EVIDENCE OF COVERAGE

A complete explanation of your plan

Health Net Seniority Plus Employer (HMO)
2021 Plan Year

Important benefit information – please read

H0562_21_19769EGEOC_C_08132020

(Plan B1J)
EOCID 630186

OMB Approval 0938-1051 (Expires: December 31, 2021)

Evidence of Coverage:

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

This booklet gives you the details about your Medicare health care coverage for your 2021 benefit period. It explains how to get coverage for the health care services you need. **This is an important legal document. Please keep it in a safe place.**

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

This document is available for free in Chinese & Spanish.

Please contact our Member Services number at 1-800-275-4737 for additional information. (TTY users should call 711). From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

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

Benefits, premium, deductible, and/or copayments/coinsurance may change for the 2022 plan year.

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

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GETTING STARTED AS A MEMBER

Introduction

You are enrolled in Health Net Seniority Plus Employer (HMO)

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

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

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 Seniority Plus Employer (HMO).

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

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

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 your employer or retiree group about how we cover 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 Seniority Plus Employer (HMO).

Each plan 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 Seniority Plus Employer (HMO) at the end of each plan year. We can also choose to stop offering the plan, or to offer it in a different service area at the end of each plan year.

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.

What makes you eligible to be a plan member?

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 "What are Medicare Part A and Medicare Part B?" tells you about Medicare Part A and Medicare Part B).
- -- *and* -- you live in our geographic service area (see the "Here is the plan service area for our plan" section below for the description of our service area).
- -- *and* -- you are a United States citizen or are lawfully present in the United States.
- -- *and* --you meet any additional eligibility requirements of your employer's or union's benefit administrator.

If you currently pay a premium for Medicare Part A and/or Medicare Part B, you must continue to pay your premium in order to keep your Medicare Part A and/or Medicare Part B and to remain a member of this plan.

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, home infusion therapy, and other outpatient services) and certain items (such as durable medical equipment (DME)and supplies).

Here is the plan service area for our plan

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

Our service area includes these counties in California:

Alameda County

Contra Costa County

Fresno County

Imperial County

Kern County

Los Angeles County

Orange County

Placer County

Riverside County

Sacramento County

San Bernardino County

San Diego County

San Francisco County

San Joaquin County

San Mateo County

Santa Barbara, the following ZIP codes only: 93013, 93014, 93067, 93101, 93102, 93103, 93105, 93106, 93107, 93108, 93109, 93110, 93111, 93116, 93117, 93118, 93120, 93121, 93130, 93140, 93150, 93160, 93190, 93199, 93252, 93427, 93436, 93437, 93438, 93440, 93441, 93460, 93463, 93464.

Santa Clara County

Santa Cruz County

Solano County

Sonoma County

Stanislaus County

Tulare County

Yolo County

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 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 the "Important phone numbers and resources" chapter of this booklet.

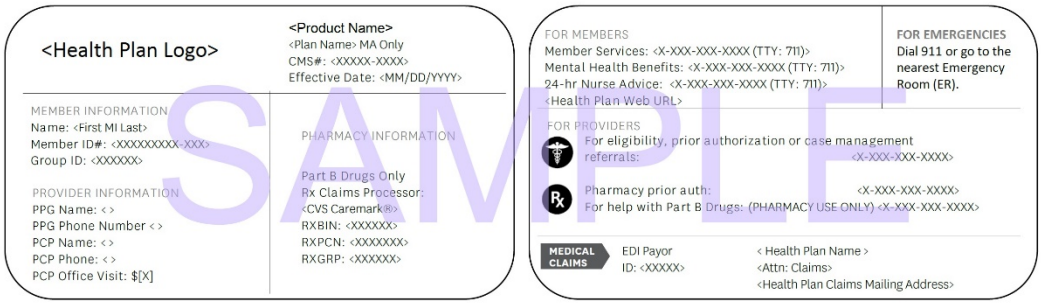
U.S. Citizen or Lawful Presence

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

What other materials will you get from us?

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

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



Do NOT use your red, white, and blue Medicare card for covered medical services while you are a member of this plan. If you use your Medicare card instead of your membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in routine research studies.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your plan 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.)

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. The most recent list of providers is available on our website at healthnet.com.

