Urgently needed services Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or	You pay $25 for each Medicare-covered urgently	You pay $50 for each Medicare-covered urgently

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. Cost sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. • Coverage in the United States [1] • Urgently needed services received outside of the United States[1] may be considered an emergency under the worldwide emergency/urgent coverage benefit. For more information, see "Worldwide Emergency/Urgent Coverage" in this Medical Benefits Chart below. [1] United States means 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.	needed services visit. You do not pay this amount if you are admitted to the hospital within 24 hours.	needed services visit. You do not pay this amount if you are admitted to the hospital within 24 hours.
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older, and Hispanic-Americans who are age 65 or older: glaucoma screening once per year. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each	You pay $10 for each Medicare-covered eye exams (diagnosis and treatment for diseases and conditions of the eye). There is no coinsurance, copayment, or deductible for Medicare-covered glaucoma screening.	You pay the amounts shown below after the one-time combined in-network and out-of-network yearly plan deductible of $150 has been satisfied, ***excluding routine vision care.*** You pay $40 for each Medicare-covered eye

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Additional covered services include: • Routine eye exam (refraction), limited to one exam per year*◈ • Routine eyewear: Choice of 1 routine eyewear purchase every 24 months*◈[1] o Limited to 1 set of frames and 1 pair of eyeglass lenses or contact lenses (non-medically necessary conventional or disposable) during a 24-month period[1] o Contact lens fit and two follow-up visits available once a comprehensive eye exam has been completed.[2] [1]Multi-year benefits may not be available in subsequent years. [2]If disposable Contact Lenses are used, you need to purchase enough pairs of disposable contact lenses to reach the benefit maximum limit at one visit. If you do not use the full benefit maximum amount during the initial purchase, the remaining balance will not carry over. *The amounts you pay for these services do not count towards your in-network maximum out-of-pocket amount of $2,500. ◈The amounts you pay for these services do not count toward your combined maximum out-of-pocket amount of $5,100. Additional routine eyewear benefits available. Refer to "Additional Benefit Information" later in this chart for more information on routine vision benefits.	You pay $10 for Medicare-covered diabetic retinopathy screening. There is no coinsurance, copayment, or deductible for Medicare-covered eyewear after cataract surgery. You pay $10 for each routine (Non-Medicare covered) eye exam.*◈ There is no copayment for routine (Non-Medicare covered) eyewear.*◈ There is no coinsurance, copayment or deductible for contact lens fit and follow-up visits. There is a combined benefit maximum limit of $250 once every 24 months for routine (Non-	exams (diagnosis and treatment for diseases and conditions of the eye). There is no coinsurance or copayment for Medicare-covered glaucoma screening. You pay $40 for Medicare-covered diabetic retinopathy screening. There is no coinsurance or copayment for Medicare-covered eyewear after cataract surgery. Health Net pays the first $45 for routine (Non-Medicare covered) eye exams. You pay any remaining balance up to the billed charge. ◈ There is no copayment for routine (Non-

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
	Medicare covered) eyewear purchased from in-network or out-of-network providers (multi-year benefits may not be available in subsequent years).	Medicare covered) eyewear.◈ There is no coinsurance, copayment or deductible for contact lens fit and follow-up visits. There is a combined benefit maximum limit of $250 once every 24 months for routine (Non-Medicare covered) eyewear purchased from in-network or out-of-network providers (multi-year benefits may not be available in subsequent years).
“Welcome to Medicare” Preventive Visit The plan covers the one-time “Welcome to Medicare” preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the “Welcome to Medicare” preventive visit only within the first 12 months you have Medicare Part B. When you make your	There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.	There is no coinsurance, copayment, or deductible for the “Welcome to Medicare” preventive visit.

Services that are covered for you	**What you must pay** when you get these services	
	In-Network	**Out-of-Network**
appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit. For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.		
Worldwide Emergency/Urgent Coverage Worldwide emergency/urgent coverage. Defined as urgent, emergent, and post-stabilization care received outside of the United States.[1] • Limited only to services that would be classified as emergency, urgently needed, or post-stabilization care had they been provided in the United States.[1] • Ambulance services are covered in situations where getting to the emergency room in any other way could endanger your health. • Foreign taxes and fees (including, but not limited to, currency conversion or transaction fees) are not covered. [1]United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.	There is no coinsurance, copayment, or deductible for worldwide emergency/ urgent coverage received outside of the United States.[1] There is an annual limit of $50,000 for Worldwide Emergency/ Urgent Coverage.	There is no coinsurance, copayment, or deductible for worldwide emergency/ urgent coverage received outside of the United States.[1] There is an annual limit of $50,000 for Worldwide Emergency/ Urgent Coverage.

Additional Benefit Information

Mental Health Care and Substance Abuse Benefits

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

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

Your plan gives you two levels of benefits and many choices of providers. You receive a specific level of benefits based on how you choose to get covered services. Think of your PPO as two plans in one:

- In-network benefits apply when you receive covered services from eligible mental health professionals in MHN's PPO network.
- Out-of-network benefits apply when you receive covered services from eligible mental health professionals who do not participate in MHN's PPO network (Out-of-Network Providers).

Getting Services from MHN In-Network providers

You may save money when using in-network providers (providers who are in MHN's PPO network), or you may pay a little more to use providers who are out-of-network (providers who are not in the MHN's PPO network).

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

MHN must authorize these services and supplies to be covered. To get authorization for in-network services, you must call MHN at **1-800-977-8216** (or TTY: **711** for the hearing and speech impaired), Monday-Friday, 8:00 a.m. - 6:00 p.m., PT. MHN will refer you to a nearby MHN Network Provider in your area. That provider will evaluate you to determine if additional treatment is necessary. If you need treatment, the MHN Network Provider will develop a treatment plan and submit that plan to MHN for review. When authorized by MHN, the proposed services will be covered by this plan.

If MHN does not approve the treatment plan, no further services or supplies will be covered for that condition. However, MHN may direct you to community resources where alternative forms of assistance are available.

For up-to-date provider information or to get in-network services, please contact MHN at **1-800-977-8216** (or TTY: **711** for the hearing and speech impaired), Monday-Friday, 8:00 a.m. - 6:00

p.m., PT. Or visit MHN's web site at www.mhn.com for a list of MHN participating providers in your area. You may also contact the Health Net Medicare Advantage Member Services Department at the telephone number located on the back cover of this booklet, or visit our website at www.healthnet.com.

Outpatient

For outpatient, office-based mental health services, you or your provider should contact MHN to confirm your benefits. You or your provider, can verify eligibility, and discuss your benefits and any applicable copayments. Confirming your outpatient benefits and cost share can help ensure smooth claims payment as your case will be in our system.

Medical necessity review may take place in the form of discussion with your provider about your treatment plan sometime during your course of treatment. MHN is available to answer any questions regarding your care. To contact MHN, call **1-800-977-8216** (or TTY: **711** for the hearing and speech impaired), Monday-Friday, 8:00 a.m. - 6:00 p.m., PT.

Getting Services from Out-of-Network Providers

Out-of-network benefits apply when covered services are received from an Out-of-Network Provider. MHN will review claims received from out-of-providers and payment will be issued if the services received are determined to have been medically necessary covered services.

What Mental Health and Substance Abuse Services are covered?

All Health Net Medicare Advantage members have Mental Health Care and Substance Abuse benefits. Please see the "Inpatient mental health care", "Outpatient mental health care" and "Outpatient substance abuse services" portions of the Medical Benefits Chart for cost-sharing information.

The following Mental Health and Substance Abuse services are covered under your plan. Please refer to the Medical Benefits Chart for copayment, coinsurance and annual maximums information.

Outpatient Services
Outpatient crisis intervention, short-term evaluation and therapy, longer-term specialized therapy and any rehabilitative care that is related to substance abuse are covered with unlimited visits, subject to medical necessity review as determined by MHN. Medication management care is also covered when appropriate. Refer to "Outpatient mental health care" and "Outpatient substance abuse services" in the Medical Benefits Chart for your cost-sharing information.

Second Opinion
For in-network benefit coverage you may request a second opinion when:

- Your MHN Network Provider renders a diagnosis or recommends a treatment plan that you are not satisfied with;
- You are diagnosed with, or a treatment plan is recommended for, a condition that threatens loss of life, limb or bodily function or a substantial impairment, including but not limited to a serious chronic condition; or

- Your MHN Network Provider is unable to diagnose your condition or test results are conflicting.

To request an authorization for a second opinion at the in-network benefit level please contact MHN at **1-800-977-8216** (or TTY: **711** for the hearing and speech impaired), Monday-Friday, 8:00 a.m. - 6:00 p.m., PT. MHN Network Providers will review your request in accordance with MHN's second opinion policy. When you request a second opinion, you will be responsible for any applicable co-payments.

Second opinions for in-network benefit coverage will only be authorized for MHN Network Providers, unless it is demonstrated that an appropriately qualified MHN Network Provider is not available. MHN will ensure that the provider selected for the second opinion is appropriately licensed and has expertise in the specific clinical area in question.

Out-of network benefits for a second opinion apply when covered services are received from an Out-of-Network Provider and have been reviewed and determined as medically necessary.

If you face an imminent and serious threat to health, including, but not limited to, the potential loss of life, limb or other major bodily function, or lack of timeliness would be detrimental to the ability to regain maximum function, the second opinion will be rendered in a timely fashion appropriate to the nature of the condition not to exceed 72 hours of MHN's receipt of the request, whenever possible. For a complete copy of this policy, contact MHN at **1-800-977-8216** (TTY: **711**), Monday-Friday, 8:00 a.m. - 6:00 p.m., PT.

Emergency Services

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

MHN has a licensed clinician available 24 hours a day, seven days a week to address all requests for immediate admission to a facility if the patient poses a danger to self or others or is gravely disabled. MHN can be contacted at **1-800-977-8216** (or TTY: **711** for the hearing and speech impaired) 24 hours a day, seven days a week.

In cases of emergency services, MHN uses the following "Prudent Layperson Standard" definition. The "Prudent Layperson Standard" is as follows: Emergency medical condition means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in: 1) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; 2) serious impairment to bodily function; and/or 3) serious dysfunction of any organ or part.

Emergency services will be covered at the in-network benefit level for hospitalization at all contracted facilities and non-contracted facilities due to an immediate medical emergency. Once the condition is stabilized, services are required to be provided at an MHN in-network facility to receive the in-network benefit level of coverage. MHN will arrange a transfer to an MHN in-

network facility, if necessary, and will be financially responsible for the cost of the transportation. Post-stabilization services received at an out-of-network facility at the member's request will be covered at the out-of-network benefit level.

Inpatient Services

Inpatient treatment of a mental disorder or substance abuse is covered, limited to a combined lifetime maximum of 190 days per member for inpatient mental health services provided in a free standing psychiatric hospital. The 190-day limit does not apply to mental health or substance abuse services provided in a psychiatric unit of a general hospital. Refer to the "Inpatient mental health care" portion of the Medical Benefits Chart for your cost-sharing information.

Covered inpatient services and supplies include:

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

Detoxification

Inpatient services for acute detoxification and treatment of acute medical conditions relating to substance abuse are covered, except as stated under "Mental Disorders and Substance Abuse Exclusion and Limitations."

Mental Disorders and Substance Abuse Exclusions and Limitations

Mental health care as a condition of parole, probation or court-ordered testing for mental disorders is limited to medically necessary services and subject to this plan's visit limits described earlier in this section.

Services and supplies for treating mental disorders and Substance Abuse are covered only as specified in the Medical Benefits Chart under "Inpatient mental health care," "Outpatient mental health care" and "Outpatient substance abuse services."

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

- Court-ordered testing and treatment, except when medically necessary and within the allowable visits under the plan contract.
- Private hospital rooms and/or private duty nursing, unless determined to be a medically necessary service by MHN.
- Treatment in a Residential Treatment Center.
- Ancillary services such as:
    - Vocational rehabilitation and other rehabilitation services.
    - Behavioral training.

  - Speech or occupational therapy.
  - Sleep therapy and employment counseling.
  - Training or educational therapy or services.
  - Other education services.
  - Nutrition services.
- Treatment by providers other than those within licensing categories recognized by Medicare or MHN as providing medically necessary services in accordance with applicable medical community standards.
- In-network inpatient services in excess of those with respect to which Authorization by MHN is obtained when authorization is required. Out-of-network services do not require authorization.
- Out-of-network services that are not "medically necessary" as determined by MHN.
- Psychological testing, except as conducted by a licensed psychologist for assistance in treatment planning, including medication management or diagnostic clarification. All educational, academic and achievement tests, psychological testing related to medical conditions or to determine surgical readiness and automated, computer-based reports are specifically excluded.
- All prescription or non-prescription drugs and laboratory fees, except for drugs and laboratory fees prescribed by a practitioner in connection with inpatient treatment.
- In-network services, treatment, or supplies rendered without authorization when authorization is required, except in the event of emergency services.
- Damage to a hospital or facility caused by the member.
- Healthcare services, treatment or supplies determined to be experimental by MHN in accordance with accepted mental health standards, except as otherwise required by law.
- Treatment for biofeedback, acupuncture or hypnotherapy.
- Healthcare services, treatment, or supplies rendered to the member, which are not medically necessary services. This includes, but is not limited to, services, treatment, or supplies primarily for rest or convalescence, custodial care or domiciliary care as determined by MHN.
- Services received before the member's effective date during an Inpatient stay that began before the member's effective date or services received after the member's coverage ended, except as specifically stated herein.
- Professional services received from a person who lives in the member's home or who is related to the member by blood or marriage.
- Services performed in any emergency room, which are not directly related to the treatment of a mental disorder.
- Services received out of the member's primary state of residence, except in the event of emergency services and as otherwise authorized by MHN.
- All other services, confinements, treatments or supplies not provided primarily for the treatment of specific covered benefits and/or specifically included as covered services elsewhere in this plan.

How do I file a claim for Mental Health and Substance Abuse Services?

In most cases, your mental health provider will submit your claims directly to MHN. If you should receive a bill for the services, submit your claim to MHN. Claims forms can be found online at www.mhn.com or call MHN's Claims Line for assistance at the toll-free number at **1-800-444-4281** (TTY: **711**, available for the hearing and speech impaired), Monday- Friday from 8:00 a.m. - 7:00 p.m., Central time.

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

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

You can also contact MHN at **1-800-977-8216** (or TTY: **711** for the hearing and speech impaired), Monday-Friday, 8:00 a.m. - 6:00 p.m., PT. to check the status of your claim. They will be able to provide a status within 72 hours of receipt of your claim. If a reimbursement is due to you, a check will be mailed no later than 60 days of receipt of your claim.

QUESTIONS?

For up-to-date provider information or to obtain authorization to receive services, please call MHN Services at **1-800-977-8216** (or TTY: **711** for hearing and speech assistance), Monday-Friday, 8:00 a.m. - 6:00 p.m., PT. Calls to these numbers are free. Or visit MHN Services' web site at www.mhn.com.

If you have any further questions about these benefits or services, please contact the Health Net Member Services department at the telephone number located on the back cover of this booklet.

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

Routine Vision Care

Routine eye exams and routine eyewear are administered by Health Net Vision, which is serviced by EyeMed Vision Care, LLC. Vision services are covered as shown in the Medical Benefits Chart earlier in this chapter. You can see any licensed vision provider to receive covered vision care. However, your cost-sharing may be higher when you receive covered services from out-of-network providers than from in-network providers.

Getting services from Health Net Vision In-Network providers

You may save money when using in-network providers (providers who are in Health Net Vision's PPO network). Health Net Vision in-network providers are listed in your *Provider Directory*. For up-to-date provider information, please contact Health Net Vision at **1-866-392-6058** Monday through Saturday, 4:30 a.m. to 8:00 p.m., and Sunday, 8:00 a.m. to 5:00 p.m. Pacific time, except major holidays (or call TTY: **711** for the hearing and speech impaired). You may also contact the Health Net Medicare Advantage Member Services department at the telephone number located on the back cover of this Evidence of Coverage, or visit our website at www.healthnet.com.

Getting services from Out-of-Network Vision providers

Out-of-network benefits apply when covered services are received from a provider not participating in Health Net Vision's network. Health Net Vision will review claims received from out-of-network vision professionals, and payment will be issued if the services received are determined to have been covered services.

What is covered by Health Net Vision?

All members have Medicare-covered vision and routine vision benefits. Please see the "Vision care" portion of the Medical Benefits Chart earlier in this chapter for cost-sharing information.

How much do I pay for routine eyewear covered by this plan?

You have the option to choose from in-network and out-of-network providers when purchasing routine eyewear. You may save money when using in-network providers (providers who are in Health Net Vision's network) or you may pay a little more to use providers who are out-of-network (providers who are not in the Health Net Vision's PPO network).

Health Net will cover one eyewear purchase every 24 months (multi-year benefits may not be available in subsequent years.)

There is no co-payment for routine eyewear; however, there is a $250 benefit maximum amount Health Net Vision will pay for frame purchases, contact lenses (non-medically necessary conventional or disposable[1]), and lenses (standard plastic) every 24 months.

[1]You need to purchase enough pairs of disposable contact lenses to reach your benefit maximum amount. If you do not use the full benefit maximum allowance during the initial purchase, the remaining balance will not carry over.

If you purchase eyewear out-of-network, you will be responsible for 100% of the remaining balance once you've reached the benefit maximum amount. If you purchase eyewear in-network, you may have additional coverage once you've reached the benefit maximum amount:

	In-network: **Once the benefit maximum is reached you pay:**	**Out-of-network:** **Once the benefit maximum is reached you pay:**
Frames, Lens and Options Package	80% of the remaining balance	100% of the remaining balance
Contact lenses (conventional)	85% of the remaining balance	100% of the remaining balance
Contact lenses (disposable)	100% of the remaining balance	100% of the remaining balance

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

What Vision services are not covered by our Plan?

The following items and services are limited or excluded as part of the Routine Vision Care services provided by Health Net Vision:

- Orthoptic or vision training, subnormal vision aids, and any associated supplemental testing.
- Medical and/or surgical treatment of the eye, eyes, or supporting structures (see the Medical Benefits Chart earlier in this chapter under "Vision care" for a description of your Medicare-covered vision coverage).
- Corrective eyewear required by an employer as a condition of employment and safety eyewear, unless specifically covered under plan.
- Services provided as a result of any Worker's Compensation law.
- Plano - non-prescription lenses and non-prescription sunglasses (except for 20% discount).
- Two pair of glasses in lieu of bifocals.
- Benefit is not available on certain frame brands in which the manufacturer imposes a "no discount" policy.
- Aniseikonic lenses.

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

How do I file a Health Net Vision claim?

When you receive services from an out-of-network vision provider, you may have to file a claim with Health Net Vision. Health Net Vision will pay you for any covered services up to the benefit maximum. You are responsible for paying the provider the difference. Please call or write to the Health Net Vision customer service department for a claim form and claim filing instructions at the toll-free number at **1-866-392-6058** Monday through Saturday, 4:30 a.m. to 8:00 p.m., and Sunday, 8:00 a.m. to 5:00 p.m. Pacific time, except major holidays (or call TTY: **711** for the hearing and speech impaired). Out-of-network providers may require payment in full at the time of service.

Attach your itemized bill to the claim form, and mail to:

Health Net Vision
Post Office Box 8504
Mason, OH 45040-7111

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

Complementary/Alternative Health Care

Complementary/Alternative Health Care services are administered by American Specialty Health Group, Inc. (ASH Group). Complementary/Alternative Health Care services consist of Subluxation-Only (Medicare-covered) Chiropractic and Routine (Non-Medicare covered) Chiropractic, Naturopathy, and Acupuncture. These services are covered as shown in the Medical Benefits Chart earlier in this chapter under "Chiropractic care" and "Complementary/Alternative health care." All covered Routine (Non-Medicare covered) Chiropractic, Acupuncture, and Naturopathy services must be Medically Necessary and may require verification of Medical Necessity, except as listed below. ASH Group-contracted practitioners understand this process and are responsible for obtaining any required verification of Medical Necessity. If you seek out-of-network services you may be responsible for obtaining medical necessity verification.

Getting services from In-Network Complementary/Alternative Health Care practitioners

You may save money when using in-network practitioners. In-network practitioners are those who are duly licensed to practice in the state in which services are furnished and who have entered into an agreement with ASH Group to provide covered services to you. ASH Group in-network practitioners are listed in the Wellnet Directory. For up-to-date practitioner information, please contact ASH Group at **1-800-678-9133** (or TTY/TDD **1-877-710-2746** for the hearing and

speech impaired) Monday through Friday, 5:00 a.m. to 6:00 p.m., Pacific time, except holidays. You may also contact the Health Net Medicare Advantage Customer Services department at the telephone number located on the back cover of this booklet, or visit our website at www.healthnet.com.

Getting services from Out-of-Network Complementary/Alternative Health Care practitioners

Out-of-network benefits apply when covered services are received from a practitioner who does not have an agreement with ASH Group. ASH Group will review claims received from out-of-network complementary/alternative care professionals, and payment will be issued if the services received are determined to have been Medically Necessary covered services.

Note: Out-of-network Complementary/Alternative Health Care Services may be subject to verification of Medical Necessity. To ensure that services are covered, prior authorization is recommended, although not required.

Chiropractic Services

What Chiropractic Services are covered?

All Health Net Medicare Advantage members have direct access to ASH Group chiropractors, or out-of-network practitioners qualified to provide the benefit in question and who accept Health Net's terms and conditions of payment for all visits. A copayment is required for each visit to the office. All Chiropractic Services, except for the initial evaluation, urgent services and emergency services may require verification of Medical Necessity.

- A new patient exam, or an established patient exam, for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of chiropractic services. A new patient is one who has not received any professional services from the practitioner, or another practitioner of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the practitioner, or another practitioner of the same specialty who belongs to the same group practice, within the past three years.
- Established patient exams assess the need to initiate, continue, extend, or change a course of treatment. The established patient exam is only covered when used to determine the appropriateness of chiropractic services. The established patient exam must be Medically Necessary.
- Follow-up office visits include manipulation of the spine, joints and/or musculoskeletal soft tissue, a re-evaluation, and/or other services, in various combinations.
- Adjunctive modalities and procedures such as rehabilitative exercise, traction, ultrasound, electrical muscle stimulation, and other therapies are covered only when Medically Necessary and provided during the same Course of Treatment and in support of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.

- X-rays and clinical laboratory tests are payable in full when provided by or referred by a Contracted Chiropractor and approved by ASH Group. Radiological consultations are a covered benefit when approved by ASH Group as Medically Necessary Services and when provided by a licensed chiropractic radiologist, medical radiologist, radiology group, or hospital that has contracted with ASH Group to provide those services.
- Chiropractic Supports and Appliances are covered up to a maximum of $50 per year when approved by ASH Group as Medically Necessary for treatment of either Musculoskeletal and Related Disorders or Pain Syndromes or both.
- Urgent Services.
- Emergency Services.

Second Opinion

You have direct access to any other ASH Group-Contracted Chiropractor or non-plan practitioner. Your visit to another ASH Group-Contracted Chiropractor or non-plan practitioner for purposes of obtaining a second opinion generally will count as one visit, and you must pay any Copayment that applies for that visit on the same terms and conditions as a visit to any other ASH Group-Contracted Chiropractor or non-plan practitioner as applicable.

X-ray and Laboratory Tests

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

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

Chiropractic procedure codes covered under the Subluxation Only (Medicare) benefit include:

CODE	PROCEDURE NAME
98940	Chiropractic Manipulative Treatment
98941	Chiropractic Manipulative Treatment
98942	Chiropractic Manipulative Treatment

NOTE: Any other procedures billed with these codes will not be covered under this benefit.

OREGON

Chiropractic procedure codes covered under the Routine benefit for Oregon include:

NEW/ESTABLISHED PATIENT EVALUATION & MANAGEMENT

CODE	DESCRIPTION	
99201	New Patient Evaluation & Management Service	covered
99202	New Patient Evaluation & Management Service	covered
99203	New Patient Evaluation & Management Service	covered
99204	New Patient Evaluation & Management Service	covered
99211	Established Patient Evaluation & Management Service	covered
99212	Established Patient Evaluation & Management Service	covered
99213	Established Patient Evaluation & Management Service	covered
99214	Established Patient Evaluation & Management Service	covered

CPT Codes 99201-99214 billed with modifier -25 will be covered at the same rate as the base code listed above.