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

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan, you must use network providers to get your medical care and services. In addition, you may be limited to providers within your Primary Care Provider's (PCP's) and/or Medical Group's network. This means that the PCP and/or Medical Group that you choose may determine the specialists and hospitals you can use. See the "Using the plan's coverage for your medical services" chapter of this booklet for more information about choosing

a PCP. The only exceptions are emergencies, urgently needed services when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers. See the "Using the plan's coverage for your medical services" chapter of this booklet for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don't have your copy of the *Provider Directory*, you can request a copy from Member Services (phone numbers are printed on the back cover of this booklet). You may ask Member Services for more information about our network providers, including their qualifications. You can also see the *Provider Directory* at 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.

Your monthly premium for your plan

How much is your plan premium?

Your coverage is provided through contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator for information about your plan premium. 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).

Many members are required to pay other Medicare premiums

Many members are required to pay other Medicare premiums. As explained in the "What makes you eligible to be a plan member?" section above, in order to be eligible for our plan, you must have both Medicare Parts A and B. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. 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 2021* tells about the Medicare premiums in the section called "2021 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* 2021 from the Medicare website (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.

Please keep your plan membership record up to date

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

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

The doctors, hospitals, and other providers in the plan's network need to have correct information about you. **These network providers use your membership record to know what services are covered 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 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 the "Important phone numbers and resources" chapter of this booklet.

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

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see the "How other insurance works with our plan" section of 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, please mail back the letter with the necessary corrections 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).

We protect the privacy of your personal health information

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 the "We must protect the privacy of your personal health information" section in the "Your rights and responsibilities" chapter of this booklet.

How other insurance works with our plan

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.

IMPORTANT PHONE NUMBERS AND RESOURCES

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

How to contact our plan's Member Services

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

Method	Member Services – Contact Information
CALL	**1-800-275-4737** Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m., seven days a week. From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays. 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** 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 a.m. to 8 p.m. 7 days a week (from October 1 to March 31), and 8 a.m. to 8 p.m., Monday – Friday (from April 1 to September 30)
FAX	**1-844-222-3180**
WRITE	PO Box 10420 Van Nuys, CA 91410
WEBSITE	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 the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter of this booklet.

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

Method	Coverage Decisions For Medical Care – Contact Information
CALL	**1-800-275-4737** Calls to this number are free. From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.
TTY	**711** 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 a.m. to 8 p.m. 7 days a week (from October 1 to March 31), and 8 a.m. to 8 p.m., Monday – Friday (from April 1 to September 30)
FAX	**1-800-793-4473**
WRITE	Medical Management 21281 Burbank Blvd. Woodland Hills, CA 91367-6607
WEBSITE	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 the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter of this booklet.

Method	Appeals For Medical Care – Contact Information
CALL	**1-800-275-4737** Calls to this number are free. 8 a.m. to 8 p.m. 7 days a week (from October 1 to March 31), and 8 a.m. to 8 p.m., Monday – Friday (from April 1 to September 30)
TTY	**711** 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 a.m. to 8 p.m. 7 days a week (from October 1 to March 31), and 8 a.m. to 8 p.m., Monday – Friday (from April 1 to September 30)
FAX	**1-844-273-2671**
WRITE	Appeals & Grievances Medicare Operations P.O. Box 10450 Van Nuys, CA 91410-0450
WEBSITE	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 the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter of this booklet.

Method	Complaints About Medical Care – Contact Information
CALL	**1-800-275-4737** Calls to this number are free. 8 a.m. to 8 p.m. 7 days a week (from October 1 to March 31), and 8 a.m. to 8 p.m., Monday – Friday (from April 1 to September 30)
TTY	**711** 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 a.m. to 8 p.m. 7 days a week (from October 1 to March 31), and 8 a.m. to 8 p.m., Monday – Friday (from April 1 to September 30)
FAX	**1-844-273-2671**
WRITE	Appeals & Grievances Medicare Operations P.O. Box 10450 Van Nuys, CA 91410-0450
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 the "Asking us to pay our share of a bill you have received for covered medical services" chapter of this booklet.

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter of this booklet.

Method	Payment Requests – Contact Information
CALL	**1-800-275-4737** Calls to this number are free. 8 a.m. to 8 p.m. 7 days a week (from October 1 to March 31), and 8 a.m. to 8 p.m., Monday – Friday (from April 1 to September 30)
TTY	**711** 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 a.m. to 8 p.m. 7 days a week (from October 1 to March 31), and 8 a.m. to 8 p.m., Monday – Friday (from April 1 to September 30)
WRITE	**Medical Claims:** **Health Net** PO Box 9030 Farmington, MO 63640
WEBSITE	healthnet.com

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

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

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

Method	Medicare – Contact Information
CALL	**1-800-MEDICARE, or 1-800-633-4227** Calls to this number are free. 24 hours a day, 7 days a week.

TTY	**1-877-486-2048** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	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.)

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

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

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

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

Method	Health Insurance Counseling and Advocacy Program HICAP (California SHIP) – Contact Information
CALL	**1-800-434-0222**
TTY	**711** These numbers require special telephone equipment and are only for people who have difficulties with hearing or speaking.
WRITE	HICAP 505 12th Street Sacramento, CA 95814
WEBSITE	www.hicapservices.net

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

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

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

You should contact Livanta in any of these situations:

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

Method	Livanta (California's Quality Improvement Organization) – Contact Information
CALL	**1-877-588-1123** Monday - Friday, 9:00 a.m. - 5:00 p.m., Weekend and federal holidays, 11:00 a.m. – 3:00 p.m.
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 10820 Guilford Road, Suite 202 Annapolis, MD 20701
WEBSITE	www.livantaqio.com

Social Security

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

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

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

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 can help people with Medicare pay for 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 the Medi-cal.

Method	Medi-cal (California's Medicaid program) – Contact Information
CALL	1-800-430-4263 Monday – Friday, 8:00 a.m. to 5:00 p.m.(excluding holidays)
TTY	1-800-430-7077 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	Department of Health Care Services P.O. Box 997417 MS 4607 Sacramento, CA 95899-7417
WEBSITE	https://www.dhcs.ca.gov/services/medi-cal/pages/applyformedi-cal.aspx

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. If you press "0," you may speak with an RRB representative from 9:00 am to 3:30 pm, Monday, Tuesday, Thursday, and Friday, and from 9:00 am to 12:00 pm on Wednesday. If you press "1", you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.
TTY	**1-312-751-4701** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
WEBSITE	rrb.gov/

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), 24 hours a day, 7 days a week, with questions related to your Medicare coverage under this plan.

USING THE PLAN'S COVERAGE FOR YOUR MEDICAL SERVICES

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

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

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

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 Medical Benefits Chart in the "Medical Benefits Chart (what is covered and what you pay)" chapter of this booklet.

Basic rules for getting your medical care covered by the plan

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

We 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 the "Medical Benefits Chart (what is covered and what you pay)" chapter of this booklet).
- **The care you receive is considered medically necessary**. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis or treatment of your medical condition and meet accepted standards of medical practice.

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

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

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

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

When you become a member of our plan, you must first choose a plan provider to be your PCP. Your PCP is your partner in health, providing or coordinating your care. Your PCP is a health care professional who meets state requirements and is trained to give you basic medical care. These include doctors specializing in family practice, general practice, and internal medicine.

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

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

"Coordinating" your covered services includes checking or consulting with other plan providers about your care and how it is going. For certain types of services or supplies, your PCP will need to get prior authorization (approval in advance). If the service you need requires prior authorization, your PCP will request the authorization from our plan. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. You will usually see your PCP first for most of your routine health care needs. We recommend you have your PCP coordinate all of your care. Please refer to "How to get care from specialists and other network providers" section of this chapter for more information.

In some cases, your PCP, or a specialist or other provider you're seeing, will need to obtain prior authorization (prior approval) from us for certain types of covered services and items. See the "Medical Benefits Chart (What is covered and what you pay)" chapter of this booklet for services and items that require prior authorization.

How do you choose your PCP?

When you enroll in our plan, you will choose a participating Medical Group from the Health Net Seniority Plus Employer (HMO) network. You will also choose a PCP from this participating Medical Group. To choose your PCP, go to our website at healthnet.com and select a PCP from our plan network. Member Services can also help you choose a PCP. Once you have chosen your PCP call Member Services with your selection. Your PCP must be in our network.

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

Please Note: If you use a PCP that is not printed on your ID card, you may incur a higher cost share or your claims may be denied. For information on how to change your PCP, please see "Changing your PCP" below.

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

Changing your PCP

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

If you wish to change your Medical Group or PCP, please call Member Services. Each plan Medical Group and PCP may make referrals to certain plan specialists and uses certain hospitals within their network. This means that the plan Medical Group and PCP you choose may determine the specialists and hospitals you may use. If there are specific specialists or hospitals you want to use, find out if your plan Medical Group and PCP uses these specialists or hospitals.

To change your PCP, call Member Services at the phone number on the back cover of this booklet. You will be issued a new ID card showing the new PCP's name and contact information. The change will be effective the first day of the following month. **Please Note**: If you use a PCP that is not printed on your ID card, you may incur a higher cost share or your claims may be denied.

Under certain circumstances, our providers are obligated to continue care after leaving our network. For specific details, contact Member Services (phone numbers are printed on the back cover of this booklet).