CHIROPRACTIC MANIPULATIVE TREATMENT

CODE	DESCRIPTION	
98940	Chiropractic Manipulative Treatment	covered
98941	Chiropractic Manipulative Treatment	covered
98942	Chiropractic Manipulative Treatment	covered
98943	Chiropractic Manipulative Treatment - Extraspinal	covered

ADJUNCTIVE THERAPY

CODE	DESCRIPTION	
97010	Hot/Cold Packs	(1)
97012	Traction, mechanical	(1)
97014	Electrical Stimulation (unattended)	(1)
G0283	Electrical Stimulation (unattended)	(1)

97016	Vasopneumatic devices	(1)
97018	Paraffin bath	(1)
97022	Whirlpool	(1)
97024	Diathermy (e.g., microwave)	(1)
97026	Infrared	(1)
97028	Ultraviolet	(1)
97032	Electrical stimulation (manual)	(1)
97033	Iontophoresis	(1)
97034	Contrast baths	(1)
97035	Ultrasound	(1)
97036	Hubbard tank	(1)
97039	Unlisted modality	(1)
97110	Therapeutic procedure, one or more areas; therapeutic exercises to develop strength & endurance, range of motion & flexibility	(1)
97112	Neuromuscular reeducation	(1)
97113	Aquatic therapy with therapeutic exercises	(1)
97139	Unlisted therapeutic procedure	(1)
97140	Manual Therapy Techniques (i.e. manual traction, myofascial release)	(1)
97140-59	Manual Therapy Techniques; if performed with CMT; every 15 min	(1)
97150	Therapeutic procedure(s), group	(1)
97150-59	Therapeutic procedure(s), group	(1)
97530	Therapeutic activities, direct patient contact	(1)
97532	Development of cognitive skills to improve attention, memory, problem solving, direct patient contact	(1)
97535	Self-care/home management training	(1)
97537	Community/work reintegration training	(1)
97542	Wheelchair management, each 15 min	(1)
97760	Orthotic(s) management and training, each 15 min.	(1)

SPECIAL SERVICES

CODE	DESCRIPTION	
29260	Strapping - Any Age - elbow/wrist	(1)
29280	Strapping - Any Age - hand/finger	(1)
29520	Strapping - Any Age - hip	(1)
29530	Strapping - Any Age - knee	(1)
29540	Strapping - Any Age - ankle/foot	(1)
29550	Strapping - Any Age - toes	(1)
97545	Work hardening/conditioning; initial 2 hours	(1)
97546	Each additional hour	(1)

Other CPT Codes and/or services for treatment, examination and/or therapy are not covered or eligible for reimbursement by ASH Group.

NOTE: ALL COVERED CODES ARE SUBJECT TO CHANGE.

What Chiropractic Services are not covered by our Plan?

The following items and services are limited or excluded as part of the Chiropractic Services provided by ASH Group:

- Services or treatments that are not approved by ASH Group as Medically Necessary, in accordance with ASH Group's Clinical Services Program. This requirement does not apply to the following services or treatments: (a) a new patient exam; (b) Urgent Services; and (c) Emergency Services.
- Services, examinations (other than an initial examination to determine the appropriateness of chiropractic services) and/or treatments for conditions other than Musculoskeletal or Related Disorders or Pain Syndromes.
- Hypnotherapy, behavior training, sleep therapy and weight programs.
- Thermography; magnets used for diagnostic or therapeutic use; nerve conduction studies (e.g., EEG, EMG, SEMG, SSEP, and NCV); or electrocardiogram (EKG) studies.
- Services, clinical laboratory studies, X-rays, Support and Appliances, and other treatments or products that are classified as Experimental or Investigational.
- Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, therapeutic radiology, and any diagnostic radiology other than covered plain film studies.
- Transportation costs, including local ambulance charges.
- Education programs, non-medical lifestyle or self-help, or any self-help physical exercise training or related diagnostic testing.
- Services or treatments for pre-employment physicals or vocational rehabilitation.
- Services or treatments for conditions caused by or arising out of the course of employment or covered under Workers' Compensation or similar laws.
- Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; all support appliances or durable medical equipment, except as defined in this agreement.
- Prescription drugs or medicines, including a non-legend or proprietary medicine or medication not requiring a prescription order.
- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services or other related services.
- Auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.
- Adjunctive physiotherapy modalities and procedures, unless provided during the same Course of Treatment and in support of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.
- Dietary and nutritional supplements, including vitamins, minerals, herbs, herbals and herbal products, injectable supplements and injection services, or other similar products.

Naturopathy Services

What Naturopathy Services are covered?

All Health Net Medicare Advantage members have direct access to an ASH Group-contracted naturopath, or out-of-network practitioners qualified to provide the benefit in question and who accept Health Net's terms and conditions of payment for all visits. A copayment is required for each visit to the office. All Naturopathic Services, except for the initial evaluation, urgent services, and emergency services may require verification of Medical Necessity.

- A new patient exam, or an established patient exam, for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of Naturopathic Services. A new patient is one who has not received any professional services from the practitioner, or another practitioner of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the practitioner, or another practitioner of the same specialty who belongs to the same group practice, within the past three years.
- Established patient exams assess the need to initiate, continue, extend, or change a course of treatment. The established patient examination is only covered when used to determine the appropriateness of naturopathic services. Unless the established patient exam is an initial evaluation of a new condition, the exam may be subject to verification of Medical Necessity.
- Subsequent office visits or consultations (including physical examination) are reimbursed as Medically Necessary, and approved according to your benefit plan. These services may be subject to verification of Medically Necessity.
- Office visits, consultations, therapeutic procedures and other services, in various combinations.
- X-rays and clinical laboratory tests are payable in full when Medically Necessary, provided by a licensed naturopath, and approved by ASH Group. Radiological consultations are a covered benefit when approved by ASH Group as Medically Necessary services and when provided by a licensed naturopathic radiologist, medical radiologist, radiology group, or hospital that has contracted with ASH Group to provide those services.
- Covered conditions and services are limited to those the practitioner is qualified to treat or perform pursuant to state licensure and scope of practice, excluding obstetrics, surgery, invasive procedures, treatment of psychiatric conditions and services listed as limitations and exclusions.
- Urgent Services.
- Emergency Services.

Second Opinion

You have direct access to any other ASH Group-contracted naturopaths or non-plan practitioner. Your visit to another ASH Group-contracted naturopaths or non-plan practitioner for purposes of obtaining a second opinion generally will count as one visit, and you must pay any Copayment that applies for that visit on the same terms and conditions as a visit to any other ASH Group-contracted naturopaths or non-plan practitioner as applicable.

What Naturopathy Services are not covered by our Plan?

The following items and services are limited or excluded as part of the Naturopathy Services provided by ASH Group:

- Services, clinical laboratory studies, X-rays and other treatments or products as determined in accordance with professionally-recognized standards of practice that are not approved by ASH Group as Medically Necessary, in accordance with ASH Group's Clinical Services Program. This requirement does not apply to the following services or treatments: (a) a new patient exam; (b) Urgent Services; or (c) Emergency Services.
- Services, examinations (other than in initial examination to determine the appropriateness of Naturopathic Services) and/or treatments for conditions that are not listed as a covered condition or that are not appropriate Naturopathic Service treatments for a covered condition.
- Immunizations, vaccinations, injectables and intravenous infusions. This item shall not apply to venipuncture for the purpose of obtaining blood samples for laboratory studies.
- Disease preventive studies, such as routine clinical laboratory studies, PAP smears, PSA studies, mammograms, contraceptive devices and fitting, including those studies referred by your physician.
- Hypnotherapy, behavior training, sleep therapy and weight programs.
- Thermography; magnets used for diagnostic or therapeutic use; nerve conduction studies (e.g., EEG, EMG, SEMG, SSEP, and NCV); or electrocardiogram (EKG) studies.
- Services, clinical laboratory studies, x-rays and other treatments or products as determined in accordance with professionally-recognized standards of practice that are classified as Experimental or Investigational.
- Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, therapeutic radiology, and diagnostic radiology other than covered plain film studies.
- Transportation costs, including local ambulance charges.
- Education programs, non-medical lifestyle or self-help, or any self-help physical exercise training or related diagnostic testing.
- Services or treatments for pre-employment physicals or vocational rehabilitation.
- Services or treatments caused by or arising out of the course of employment or covered under Workers' Compensation or similar laws.
- Air conditioners, air purifiers, therapeutic mattresses, supplies, or any other similar devices or appliances or durable medical equipment.
- Prescription drugs or medicines, including non-legend or proprietary medicine or

medication not requiring a prescription order.
- Hospitalization surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services and other related services.
- Auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.
- Adjunctive therapy that is considered by ASH Group to be invasive.

Acupuncture Services

What Acupuncture Services are covered?

All Health Net Medicare Advantage members have direct access to ASH Group-contracted acupuncturists, or out-of-network practitioners qualified to provide the benefit in question, and who accept Health Net's terms and conditions of payment for all visits. A copayment is required for each visit to the office. All Acupuncture Services, except for the initial evaluation, urgent service, and emergency services may require verification of Medical Necessity.

- A new patient exam, or an established patient exam, for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of acupuncture services. A new patient is one who has not received any professional services from the practitioner, or another practitioner of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the practitioner, or another practitioner of the same specialty who belongs to the same group practice, within the past three years.
- Established patient exams assess the need to initiate, continue, extend, or change a Course of Treatment. The established patient examination is only covered when used to determine the appropriateness of Acupuncture Services. The established patient exam must be Medically Necessary.
- Follow-up office visits include the provision of acupuncture services and/or a reevaluation.
- Adjunctive Therapies or Modalities within the scope of practice of the acupuncture provider may be covered, but only when provided during the same Course of Treatment and in support of Acupuncture Services. However, the following exception applies for the application of acupressure: if (a) a Contracted Practitioner of Acupuncture Services would recommend Acupuncture Services for a Member as a Covered Service but cannot do so in accordance with professionally-recognized, valid, evidence-based standards of practice because the insertion of needles is contraindicated (e.g., for a patient with an infectious disease that may be transmitted through blood or other bodily fluids), and (b) professionally-recognized, valid, evidence-based standards of practice indicate that acupressure would be efficacious in the treatment of the Member, then Acupuncture Services shall be deemed to include acupressure in that circumstance, even if Acupuncture Services are not provided to the Member at the same time and the Member

shall be entitled to receive other Adjunctive Therapies or Modalities in conjunction with the provision of acupressure, in that circumstance, to the same extent as would be the case if the Member were receiving Acupuncture Services
- Urgent Services.
- Emergency Services.

Second Opinion

You have direct access to any other ASH Group-contracted acupuncturists or non-plan practitioner. Your visit to other ASH Group-contracted acupuncturists or non-plan practitioners for purposes of obtaining a second opinion generally will count as one visit for purposes of any Maximum Benefit. And you must pay any Copayment that applies for that visit on the same terms and conditions as a visit to any other ASH Group-contracted acupuncturist or non-plan practitioner as applicable.

What Acupuncture Services are not covered by our Plan?

The following items and services are limited or excluded as part of the Acupuncture Services provided by ASH Group:

- Services or treatments that are not approved by ASH Group as Medically Necessary, in accordance with ASH Group's Clinical Services Program. This requirement does not apply to the following services or treatments: (a) a new patient exam; (b) Urgent Services; and (c) Emergency Services.
- Hypnotherapy, behavior training, sleep therapy and weight programs.
- Thermography, magnets used for diagnostic or therapeutic use, ion cord devices, manipulation or adjustments of the joints, physical therapy services, iridology, hormone replacement products, acupuncture point or trigger-point injections (including injectable substances), laser/laser biostim, colorpuncture, NAET diagnosis and/or treatment, and direct moxibustion.
- Services and other treatments that are classified as Experimental or Investigational.
- Radiological X-rays (plain film studies), magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, diagnostic radiology, and laboratory services.
- Transportation costs, including local ambulance charges.
- Education programs, non-medical lifestyle or self-help, or self-help physical exercise training or any related diagnostic testing.
- Services or treatments for pre-employment physicals or vocational rehabilitation.
- Services or treatments caused by or arising out of the course of employment or covered under Workers' Compensation or similar laws.
- Air conditioners/purifiers, therapeutic mattresses, supplies, or any other similar devices or durable medical equipment.
- Prescription drugs or medicines, including a non-legend or proprietary medicine or medication not requiring a prescription order.

- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services and other related services.
- Auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.
- Adjunctive therapy not associated with acupuncture.
- Dietary and nutritional supplements, including vitamins, minerals, herbs, herbals and herbal products, injectable supplements and injection services, or other similar products.

How do I file a Complementary/Alternative Health Care claim with ASH Group?

In most cases, your complementary/alternative health care practitioner will submit your claims directly to ASH Group. If you should receive a bill for the services, you can send us a letter or complete an ASH Group claim form. Please call or write to the ASH Group customer service department for a claim form and claim filing instructions at the toll-free number, **1-800-678-9133** (or TTY/TDD **1-877-710-2746**), Monday through Friday, 5:00 a.m. to 6:00 p.m., Pacific time, except holidays.

Attach your itemized bill to the claim form or letter, and mail to:

Claims Administration
American Specialty Health Group, Inc.
P.O. Box 509002
San Diego, CA 92150-9002

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

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

The Silver&Fit® Program

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

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

How do I enroll?

Simply choose a participating fitness facility online at SilverandFit.com or call Silver&Fit customer service at 1-888-797-7757 or TTY/TDD phone 1-877-710-2746, Monday – Friday, 5:00 a.m. – 6:00 p.m. (Pacific Time) excluding holidays to choose a facility. Once you have chosen a fitness facility, take your fitness card, located on the enrollment flier, to the fitness facility of your choice. You may be required by the fitness facility you choose to sign a membership agreement. The membership agreement that you may be required to sign at the fitness facility is for a no-cost "standard fitness facility membership," which includes the covered services available through the program, described below. If you choose to access fitness facility services otherwise available by the facility at an additional fee, then the agreement may reflect costs associated with those non-program related services.

If you wish to enroll in the Silver&Fit Home Fitness program, you can enroll online at www.SilverandFit.com or by calling Silver&Fit customer service at 1-888-797-7757 or TTY/TDD phone 1-877-710-2746, Monday – Friday, 5:00 a.m. – 6:00 p.m. (Pacific Time) excluding holidays.

Explanation of Covered Services (i.e. what is a "standard fitness facility membership?")

Fitness Clubs

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

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

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

Exercise Centers

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

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

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

- Cardio Strength Kit
- Walking Kit (pedometer and walking program instructions)

- Yoga Kit
- Tai Chi Beginner Kit
- Tai Chi for Balance Intermediate Kit
- Chair Pilates Kit
- Aquatic Exercise Kit
- Stress Management Kit
- Chair Dancing Kit
- Chair Boxing Kit
- Chair Resistance Band Kit
- Chair Tai Chi Kit
- Chair Aerobics Kit
- Chair Yoga Kit
- Exercise for the Bed Ridden Kit
- High Intensity Workout I and II Kits

The Silver&Fit Home Fitness Program kits may include:

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

Services offered through the "Customer Service Hotline"

You may call Silver&Fit member services at 1-888-797-7757 or TTY/TDD 1-877-710-2746, Monday through Friday, 5:00 a.m. – 6:00 p.m. (Pacific Time) excluding holidays, for information on any of the following:

- Fitness facility search
- Enrollment
- Program design
- Eligibility
- Changing fitness facilities
- Fitness facility nominations

Silver&Fit Website

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

- Utilize the fitness facility search
- Access Healthy Aging classes to help you make better health decisions
- Utilize the Silver&Fit Connected!™ program, a fun and easy way to track your exercise at a facility or through a wearable fitness device or app and earn rewards
- Access Silver&Fit member newsletters, *The Silver Slate*®

- Access to other web tools such as challenges, online classes, and more

Exclusions and limitations

The following services are not offered:

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

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

Decision Power® - Health and Wellness
A bridge to healthy actions

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

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

Decision Power® – Here to Help You Achieve Your Health and Wellness Goals
We make it personal, so you can make lasting changes.

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

Health Promotion programs

Want a more flexible way to improve your health and wellness – on your terms? Our Decision Power Health Promotion programs offer a self-directed, online way to achieve and maintain your health goals. These programs are available online, so you can take steps for positive and lasting changes when and where it's most convenient for you. Topics include weight loss, stress relief, and healthy diet.

Wellness health coaching

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

Tobacco Cessation

The tobacco cessation program covers any type of tobacco, lets you talk with a coach for encouragement and support, and offers a personalized plan to quit. Here's a look at what you get:

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

To learn more about these services log in at our Wellness Center at www.healthnet.com to get started.

Valuable tools that put health information in reach

Nurse Advice Line
Toll-free telephonic coaching and nurse advice from trained clinicians are available 24 hours a day, 7 days a week. Health Net's Nurse Advice Line provides real time health care assessments to help the member determine the level of care needed at the moment. Nurses provide 1:1 consultation, answers to health questions and symptom management support that empower members to make confident and appropriate decisions about their care and treatment. Members can access the nurse advice line by calling 1-800-893-5597, TTY (711).

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

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

Try it today! Log on to www.healthnet.com or call the Member Services number on your Health Net ID card for more information or to be connected to the nurse advice services.

You have access to Decision Power® through your current enrollment with Health Net Life Insurance Company.

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.

Section 2.2 Extra "optional supplemental" benefits you can buy

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

How can you enroll in the Optional Supplemental Benefits?

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

- from October 15, 2016 through December 31, 2016, for a January 1, 2017 effective date; or
- from January 1, 2017 through January 31, 2017 for a February 1, 2017 effective date.

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

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

Comprehensive Dental Optional Supplemental Benefits includes coverage for PPO preventive and comprehensive dental services for an additional monthly premium of $39.

Preventive Dental Optional Supplemental Benefits includes coverage for PPO preventive dental services for an additional monthly premium of $15.

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

Enrollment Services
Health Net Medicare Programs
P.O. Box 10420
Van Nuys, CA 91410-0420

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

How can you disenroll from the Optional Supplemental Benefits?

You may disenroll from these Optional Supplemental Benefits at any time and switch back to the basic Medicare Advantage plan benefits. To disenroll from the Optional Supplemental Benefits, send a letter to Health Net requesting to be disenrolled. You may also fax the letter to **1-866-214-1992**. It is important that you state your request is for disenrollment from the Optional Supplemental Benefits only, and the letter must be signed. We will then send you a letter that tells you when your Optional Supplemental Benefits will end. This is your Optional Supplemental Benefits **disenrollment date**. In most cases, your disenrollment date will be the first day of the month following the month we receive your request to discontinue these benefits.

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

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

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

Additional Information

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

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

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

Comprehensive Dental Optional Supplemental Benefits

You pay $39 each month in addition to your monthly plan premium shown in Chapter 1, Section 4.1 and the Medicare Part B premium for these optional benefits.

- Preventive dental services
- Comprehensive dental services

Comprehensive Dental Services	
Calendar Year Maximum	$1,000 (in-network and out-of-network combined)
	You Pay:
Deductible – Must be paid in addition to the applicable cost for each service received.	**In-network** $50 **Out-of-Network** $100
Preventive Services Initial/routine oral exams, teeth cleaning and routine scaling, fluoride treatment, sealant, x-rays as part of a general exam, emergency exam, space maintainers	**In-network** Covered at 100% **Out-of-Network** 50% of MAC◆
General Services Fillings, general anesthetics	**In-network** 20% **Out-of-Network** 50% of MAC◆
Major Services Crowns, removable and fixed bridges, complete and partial dentures, oral surgery, periodontics, endodontics	**In-network** 50% **Out-of-Network** 50% of MAC◆
◆ Maximum Allowable Charge (MAC) is the maximum dollar amount allowed by the plan for a covered dental service. Balance billing occurs when a dentist bills you for the difference between the plan's Maximum Allowable Charge (MAC) and the dentist's total billed charge. Network dentists cannot balance bill you for covered services which exceed the Maximum Allowable Charge (MAC) they have contractually agreed to; however, it is possible that non-network dentists may balance bill you for treatment rendered.	

Preventive Dental Optional Supplemental Benefits

You pay $15 each month in addition to your monthly plan premium shown in Chapter 1, Section 4.1 and the Medicare Part B premium for these optional benefits.

- Preventive dental services

Preventive Dental Services	
Calendar Year Maximum	$500 (in-network and out-of-network combined)
Deductible – Must be paid in addition to the applicable cost for each service received.	You Pay: $35 (in-network and out-of-network combined)
Preventive Services Initial/routine oral exams, teeth cleaning and routine scaling, fluoride treatment, sealant, x-rays as part of a general exam, emergency exam, space maintainers.	**In-network** Covered at 100% of MAC◆ **Out-of-Network** 20% of UCR▪

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

Optional Supplemental Benefit Information

Comprehensive Dental Services

NOTE: As a member of our plan, you have Medicare-covered dental benefits. Refer to the Medical Benefits Chart earlier in this chapter for copayment and benefit information. Only members who have purchased the Optional Supplemental Benefits - Comprehensive Dental also have non-Medicare covered preventive and comprehensive dental benefits.

Optional Supplemental Benefit packages include extra dental services and additional benefit allowances. To receive these added benefits, you must sign up for them and pay an additional premium.

Dental services are administered by Dental Benefit Providers, Inc. Dental services are covered as shown in the Optional Supplemental Benefits – Comprehensive Dental Services chart in this section. You can see any licensed dentist to receive covered dental services. However, your cost shares are higher when you receive covered services from out-of-network providers than from in-network providers.

Network Access: You save when using a contracted dentist. Contracted dentists have agreed to reduce their treatment fees. Using a contracted dentist lowers your out-of-pocket expenses.

Getting Services from Health Net Dental Plan Providers

Dental services are offered through Health Net Dental network providers. Health Net Dental providers are listed in your provider directory, or please contact the Health Net Dental customer service department for a list of plan providers. To locate an in-network provider, inquire about current benefit information, or to obtain a new dental identification card, please contact Health Net Dental at **1-877-410-0176** (or TTY: **711**) for the hearing and speech impaired), Monday through Friday, 5:00 a.m. to 8:00 p.m., Pacific time, except holidays.

You may also contact Health Net's Customer Service Department at the telephone number located on the back cover of this booklet, or visit our website at www.healthnet.com.

Getting services from Out-of-Network Dental providers

Out-of-network benefits apply when covered services are received from a provider not participating in Health Net Dental's network. Health Net Dental will review claims received from out-of-network dental professionals, and payment will be issued if the services received are determined to have been medically necessary covered services.

What Health Net Dental Services Are Covered?

Preventive and comprehensive services listed below from in-network and out-of-network plan providers are covered. See the Medical Benefits Chart under "Dental Services" for details on your deductible, coinsurance, and benefit maximum.

- Periodic oral examinations (covered as a separate benefit only if no other service was done during the visit other than X-rays)
- Bitewing X-rays
- Panoramic and full-mouth X-rays
- Dental prophylaxis (cleanings)
- Fluoride
- Fillings
- Extractions
- Sealants
- Extraoral X-rays
- Crowns
- Endodontics
- Periodontics
- Oral surgery
- Crowns/Bridges
- Dentures

DENTAL PLAN HIGHLIGHTS

Benefit Description	In-Network^	Out-of-Network
Calendar Year Maximum Allowable	$1,000 (In and Out-of-Network combined)	
Calendar Year Deductible	You pay $50 (In-Network)	You pay $100 (Out-of-Network)
Preventive Services Initial/routine oral exams, teeth cleaning and routine scaling, fluoride treatment, sealant, x-rays as part of a general exam, emergency exam, space maintainers	You pay 0% Deductible applies	You pay 50% of MAC◆ Deductible applies
General Services Fillings, general anesthetics	You pay 20% Deductible applies	You pay 50% of MAC◆ Deductible applies
Major Services Crowns, removable and fixed bridges, complete and partial dentures, oral surgery, periodontics, endodontics	You pay 50% Deductible applies	You pay 50% of MAC◆ Deductible applies

^ Plan enrollees have access to contracted dentists who have agreed to accept our fee schedule as payment in full for covered procedures.

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

What Health Net Dental Services Are Not Covered?

In addition to any exclusions or limitations described later in this chapter, the following items and services are limited, or not covered, as part of the routine dental benefits provided by Health Net Dental.