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

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

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider.
- Flu shots and pneumonia vaccinations, as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, (e.g., when you are temporarily outside of the plan's service area).
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away. Phone numbers for Member Services are printed on the back cover of this booklet.)
- Refer to "Use this Medical Benefits Chart to find out what is covered for you and how much you will pay" section of this chapter "Medical Benefits Chart (what is covered and what you pay)" for details section of this chapter which covered services may require an approval in advance (referral) from your PCP.

How to get care from specialists and other network providers

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

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

In order for you to see a specialist, you usually need to get your PCP's approval first. This is called getting a "referral" to a specialist. It is very important to get a referral from your PCP before you see a plan specialist or certain other providers. There are a few exceptions, including routine women's health care, as explained in "What kinds of medical care can you get without getting approval in advance from your PCP?" section of this chapter. If you don't have a referral before you get services from a specialist, you may have to pay for these services yourself.

If the specialist wants you to come back for additional care, check first to be sure that the referral you got from your PCP for the first visit covers additional visits to the specialist.

Each Medical Group and PCP may make referrals to certain plan specialists and uses certain hospitals within their network. This means that the Medical Group and PCP you choose may determine the specialists and hospitals you may use. If there are specific specialists or hospitals you want to use, find out if your Medical Group or PCP uses these specialists or hospitals. You may generally change your PCP at any time if you want to see a plan specialist or go to a hospital that your current PCP can't refer you to. Your PCP change may be effective the first day of the following month. In "You must choose a Primary Care Provider (PCP) to provide and oversee your medical care" section of this chapter, we tell you how to change your PCP.

Some types of services will require getting approval in advance from our plan and/or your Medical Group. This is called getting "prior authorization". If the service you need requires prior authorization, your PCP or other network provider will request the authorization from our plan and/or your Medical Group. The request will be reviewed and a decision (organization determination) will be sent to you and your provider. See the "Medical Benefits Chart (what is covered and what you pay)" chapter in this booklet for the specific services that require prior authorization.

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

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

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.

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

How to get care from out-of-network providers

If you need Medicare-covered medical care and a network provider is unable to provide this care, you may be able to get care from an out-of-network provider. Our plan must confirm there is not a network provider available and contact the plan to request authorization for you to obtain services from an out-of-network provider. If approved, the out-of-network provider will be issued an authorization to provide the service(s).

You are entitled to receive services from out-of-network providers for emergency or out-of-area urgently needed services. In addition, our plan must cover dialysis services for members with End-Stage Renal Disease (ESRD) who have traveled outside the plan's service area and are not able to access network providers. ESRD services must be received at a Medicare-certified dialysis facility.

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

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 PCP.
- **As soon as possible, make sure that our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The phone number for Member Services is printed on the back cover of this booklet.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Health Net Seniority Plus Employer (HMO) includes world-wide emergency/urgent coverage. 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 the "Medical Benefits Chart (what is covered and what you pay)" chapter of this booklet.

Medicare does not cover emergency care outside of the United States. However, with our plan you may get covered emergency medical care outside the United States. For more information, see "Worldwide Emergency/Urgent Coverage" in the Benefits Chart in this booklet or call Member Services at the phone number printed on the back cover of this booklet.

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

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

What if it wasn't a medical emergency?

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

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

- You go to a network provider to get the additional care.

- – *or* –The additional care you get is considered "urgently needed services" and you follow the rules for getting these urgently needed services (for more information about this, see the "Getting care when you have an urgent need for services" section of this chapter below).

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?

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

When you need urgent care, contact your PCP or Medical Group. If your PCP or Medical Group is unavailable, please see your *Provider Directory* for network urgent care facilities. You can also find network urgent care facilities at healthnet.com. The Medical Benefits Chart (what is covered and what you pay) chapter of this booklet explains how much you should expect to pay for covered urgent care services.

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

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

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

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances: defined as urgent, emergent, and post-stabilization care received outside of the United States and its territories. Transportation back to the United States from another country is not covered. For more information, see the "Worldwide Emergency/Urgent

Coverage" section in the Medical Benefits Chart (what is covered and what you pay)" chapter in this *Evidence of Coverage*, or call Member Services at the phone number listed on the back cover of this booklet.

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: healthnet.com for information on how to obtain needed care during a disaster.

Generally, if you cannot use a network provider during a disaster, your plan will allow you to obtain care from out-of-network providers at in-network cost-sharing.

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

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, see the "Asking us to pay our share of a bill you have received for covered medical services" chapter in this booklet for information about what to do.

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

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

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

The "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter in this booklet 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.