General Dental Limitations

1. **Periodic oral examinations.** Limited to two (2) times per calendar year.
2. **Complete series or panorex radiographs.** Limited to 1 time per consecutive 36 months. Exception to this limit will be made for Panorex Radiographs if taken for diagnosis of third molars, cysts, or neoplasms.
3. **Bitewing radiographs.** Limited to 1 series of films per calendar year.
4. **Extraoral radiographs.** Limited to 1 film per calendar year.
5. **Dental prophylaxis (cleaning).** Limited to 2 times per calendar year.
6. **Fluoride treatments.** Limited to once every calendar year for adults (age 18 and older) and children (age 17 and under).
7. **Space maintainers.** Limited to covered persons under the age of 16 years, limited to 1 per consecutive 60 months. Benefit includes all adjustments within 6 months of installation.
8. **Sealants.** Limited to covered persons under the age of 17 years, and once per permanent molar every consecutive 36 months.
9. **Restorations.** Multiple restorations on one surface will be treated as a single filling.
10. **Pin retention.** Limited to 2 pins per tooth; not covered in addition to cast restoration.
11. **Inlays and onlays.** Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
12. **Crowns.** Limited to 1 time per tooth per consecutive 60 months. Covered only when a filling cannot restore the tooth.
13. **Post and cores.** Covered only for teeth that have had root canal therapy.
14. **Sedative fillings.** Covered as a separate benefit only if no other service, other than x-rays and exam, were performed on the same tooth during the visit.

15. **Scaling and root planing.** Limited to 1 time per quadrant per consecutive 24 months.
16. **Periodontal maintenance.** Limited to 2 times per calendar year following active and adjunctive periodontal therapy, exclusive of gross debridement.
17. **Full dentures.** Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
18. **Partial dentures.** Limited to 1 time every consecutive 60 months. No additional allowances for precision or semi-precision attachments.
19. **Relining and rebasing dentures.** Limited to relining/rebasing performed more than 6 months after the initial insertion. Limited to 1 time per consecutive 12 months.
20. **Repairs to full dentures, partial dentures, bridges.** Limited to repairs or adjustments performed more than 12 months after the initial insertion. Limited to 1 per consecutive 6 months.
21. **Palliative treatment.** Covered as a separate benefit only if no other service, other than the exam and radiographs, were performed on the same tooth during the visit.
22. **Occlusal guards.** Limited to 1 guard every consecutive 36 months and only if prescribed to control habitual grinding.
23. **Full-mouth debridement.** Limited to 1 time every consecutive 36 months.
24. **General anesthesia.** Covered only where clinically necessary.
25. **Osseous grafts.** Limited to 1 per quadrant or site per consecutive 36 months.
26. **Periodontal surgery.** Hard tissue and soft tissue periodontal surgery are limited to 1 per quadrant or site per consecutive 36 months per surgical area.
27. **Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays.** Replacement of complete dentures, fixed or removable partial dentures, crowns, inlays or onlays previously submitted for payment under the plan is limited to 1 time per consecutive 60 months from initial or supplemental placement. This includes retainers, habit appliances, and any fixed or removable interceptive orthodontic appliances.

What services are covered under Preventive Dental?

Preventive dental services are covered with the following limitations:

- Periodic oral exams – two per year
- Cleanings (adult prophylaxis) – two per year
- Bitewing x-rays – one per year
- Fluoride treatment - 1 per calendar year, adults (18 and older), children (17 and under)
- Complete series or panoramic x-rays – once every 3 years[1]

[1] Multi-year benefits may not be available in subsequent years.

Dental procedure codes covered under Preventive Dental

ADA Code	Procedure Name
D0120	Periodic Oral Evaluation
D0140	Limited Oral Evaluation – Problem Focused
D0150	Comprehensive Oral Evaluation – New or Established Patient
D0210	Intraoral – Complete Series Including Bitewings
D0220	Intraoral – Periapical - First Film
D0230	Intraoral – Periapical - Each Additional Film
D0250	Extraoral – First Film
D0260	Extraoral – Each Additional Film
D0270	Bitewing – Single Film
D0272	Bitewings – Two Films
D0273	Bitewings – Three Films
D0274	Bitewings – Four Films
D0277	Vertical Bitewings – 7 to 8 Films
D0330	Panoramic Film
D1110	Prophylaxis – Adults
D1206	Topical application of fluoride varnish
D1208	Topical application of fluoride

What services are covered under Basic Restorative Dental?

Basic Restorative dental services are covered with the following limitations:

- Amalgam (metal) fillings – one restoration per tooth surface every 3 years[1]
- Resin composite fillings – one restoration per tooth surface every 3 years[1]

[1] Multi-year benefits may not be available in subsequent years.

Dental procedure codes covered under Basic Restorative Dental

ADA Code	Procedure Name
D2140	Amalgam – one surface primary/permanent
D2150	Amalgam – two surfaces primary/permanent
D2160	Amalgam – three surfaces primary/permanent
D2161	Amalgam – four surfaces primary/permanent
D2330	Resin composite – one surface anterior
D2331	Resin composite – two surfaces anterior
D2332	Resin composite – three surfaces anterior
D2335	Resin composite – four or more surfaces w/ incisal angle (anterior)
D2391	Resin composite – one surface posterior
D2392	Resin composite – two surfaces posterior
D2393	Resin composite – three surfaces posterior

ADA Code	Procedure Name
D2394	Resin composite – four or more surfaces w/ incisal angle (posterior)

What services are covered under Periodontal Dental?

Non-surgical Periodontal dental services are covered with the following limitations:

- Perio scaling/root planing – two quadrants per visit
  - Two quadrants per visit, unless medically necessary
  - Limited to pocket depths of 4mm or more and radiographic signs of calculus, accumulation of subgingival calculus, and/or bleeding points
  - Inclusive with gingival flap procedure or osseous surgery on same date

- Full-mouth debridement
  - Heavy calculus should be evident on most teeth
  - Not covered on same date as scaling and root planing, prophylaxis or any examination

- Periodontal maintenance – two visits per year
  - Prior history of periodontal therapy
  - Not eligible during the first 90 days after periodontal therapy
  - Re-evaluation is required if no periodontal maintenance was received in the last 12 months

Dental procedure codes covered under Non-Surgical Periodontal Dental

ADA Code	Procedure Name
D4341	Periodontal Scaling/Root Planing – four or more contiguous teeth per quadrant
D4342	Periodontal Scaling/Root Planing – one to three teeth per quadrant
D4355	Full-Mouth Debridement to enable comprehensive evaluation and diagnosis
D4910	Periodontal Maintenance – two per year

General Dental Exclusions

1. Dental services that are not medically necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons (cosmetic procedures are those procedures that improve physical appearance).
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury or congenital anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.

7. Procedures that are considered to be experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the covered person by any municipality, county or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the policy.
10. Dental services otherwise covered under the policy but rendered after the date the individual coverage under the policy terminates, including dental services for dental conditions arising prior to the date the individual coverage under the policy terminates.
11. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including spouse, brother, sister, parent or child.
12. Foreign Services are not covered unless required as an Emergency.
13. Replacement of complete dentures, fixed or removable partial dentures, and crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
15. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
16. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
17. Placement of dental implants, implant-supported abutments and prostheses.
18. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
19. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or congenital anomalies of hard or soft tissue, including excision.
20. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.

21. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jawbone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
22. Acupuncture, acupressure and other forms of alternative treatment, whether or not used as anesthesia.
23. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
24. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours' notice.
25. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.
26. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
27. Orthodontic Services.

How Do I File a Health Net Dental Claim?

When you see an out-of-network dentist, you will have to file a claim with Health Net Dental. Health Net Dental will pay your provider its share of the bill for any covered services that are determined to have been medically necessary and let you know what, if anything, you must pay your provider. Please call or write to the Health Net Dental Customer Service Department for a claim form and claim filing instructions at the toll-free number below:

1-877-410-0176 (or TTY: **711**), Monday through Friday, 5:00 a.m. to 8:00 p.m., Pacific time, except holidays.

Attach your itemized bill to the claim form or letter, and mail to:

Health Net Dental
P.O. Box 30567
Salt Lake City, UT 84130-0567

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

Preventive Dental Services

NOTE: As a member of our plan, you have Medicare-covered dental benefits. Refer to the Medical Benefits Chart earlier in this chapter for copayment and benefit information. Only members who have purchased the Optional Supplemental Benefits - Preventive Dental also have non-Medicare covered preventive dental benefits.

Optional Supplemental Benefit packages include extra dental services and additional benefit allowances. To receive these added benefits, you must sign up for them and pay an additional premium.

Dental services are administered by Dental Benefit Providers, Inc. Dental services are covered as shown in the Optional Supplemental Benefits – Preventive Dental Services chart in this section. You can see any licensed dentist to receive covered dental services. However, your cost shares are higher when you receive covered services from out-of-network providers than from in-network providers.

Network Access: You save when using a contracted dentist. Contracted dentists have agreed to reduce their treatment fees. Using a contracted dentist lowers your out-of-pocket expenses.

Getting Services from Health Net Dental Plan Providers

Dental services are offered through Health Net Dental network providers. Health Net Dental providers are listed in your provider directory, or please contact the Health Net Dental customer service department for a list of plan providers. To locate an in-network provider, inquire about current benefit information, or to obtain a new dental identification card, please contact Health Net Dental at **1-877-410-0176** (or TTY: **711** for the hearing and speech impaired), Monday through Friday, 5:00 a.m. to 8:00 p.m., Pacific time, except holidays.

You may also contact Health Net's Customer Service Department at the telephone number located on the back cover of this booklet, or visit our website at www.healthnet.com.

Getting services from Out-of-Network Dental providers

Out-of-network benefits apply when covered services are received from a provider not participating in Health Net Dental's network. Health Net Dental will review claims received from out-of-network dental professionals, and payment will be issued if the services received are determined to have been medically necessary covered services.

What Health Net Dental Services Are Covered?

Preventive services listed below from in-network and out-of-network plan providers are covered. See the Medical Benefits Chart under "Dental Services" for details on your deductible, coinsurance, and benefit maximum.

- Periodic oral examinations (covered as a separate benefit only if no other service was done during the visit other than X-rays)

- Bitewing X-rays
- Panoramic and full-mouth X-rays
- Dental prophylaxis (cleanings)
- Fluoride treatment

DENTAL PLAN HIGHLIGHTS

Benefit Description	In-Network^	Out-of-Network
Calendar Year Maximum Allowable	$500 (In and Out-of-Network combined)	
Calendar Year Deductible	$35 (Applies to all services)	
Preventive Services Initial/routine oral exams, teeth cleaning and routine scaling, fluoride treatment, sealant, x-rays as part of a general exam, emergency exam	You pay 0% of MAC ◆ Deductible applies	You pay 20% of UCR ■ Deductible applies

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

^ Plan enrollees have access to contracted dentists who have agreed to accept our fee schedule as payment in full for covered procedures.

What dental services are covered under Preventive Dental?

Preventive dental services are covered with the following limitations:

- Periodic oral exams – two per year
- Cleanings (adult prophylaxis) – two per year
- Bitewing x-rays – one per year
- Fluoride treatment - 1 per calendar year, adults (18 and older), children (17 and under)
- Complete series or panoramic x-rays – once every 3 years[1]

[1] Multi-year benefits may not be available in subsequent years.

Dental procedure codes covered under Preventive Dental

ADA Code	Procedure Name
D0120	Periodic Oral Evaluation

ADA Code	Procedure Name
D0140	Limited Oral Evaluation – Problem Focused
D0150	Comprehensive Oral Evaluation – New or Established Patient
D0210	Intraoral – Complete Series Including Bitewings
D0220	Intraoral – Periapical - First Film
D0230	Intraoral – Periapical - Each Additional Film
D0250	Extraoral – First Film
D0260	Extraoral – Each Additional Film
D0270	Bitewing – Single Film
D0272	Bitewings – Two Films
D0273	Bitewings – Three Films
D0274	Bitewings – Four Films
D0277	Vertical Bitewings – 7 to 8 Films
D0330	Panoramic Film
D1110	Prophylaxis – Adults
D1206	Topical application of fluoride varnish
D1208	Topical application of fluoride

General Dental Exclusions

1. Dental services that are not medically necessary.
2. Hospitalization or other facility charges.
3. Any dental procedure performed solely for cosmetic/aesthetic reasons (cosmetic procedures are those procedures that improve physical appearance).
4. Reconstructive surgery, regardless of whether or not the surgery is incidental to a dental disease, injury or congenital anomaly, when the primary purpose is to improve physiological functioning of the involved part of the body.
5. Any dental procedure not directly associated with dental disease.
6. Any procedure not performed in a dental setting.
7. Procedures that are considered to be experimental, investigational or unproven. This includes pharmacological regimens not accepted by the American Dental Association (ADA) Council on Dental Therapeutics. The fact that an experimental, investigational or unproven service, treatment, device or pharmacological regimen is the only available treatment for a particular condition will not result in coverage if the procedure is considered to be experimental, investigational or unproven in the treatment of that particular condition.
8. Services for injuries or conditions covered by Worker's Compensation or employer liability laws, and services that are provided without cost to the covered person by any municipality, county or other political subdivision. This exclusion does not apply to any services covered by Medicaid or Medicare.
9. Expenses for dental procedures begun prior to the covered person becoming enrolled under the policy.

10. Dental services otherwise covered under the policy but rendered after the date the individual coverage under the policy terminates, including dental services for dental conditions arising prior to the date the individual coverage under the policy terminates.
11. Services rendered by a provider with the same legal residence as a covered person or who is a member of a covered person's family, including spouse, brother, sister, parent or child.
12. Foreign Services are not covered unless required as an Emergency.
13. Replacement of complete dentures, fixed or removable partial dentures, and crowns if damage or breakage was directly related to provider error. This type of replacement is the responsibility of the Dentist. If replacement is necessary because of patient non-compliance, the patient is liable for the cost of replacement.
14. Fixed or removable prosthodontic restoration procedures for complete oral rehabilitation or reconstruction.
15. Attachments to conventional removable prostheses or fixed bridgework. This includes semi-precision or precision attachments associated with partial dentures, crown or bridge abutments, full or partial overdentures, any internal attachment associated with an implant prosthesis and any elective endodontic procedure related to a tooth or root involved in the construction of a prosthesis of this nature.
16. Procedures related to the reconstruction of a patient's correct vertical dimension of occlusion (VDO).
17. Placement of dental implants, implant-supported abutments and prostheses.
18. Placement of fixed partial dentures solely for the purpose of achieving periodontal stability.
19. Treatment of benign neoplasms, cysts, or other pathology involving benign lesions, except excisional removal. Treatment of malignant neoplasms or congenital anomalies of hard or soft tissue, including excision.
20. Setting of facial bony fractures and any treatment associated with the dislocation of facial skeletal hard tissue.
21. Services related to the temporomandibular joint (TMJ), either bilateral or unilateral. Upper and lower jawbone surgery (including that related to the temporomandibular joint). No coverage is provided for orthognathic surgery, jaw alignment, or treatment for the temporomandibular joint.
22. Acupuncture, acupressure and other forms of alternative treatment, whether or not used as anesthesia.
23. Drugs/medications, obtainable with or without a prescription, unless they are dispensed and utilized in the dental office during the patient visit.
24. Charges for failure to keep a scheduled appointment without giving the dental office 24 hours' notice.
25. Occlusal guards used as safety items or to affect performance primarily in sports-related activities.

26. Dental Services received as a result of war or any act of war, whether declared or undeclared or caused during service in the armed forces of any country.
27. Orthodontic Services.

How Do I File a Health Net Dental Claim?

When you see an out-of-network dentist, you will have to file a claim with Health Net Dental. Health Net Dental will pay your provider its share of the bill for any covered services that are determined to have been medically necessary and let you know what, if anything, you must pay your provider. Please call or write to the Health Net Dental Customer Service Department for a claim form and claim filing instructions at the toll-free number below:

1-877-410-0176 (or TTY: **711**), Monday through Friday, 5:00 a.m. to 8:00 p.m., Pacific time, except holidays.

Attach your itemized bill to the claim form or letter, and mail to:

Health Net Dental
P.O. Box 30567
Salt Lake City, UT 84130-0567

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

SECTION 3 What services are not covered by the plan?

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

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

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

If you get services that are excluded (not covered), you must pay for them yourself. We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception: we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 5.3 in this booklet.)

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

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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare	√	
Experimental medical and surgical procedures, equipment and medications. Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		√ May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5 for more information on clinical research studies.)
Private room in a hospital.		√ Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
television.		
Full-time nursing care in your home.	√	
*Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care.	√	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation.	√	
Fees charged for care by your immediate relatives or members of your household.	√	
Cosmetic surgery or procedures		√ • Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Dentures		√ Partial or Complete Dentures are offered as an optional supplemental benefit that you can buy. See Section 2.2 above for information
Non-routine dental care		√ Non-routine dental care is offered as an optional supplemental benefit that you can buy. See Section 2.2 above for information
Routine foot care (Podiatry)		√ Some limited coverage provided according to Medicare guidelines, e.g., if you have diabetes.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Home-delivered meals	√	
Orthopedic shoes		√ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
Supportive devices for the feet		√ Orthopedic or therapeutic shoes for people with diabetic foot disease.
Routine hearing exams, hearing aids, or exams to fit hearing aids.	√	
Radial keratotomy, LASIK surgery, vision therapy and other low vision aids.	√	
Reversal of sterilization procedures and/or non prescription contraceptive supplies.	√	
Services provided to veterans in Veterans (VA) facilities		√ However, when emergency services are received at a VA hospital and the VA cost sharing is more than the cost sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost sharing amounts.
Treatment at a Residential Treatment Center	√	
Transportation (Routine)	√	

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

CHAPTER 5

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

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

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

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

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

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

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

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

When you received care from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. (Your share of the cost may be higher for an out-of-network provider than for a network provider.) You should ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
    - If the provider is owed anything, we will pay the provider directly.
    - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.
- **Please note:** While you can get your care from an out-of-network provider, the provider must be eligible to participate in Medicare. Except for emergency care, we cannot pay a provider who is not eligible to participate in Medicare. If the provider is not eligible to participate in Medicare, you will be responsible for the full cost of the services you receive.

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

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

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges. For more information about "balance billing," go to Chapter 4, Section 1.4.
- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. If you are retroactively enrolled in our plan.

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

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

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

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

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

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

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

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

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

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

Health Net Life Insurance Company
P.O. Box 14130
Lexington, KY 40512

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

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

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

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

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

- If we decide that the medical care is covered and you followed all the rules for getting the care, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the

service yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered.)

- If we decide that the medical care is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

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

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

For the details on how to make this appeal, go to Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*). The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to the Section 5.3 in Chapter 7 that tells what to do if you want to make an appeal about getting paid back for a medical service.

CHAPTER 6

Your rights and responsibilities

Chapter 6. Your rights and responsibilities

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

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

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

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. For assistance with this information in another language, please contact Member Services at 1-888-445-8913 (TTY: 711). Hours of operation are 8:00 a.m. to 8:00 p.m., Pacific time, 7 days a week. We can also give you information in audio, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet).

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

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

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

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

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

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

You have the right to choose a provider for your care.

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

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

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

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

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

How do we protect the privacy of your health information?

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

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us

to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

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

If you have questions or concerns about the privacy of your personal health information, please call Member Services (phone numbers are printed on the back cover of this booklet). Our Notice of Privacy Practices is listed in Chapter 9, Section 9.

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

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

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

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers.**
    - For example, you have the right to get information from us about the qualifications of the providers in our network and how we pay the providers in our network.
    - For a list of the providers in the plan's network, see the *Provider Directory*.
    - For more detailed information about our providers, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our website at www.healthnet.com.
- **Information about your coverage and the rules you must follow when using your coverage.**
    - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
    - If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).

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

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

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

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

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

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

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

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

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

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

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

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. In Oregon, advanced directives must be in the form prescribed pursuant to O.R.S. 127.531. A copy of the advanced directive can be located at http://www.oregon.gov/DCBS/insurance/shiba/topics/Pages/advancedirectives.aspx. For more information about advance directives, contact the Senior Health Insurance Benefits Assistance Program (SHIBA) at the number located in Chapter 2, Section 3 of this EOC.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. In Oregon, two adults must witness your signing the advance directive or your acknowledgement of your signing the advance directive. At least one of the witnesses must not be related to you by blood, marriage or adoption, nor entitled to any portion of your estate, nor be an owner, operator or employee of a health care facility where you are a patient or resident. Your attending physician and attorney-in-fact may not serve as witnesses.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with your local Office for Civil Rights.

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

The telephone number is 1-800-368-1019 (TDD: 1-800-537-7697).

Please be aware of the following:

- Health Net ensures that when Health Net receives an advanced directive from a Member that the advanced directive is documented within the Member's Health Net record.
- Health Net will comply with State law on advance directives.
- Health Net educates its staff about its policies and procedures for advance directives.
- Health Net provides for community education regarding advance directives.

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

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints. What you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly**.

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

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

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

Section 1.9 Evaluation of new technologies

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

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

Section 1.10 What can you do if you believe you are being treated unfairly or your rights are not being respected?

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

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

Is it about something else?

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

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).

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

Section 1.11 How to get more information about your rights

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

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
    - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at: http://www.medicare.gov/Pubs/pdf/11534.pdf.)
    - Or, you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

Section 2.1 What are your responsibilities?

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

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* booklet to learn what is covered for you and the rules you need to follow to get your covered services.
    - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
- **If you have any other health insurance coverage in addition to our plan, you are required to tell us.** Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).
    - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating

the health benefits you get from our plan with any other health benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)

- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care.
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
    - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
    - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe.** As a plan member, you are responsible for these payments:
    - You must pay your plan premiums to continue being a member of our plan.
    - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
    - For some of your medical services covered by the plan, you must pay your share of the cost when you get the service. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells what you must pay for your medical services.
    - If you get any medical services that are not covered by our plan or by other insurance you may have, you must pay the full cost.
        - If you disagree with our decision to deny coverage for a service, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).
    - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare

plan available in your new area. We can let you know if we have a plan in your new area.

- **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.

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

CHAPTER 7

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

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

BACKGROUND

SECTION 1 Introduction

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

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

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

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

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

Section 1.2 What about the legal terms?

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

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

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

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

Section 2.1 Where to get more information and personalized assistance

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

Get help from an independent government organization

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

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

You can also get help and information from Medicare

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

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

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes. My problem is about benefits or coverage.

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

No. My problem is not about benefits or coverage.

Skip ahead to **Section 9** at the end of this chapter: **"How to make a complaint about quality of care, waiting times, customer service, or other concerns."**

COVERAGE DECISIONS AND APPEALS

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

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

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

Asking for coverage decisions

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

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

Making an appeal

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

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review, we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

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

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

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

Section 4.3 Which section of this chapter gives the details for your situation?

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

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

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

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

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

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

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

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.

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

Which of these situations are you in?

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

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

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

Legal Terms

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

A "fast coverage decision" is called an **"expedited determination."**

How to request coverage for the medical care you want

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

Generally we use the standard deadlines for giving you our decision

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

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

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

- **A fast coverage decision means we will answer within 72 hours.**
    - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.

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

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

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

Deadlines for a "fast" coverage decision

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

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

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

Deadlines for a "standard" coverage decision

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

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

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

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

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

What to do

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

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

- You have the right to ask us for a copy of the information regarding your appeal.
- If you wish, you and your doctor may give us additional information to support your appeal.

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

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."

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

- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

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

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

Deadlines for a "fast" appeal

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

- **If our answer is no to part or all of what you requested,** we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a "standard" appeal

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

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

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

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

If we say no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews

our decision for your first appeal. This organization decides whether the decision we made should be changed.

Step 1: The Independent Review Organization reviews your appeal.

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

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

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

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

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

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

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

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

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

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

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

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

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

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To

make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical Benefits Chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

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

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

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

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

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

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

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

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

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

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

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

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

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

2. **You must sign the written notice to show that you received it and understand your rights.**

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

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

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

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

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

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

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

What is the Quality Improvement Organization?

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

How can you contact this organization?

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

Act quickly:

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

Ask for a "fast review":

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

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

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

What happens during this review?

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

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

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

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

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

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

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

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

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

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

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

Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

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

- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

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

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

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

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

You can appeal to us instead

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

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

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

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

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

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

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

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

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

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

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

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

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

Step-by-Step: Level 2 *Alternate* Appeal Process

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

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

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

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

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

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

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

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

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

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

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

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

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*.

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

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

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

Legal Terms

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

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

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
   - The written notice tells you the date when we will stop covering the care for you.
   - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.
2. **You must sign the written notice to show that you received it.**
   - You or someone who is acting on your behalf must sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
   - Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan that it's time to stop getting the care.

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

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

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our

plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 9 of this chapter tells you how to file a complaint.)

- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

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

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

What is the Quality Improvement Organization?

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

How can you contact this organization?

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

What should you ask for?

- Ask this organization for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care*.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5.

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage

for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers informed us of your appeal, and you will also get a written notice from us that explain in detail our reasons for ending our coverage for your services.

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

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

What happens if the reviewers say yes to your appeal?

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

What happens if the reviewers say no to your appeal?

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

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

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

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

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

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

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

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

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

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

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision.

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

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

What happens if the review organization says no?

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

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

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

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

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

You can appeal to us instead

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

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

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

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

Here are the steps for a Level 1 Alternate Appeal:

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

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

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

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

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

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

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

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

Step-by-Step: Level 2 *Alternate* Appeal Process

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

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

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

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

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

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

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

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

SECTION 8 Taking your appeal to Level 3 and beyond

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

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

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

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

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

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

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

- **If the answer is yes, or if the Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over** - We

will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.

- If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Appeals Council's decision.
- If we decide to appeal the decision, we will let you know in writing.

- **If the answer is no or if the Appeals Council denies the review request, the appeals process *may* or *may not* be over**.
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

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

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

MAKING COMPLAINTS

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

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

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

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

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

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you have received (including care in the hospital)?
Respecting your privacy	• Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with how our Member Services has treated you? • Do you feel you are being encouraged to leave the plan?
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors or other health professionals? Or by our Member Services or other staff at the plan? o Examples include waiting too long on the phone, in the waiting room, or in the exam room.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Do you believe we have not given you a notice that we are required to give? • Do you think written information we have given you is hard to understand?

Complaint	Example
Timeliness (These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)	The process of asking for a coverage decision and making appeals is explained in sections 4-8 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process. However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples: • If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint. • If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint. • When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint. • When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

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

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

Section 9.3 Step-by-step: Making a complaint

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

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. 1-888-445-8913 (TTY:711). Hours of operation are 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- If you ask for a written response, file a written complaint (grievance), or if your complaint is related to quality of care, we will respond to you in writing. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaint. We call this the Grievance Procedure.** To make a complaint, or if you have questions about this procedure, please call Member Services at the phone number above. Or, you may mail or fax us a written request to the address or fax number listed under *Appeals for Medical Care* or *Complaints about Medical Care* in Chapter 2 of this booklet.
    - You need to file your complaint within 60 calendar days after the event. You can submit your Grievance, formally, in writing or via fax at the address or fax number listed under *Appeals for Medical Care* or *Complaints about Medical Care* in Chapter 2 of this booklet.
    - We must notify you of our decision about your complaint as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.

- In certain cases, you have the right to ask for a fast review of your complaint. This is called the Expedited Grievance Procedure. You are entitled to a fast review of your complaint if you disagree with our decision in the following situations:
  - We deny your request for a fast review of a request for medical care.
  - We deny your request for a fast review of an appeal of denied services.
  - We decide additional time is needed to review your request for medical care.
  - We decide additional time is needed to review your appeal of denied medical care.
- You may submit this type of complaint by phone by calling Member Services at the phone number on the back cover of this booklet. You may also submit the complaint to us in writing or by fax at the address or fax number listed under *Appeals for Medical Care* or *Complaints about Medical Care* in Chapter 2 of this booklet. Once we receive the expedited grievance (complaint), a Clinical Practitioner will review the case to determine the reasons for the denial of your request for a fast review or if the case extension was appropriate. We will notify you of the decision of the fast case orally and in writing within 24 hours of receiving your complaint.

- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint".** If you have a "fast" complaint, it means we will give you **an answer within 24 hours**.

Legal Terms
What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).
    - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.
    - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY users can call 1-877-486-2048.

CHAPTER 8

Ending your membership in the plan

Chapter 8. Ending your membership in the plan

SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

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

- You might leave our plan because you have decided that you *want* to leave.
  - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the annual Medicare Advantage Disenrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1 You can end your membership during the Annual Enrollment Period

You can end your membership during the **Annual Enrollment Period** (also known as the "Annual Coordinated Election Period"). This is the time when you should review your health and drug coverage and make a decision about your coverage for the upcoming year.

- **When is the Annual Enrollment Period?** This happens from October 15 to December 7.
- **What type of plan can you switch to during the Annual Enrollment Period?** During this time, you can review your health coverage and your prescription drug coverage. You can choose to keep your current coverage or make changes to your coverage for the upcoming year. If you decide to change to a new plan, you can choose any of the following types of plans:

- Another Medicare health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
- Original Medicare *with* a separate Medicare prescription drug plan.
- – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

- **When will your membership end?** Your membership will end when your new plan's coverage begins on January 1.

Section 2.2 You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited

You have the opportunity to make *one* change to your health coverage during the annual **Medicare Advantage Disenrollment Period**.

- **When is the annual Medicare Advantage Disenrollment Period?** This happens every year from January 1 to February 14.
- **What type of plan can you switch to during the annual Medicare Advantage Disenrollment Period?** During this time, you can cancel your Medicare Advantage Plan enrollment and switch to Original Medicare. If you choose to switch to Original Medicare during this period, you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage.
- **When will your membership end?** Your membership will end on the first day of the month after we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

Section 2.3 In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of our plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (www.medicare.gov):
  - Usually, when you have moved.
  - If you have the Oregon Health Plan (Medicaid).
  - If we violate our contract with you.

  - If you are getting care in an institution, such as a nursing home or long-term care (LTC) hospital.
  - If you enroll in the Program of All-inclusive Care for the Elderly (PACE).

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare health plan (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.);
  - Original Medicare *with* a separate Medicare prescription drug plan;
  - *– or –* Original Medicare *without* a separate Medicare prescription drug plan.
- **When will your membership end?** Your membership will usually end on the first day of the month after your request to change your plan is received.

Section 2.4 Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can find the information in the ***Medicare & You 2017*** Handbook.
  - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (http://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 How do you end your membership in our plan?

Section 3.1 Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 in this chapter for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan. There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).
- --*or*--You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	**This is what you should do:**
Another Medicare health plan.	Enroll in the new Medicare health plan. You will automatically be disenrolled from our plan when your new plan's coverage begins.
Original Medicare *with* a separate Medicare prescription drug plan.	Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from our plan when your new plan's coverage begins.
Original Medicare *without* a separate Medicare prescription drug plan.	**Send us a written request to disenroll.** Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. You will be disenrolled from our plan when your coverage in Original Medicare begins.

SECTION 4 Until your membership ends, you must keep getting your medical services through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care through our plan.

- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

SECTION 5 We must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

We must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
    - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Member Services are printed on the back cover of this booklet.)
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

- If you do not pay the plan premium for two months.
    - We must notify you in writing that you have two months to pay the plan premium before we end your membership.

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Member Services** for more information (phone numbers are printed on the back cover of this booklet).

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

We are not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 9 for information about how to make a complaint.

CHAPTER 9

Legal notices

Chapter 9. Legal notices

SECTION 1 Notice about governing law

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

SECTION 2 Notice about non-discrimination

We don’t discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location. All organizations that provide Medicare Advantage plans, like our plan, must obey Federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, and all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

Health Net complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Health Net does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Health Net:

• Provides free aids and services to people with disabilities to communicate effectively with us, such as qualified sign language interpreters and written information in other formats (large print, accessible electronic formats, other formats).

• Provides free language services to people whose primary language is not English, such as qualified interpreters and information written in other languages.

If you need these services, contact Health Net's Customer Contact Center at 1-888-445-8913 (TTY: 711), 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Customer Contact Center is available to help you.

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights, electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf or by mail or phone at: U.S.

Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, 1-800–368–1019, (TDD: 1-800–537–7697).

Complaint forms are available at http://www.hhs.gov/ocr/office/file/index.html

SECTION 3 Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, our plan, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

SECTION 4 Recovery of benefits paid by Health Net under your Health Net Aqua (PPO) plan

When you are injured

If you are ever injured through the actions of another person, or yourself (responsible party), Health Net will provide benefits for all covered services that you receive through this Plan. However, if you receive money or are entitled to receive money because of your injuries, whether through a settlement, judgment or any other payment associated with your injuries, Health Net and/or the medical providers retain the right to recover the value of any services provided to you through this Plan.

As used throughout this provision, the term responsible party means any party actually or potentially responsible for making any payment to a Member due to a Member's injury, illness or condition. The term responsible party includes the liability insurer of such party or any insurance coverage.

Some examples of how you could be injured through the actions of a responsible party are:

- You are in a car accident;
- You slip and fall in a store.

Health Net's right of recovery applies to any and all recoveries received by you, made to you by a third party, or made on your behalf from the following sources, including but not limited to:

- Payments made by a third party or any insurance company on behalf of a third party;
- Uninsured or underinsured motorist coverage;
- Personal injury protection, no fault or any other first party coverage;
- Workers Compensation or Disability award or settlement;

- Medical payments coverage under any automobile policy, premises or homeowners' insurance coverage, umbrella coverage;
- Any settlement received arising out of legal action or a lawsuit;
- Any judgment received arising out of legal action or a lawsuit;
- Medical expenses incurred as a result of medical malpractice; and
- Any other payments from any other source received as compensation for the responsible party's actions or omissions.

By accepting benefits under this Plan, you acknowledge that Health Net has a first priority right of subrogation and reimbursement that attaches when this Plan has paid for health care benefits for expenses incurred due to the actions or omissions of a responsible party and you or your representative recovers, or is entitled to recover, any amounts from a responsible party.

By accepting benefits under this Plan, you also (i) grant Health Net an assignment of your right to recover medical expenses from any coverage available to the extent of the full cost of all covered services provided by the Plan and (ii) you agree to specifically direct such third parties or insurance carriers to directly reimburse the Plan on your behalf.

By accepting benefits under this Plan, you also grant Health Net a first priority lien on any recovery, settlement or judgment, or other source of compensation and all reimbursement due to Health Net for the full cost of benefits paid under the Plan that are associated with injuries, illnesses or conditions due to the actions or omissions of a responsible party regardless of whether specifically identified as a recovery for medical expenses and regardless of whether you are made whole or fully compensated for your loss. Health Net may recover the full cost of all benefits provided by this Plan without regard to any claim of fault on the part of the Member, whether by comparative negligence or otherwise. No attorney fees may be deducted from Health Net's recovery, and Health Net is not required to pay or contribute to paying court costs or attorneys' fees for the attorney hired to pursue the claim or lawsuit against any responsible party.

Steps you must take

If you are injured because of a responsible party, you must cooperate with Health Net's and/or the medical providers' efforts to recover its expenses, including:

- Telling Health Net and the medical providers the name and address of the responsible party and/or his or her lawyer, if you know it, the name and address of your lawyer, if you are using a lawyer, the name and address of any insurance company involved with your injuries or claim, including a description of how the injuries were caused.
- Completing any paperwork that Health Net or the medical providers may reasonably require to assist in enforcing the lien or right of recovery at issue.
- Promptly responding to inquiries from Health Net about the status of the case or claim and any settlement discussions.
- Notifying Health Net immediately upon you or your lawyer receiving any money from the responsible party(s), any insurance companies, or any other source.
- Pay the health care lien or Plan recovery amount from any recovery, settlement or judgment, or other source of compensation, including payment of all reimbursement due

to Health Net for the full cost of benefits paid under the Plan that are associated with injuries, illnesses or conditions due to a responsible party regardless of whether specifically identified as recovery for medical expenses and regardless of whether you are made whole or fully compensated for your loss;

- Do nothing to prejudice Health Net's rights as set forth above. This includes, but is not limited to, refraining from any attempts to reduce or exclude from settlement or recovery the full cost of all benefits paid by the Plan or any attempts to deny Health Net its first priority right of recovery; and hold any money that you or your lawyer receive from the responsible party(s), or from any other source, in trust, and reimbursing Health Net and the medical providers for the amount of the recovery due to the Plan as soon as you are paid and prior to payment of any other potential lien holders or third parties claiming a right to recover.

SECTION 5 Membership card

A membership card issued by Health Net under this *Evidence of Coverage* is for identification purposes only. Possession of a membership card does not confer any right to services or other benefits under this *Evidence of Coverage*. To be entitled to services or benefits under this *Evidence of Coverage*, the holder of the card must be eligible for coverage and be a member under this *Evidence of Coverage*. Any person receiving services to which he or she is not then entitled under this *Evidence of Coverage* will be responsible for payment for those services. A Member must present their Health Net membership card, not Medicare card, at the time of service. Please call Member Services at the number located on the back cover of this booklet if you need your membership card replaced.

Note: Any member knowingly permitting abuse or misuse of the membership card may be disenrolled for cause. Health Net is required to report a disenrollment that results from membership card abuse or misuse to the Office of the Inspector General, which may result in criminal prosecution.

SECTION 6 Independent contractors

The relationship between Health Net and each participating provider is an independent contractor relationship. Participating providers are not employees or agents of Health Net and neither Health Net, nor any employee of Health Net, is an employee or agent of a participating provider. In no case will Health Net be liable for the negligence, wrongful act, or omission of any participating or other health care provider. Participating physicians, and not Health Net, maintain the physician-patient relationship with the member. Health Net is not a provider of health care.

SECTION 7 Health care plan fraud

Health care plan fraud is defined as a deception or misrepresentation by a provider, Member, employer or any person acting on their behalf. It is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to

defraud the health care plan by filing a claim that contains a false or deceptive statement is guilty of insurance fraud.

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

SECTION 8 Circumstances beyond Health Net's control

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

SECTION 9 Notice of privacy practices

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

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

We are required by federal and state laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information, and notify you in the event of a breach of your unsecured protected health information. We must follow the terms of this Notice while it is in effect. We reserve the right to change this Notice. We reserve the right to make the revised or changed Notice effective for your protected health information we already have as well as any of your protected health information we receive in the future. We will promptly revise and distribute this Notice whenever there is a material change to the uses or disclosures, your rights, our legal duties, or other privacy practices stated in the Notice. This will include, but may not be limited to updating the Notice on our website. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

I. How We May Use and Disclose Your Protected Health Information: We may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment:

- **Payment.** We use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims, to be reimbursed by another insurer that may be responsible for payment or for premium billing.

- **Health Care Operations.** We use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or customer service.

- **Treatment.** We may use and disclose your protected health information to assist your health care providers (doctors, pharmacies, hospitals, and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.

- **Plan Sponsor.** We may disclose your protected health information to a sponsor of the group health plan, such as an employer or other entity that is providing a health care program to you, if the sponsor has agreed to certain restrictions on how it will use or disclose the protected health information (such as agreeing not to use the protected health information for employment-related actions or decisions).

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

II. Other Permitted or Required Disclosures:

- **As Required by Law.** We must disclose protected health information about you when required to do so by law.

- **Public Health Activities.** We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury, or disability.

- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose protected health information to government agencies about abuse, neglect, or domestic violence.

- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g., California Department of Health Services) for activities authorized by law.

- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request, or other lawful process.

- **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

- **Coroners, Funeral Directors, Organ Donation.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.

- **Research.** Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.

- **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Special Government Functions**. We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.

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

- **Fundraising Activities.** We may use or disclose your protected health information for fundraising activities, such as raising money for a charitable foundation or similar entity to help finance its activities. If we do contact you for fundraising activities, we will give you the opportunity to opt-out, or stop, receiving such communications in the future.

- **Underwriting Purposes.** If applicable, we may use or disclosure your protected health information for underwriting purposes, such as to make a determination about a coverage application or request. If we do use or disclose your protected health information for underwriting purposes, we are prohibited from using or disclosing your protected health information that is genetic information in the underwriting process.

III. Other Uses or Disclosures that Require Your Written Authorization: We are required to obtain your written authorization to use or disclose your protected health information, with limited exceptions, for the following reasons:

- **Marketing.** We will request your written authorization to use or disclose your protected health information for marketing purposes with limited exceptions, such as when we have face-to-face marketing communications with you or when we provide promotional gifts of nominal value.

- **Sale of Protected Health Information.** We will request your written authorization before we make any disclosure that is deemed a sale of your protected health information, meaning that we are receiving compensation for disclosing the protected health information in this manner.

- **Psychotherapy Notes**. We will request your written authorization to use or disclose any of you psychotherapy notes that we may have on file with limited exception, such as for certain treatment, payment or health care operation functions.
- **Other Uses or Disclosures.** All other uses or disclosures of your protected health information not described in this Notice will be made only with your written authorization, unless otherwise permitted or required by law.

- **Revocation of an Authorization.** You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

IV. Your Rights Regarding Your Protected Health Information: You have certain rights regarding protected health information that the Plan maintains about you.

- **Right to Access Your Protected Health Information.** You have the right to review or obtain copies of your protected health information contained in a designated record set, with some limited exceptions. You may request that we provide copies of this protected health information in a format other than photocopies, such as providing them to you electronically, if it is readily producible in such form and format. Usually the protected health information contained in a designated record set includes enrollment, billing, claims payment, and case or medical management records.

  Your request to review and/or obtain a copy of this protected health information must be made in writing. We may charge a fee for the costs of producing, copying, and mailing or sending electronically your requested information, but we will tell you the cost in advance. If we deny your request for access, we will provide you a written explanation and will tell you if the reasons for the denial can be reviewed and how to ask for such a review or if the denial cannot be reviewed.

- **Right to Amend Your Protected Health Information.** If you feel that protected health information maintained by the Plan is incorrect or incomplete, you may request that we

amend, or change, the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by the Plan, as is often the case for health information in our records, or you ask to amend a record that is already accurate and complete.

If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision, and we have the right to rebut that statement.

- **Right to an Accounting of Disclosures by the Plan.** You have the right to request an accounting of certain disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

  Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.

- **Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. *We may not agree to your request.* If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

- **Right to Receive Confidential Communications.** You have the right to request that we use a certain method to communicate with you about the Plan or that we send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Notice in the Event of a Breach.** You have a right to receive a notice of a breach involving your protected health information (PHI) should one occur.

- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.

- **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by contacting our Privacy Office. See the end of this Notice for the contact information.

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

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

VII. Privacy Complaints: If you believe that your privacy rights have been violated, you may file a complaint with us and/or with the Secretary of the U.S. Department of Health and Human Services and Human Services Office for Civil Rights by sending a letter to 200 Independence Avenue, S.W., Room 509F HHH Bldg., Washington, D.C. 20201, calling 1-800-368-1019, (TDD: 1-800-537-7697) or visiting www.hhs.gov/ocr/privacy/hipaa/complaints/. All complaints to this agency must be made in writing (either U.S. mail or online at their website).

We support your right to protect the privacy of your protected health information. We will not retaliate against you or penalize you for filing a complaint.

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

Address:
Health Net, Inc.:
Attention: Privacy Officer
P.O. Box 9103
Van Nuys, CA 91409

You may also contact us at:
Telephone: 1-800-522-0088
Fax: 1-818-676-8314
Email: Privacy@healthnet.com

Note: All complaints to the Plan must be made in writing and sent to the Health Net Privacy Officer listed above.

FINANCIAL INFORMATION PRIVACY NOTICE

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

We are committed to maintaining the confidentiality of your personal financial information. For the purposes of this notice, "personal financial information" means information about an enrollee or an applicant for health care coverage that identifies the individual, is not generally publicly available, and is collected from the individual or is obtained in connection with providing health care coverage to the individual.

Information We Collect:

We collect personal financial information about you from the following sources:

- Information we receive from you on applications or other forms, such as name, address, age, medical information and Social Security number;
- Information about your transactions with us, our affiliates or others, such as premium payment and claims history; and
- Information from consumer reports.

Disclosure of Information:

We do not disclose personal financial information about our enrollees or former enrollees to any third party, except as required or permitted by law. For example, in the course of our general business practices, we may, as permitted by law, disclose any of the personal financial information that we collect about you, without your authorization, to the following types of institutions:

- To our corporate affiliates, such as other insurers;
- To nonaffiliated companies for our everyday business purposes, such as to process your transactions, maintain your account(s), or respond to court orders and legal investigations; and
- To nonaffiliated companies that perform services for us, including sending promotional communications on our behalf.

Confidentiality and Security:

We maintain physical, electronic and procedural safeguards, in accordance with applicable state and federal standards, to protect your personal financial information against risks such as loss, destruction or misuse. These measures include computer safeguards, secured files and buildings, and restrictions on who may access your personal financial information.

Questions about this Notice:

If you have any questions about this notice:

Please **call the toll-free phone number on the back of your ID card** or contact the Health Net at 1-800-522-0088.

****This Notice of Privacy Practices also applies to enrollees in any of the following Health Net entities:** Health Net of Arizona, Inc., Health Net Community Solutions of Arizona, Inc., Health Net of California, Health Net Life Insurance Company, Health Net Health Plan of Oregon, Inc., Managed Health Network, Health Net Community Solutions, Inc.

Rev. 06/07/2016

CHAPTER 10

Definitions of important words

Chapter 10. Definitions of important words

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – A set time each fall when members can change their health or drugs plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services after you pay any deductibles. Coinsurance is usually a percentage (for example, 20%).

Combined Maximum Out-of-Pocket Amount – This is the most you will pay in a year for all covered medical services from both network (preferred) providers and out-of-network (non-preferred) providers. See Chapter 4, Section 1.3 for information about your combined maximum out-of-pocket amount.

Complaint – The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription.

Cost-sharing – Cost-sharing refers to amounts that a member has to pay when services are received. (This is in addition to the plan's monthly premium.) Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed "copayment" amount that a plan requires when a specific service is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service, that a plan requires when a specific service is received.

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

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Deductible – The amount you must pay for health care before our plan begins to pay.

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Durable Medical Equipment – Certain medical equipment that is ordered by your doctor for medical reasons. Examples are walkers, wheelchairs, or hospital beds.

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

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

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

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

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

Hospice – An enrollee who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

In-Network Maximum Out-of-Pocket Amount – The most you will pay for covered medical services received from network (preferred) providers. After you have reached this limit, you will not have to pay anything when you get covered services from network providers for the rest of the contract year. However, until you reach your combined out-of-pocket amount, you must continue to pay your share of the costs when you seek care from an out-of-network (non-preferred) provider. See Chapter 4, Section 1.3 for information about your in-network maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6 for information about how to contact Medicaid in your state.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a PACE plan, or a Medicare Advantage Plan.

Medicare Advantage Disenrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to Original Medicare. The Medicare Advantage Disenrollment Period is from January 1 until February 14, 2017.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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

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

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

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

Network Provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**network providers**" when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

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

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. The Medicare Advantage plan's network provider or facility has also made an organization determination when it provides you with an item or service, or refers you to an out-of-network provider for an item or service. Organization determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan such as Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's "out-of-pocket" cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

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

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Physician of Choice (POC) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. Some people may call a POC a "Primary Care Provider" or "PCP". See Chapter 3, Section 2.1 for information about Physicians of Choice.

Prior Authorization – Approval in advance to get covered services. In the network portion of a PPO, some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. In a PPO, you do not need prior authorization to obtain out-of-network services. However, you may want to check with the plan before obtaining services from out-of-network providers to confirm that the service is covered by your plan and what your cost-sharing responsibility is. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4 for information about how to contact the QIO for your state.

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

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's

also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you permanently move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drugs plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you move into a nursing home, or if we violate our contract with you.

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

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

Health Net Aqua (PPO) Member Services

Method	Member Services – Contact Information
CALL	1-888-445-8913 Calls to this number are free. From October 1 - February 14, Member Services is open seven days a week from 8:00 a.m. to 8:00 p.m. Pacific time. Please see Chapter 2, Section 1 for details about our hours of operation throughout the year. Member Services also has free language interpreter services available for non-English speakers.
TTY	711 (National Relay Service) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	1-866-214-1992
WRITE	Health Net Medicare Programs P.O. Box 10420 Van Nuys, CA 91410-0420
WEBSITE	www.healthnet.com

Senior Health Insurance Benefits Assistance Program (SHIBA) (Oregon SHIP)

SHIBA is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Contact Information
CALL	1-800-722-4134
TTY	711 (National Relay Service) This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Senior Health Insurance Benefits Assistance Program (SHIBA) P.O. Box 14480 Salem, OR 97309-0405
WEBSITE	http://www.oregonshiba.org