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

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 our plan or your PCP. The providers that deliver your care as part of the clinical research study do *not* need to be part of our plan's network of providers.

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

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

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 be 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 the "Asking us to pay our share of a bill you have received for covered medical services" chapter of this *Evidence of Coverage* 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.

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

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.

Receiving Care From a Religious Non-Medical Health Care Institution

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 the "Medical Benefits Chart (what is covered and what you pay)" chapter of this booklet.

Rules for ownership of durable medical equipment

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

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

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

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

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

If you made fewer than 13 payments for the DME item under Original Medicare *before* you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

Rules for Oxygen Equipment, Supplies, and Maintenance

What oxygen benefits are you entitled to?

If you qualify for Medicare oxygen equipment coverage, then for as long as you are enrolled, Health Net Seniority Plus Employer (HMO) will cover:

- Rental of oxygen equipment
- Delivery of oxygen and oxygen contents
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents
- Maintenance and repairs of oxygen equipment

If you leave Health Net Seniority Plus Employer (HMO) or no longer medically require oxygen equipment, then the oxygen equipment must be returned to the owner.

What is your cost sharing? Will it change after 36 months?

Your cost sharing for Medicare oxygen equipment coverage is $0 copay every month.

If prior to enrolling in Health Net Seniority Plus Employer (HMO) you had made 36 months of rental payment for oxygen equipment coverage, your cost sharing in Health Net Seniority Plus Employer (HMO) is $0 copay.

What is your cost sharing? Will it change after 36 months? What happens if you leave your plan and return to Original Medicare?

If you return to Original Medicare, then you start a new 36-month cycle which renews every five years. For example, if you had paid rentals for oxygen equipment for 36 months prior to joining Health Net Seniority Plus Employer (HMO), join Health Net Seniority Plus Employer (HMO) for 12 months, and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

Similarly, if you made payments for 36 months while enrolled in Health Net Seniority Plus Employer (HMO) and then return to Original Medicare, you will pay full cost sharing for oxygen equipment coverage.

MEDICAL BENEFITS CHART (WHAT IS COVERED AND WHAT YOU PAY)

Understanding your out-of-pocket costs for covered services

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

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

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

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

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

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

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

As a member of our plan, the most you will have to pay out-of-pocket for in-network covered services in 2021 is $3400. The amounts you pay for the deductibles (if applicable to your plan), copayments, and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. (The amounts you pay for any plan premiums (if applicable to your plan) do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with a diamond (◈) in the Medical Benefits Chart.) If you reach the maximum out-of-pocket amount of $3400, you will not have to pay any out-of-pocket costs for the rest of the year for covered services. However, you must continue to pay your plan premium (if applicable) and the

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

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

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

Use this Medical Benefits Chart to find out what is covered for you and how much you will pay

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:

- With the exception of Employer-Sponsored benefits (benefits beyond the basic Medicare-covered benefits), your Medicare-covered services must be provided according

to the coverage guidelines established by Medicare.

- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. See the "Using the plan's coverage for your medical services" chapter in this booklet, as it provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a "referral." See the "Using the plan's coverage for your medical services" chapter in this booklet, as it provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that may need approval in advance are marked in the Medical Benefits Chart with an asterisk (*).

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less.* (If you want to know more about the coverage and costs of Original Medicare, look in your *Medicare & You 2021* 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 the plan year, either Medicare or our plan will cover those services.

 You will see this apple next to the preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Services that are covered for you	What you must pay when you get these services
INPATIENT CARE	
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. You are covered for unlimited days 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	*Prior authorization (approval in advance) may be required.* A referral may be required. There is no copayment for the Medicare-covered services listed. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.

Services that are covered for you	What you must pay when you get these services
• Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Contact Member Services for details regarding the plan's policy for transplant travel coverage. • 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 to the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient 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: www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.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.	

Services that are covered for you	What you must pay when you get these services
Inpatient Mental Health care Covered services include mental health care services that require medical supervision and confinement in a hospital providing psychiatric care. You are covered for unlimited days.	*Prior authorization (approval in advance) may be required.* There is no copayment for Medicare-covered services in a network hospital.
Inpatient substance abuse care Residential care in a hospital or residential treatment center for psychiatric or chemical dependency. You are covered for unlimited days.	*Prior authorization (approval in advance) may be required.* There is no copayment for inpatient substance abuse care covered services in a network hospital.
Inpatient stay: Covered services received in a hospital or SNF during a non-covered inpatient stay 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 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	*Prior authorization (approval in advance) may be required.* A referral may be required. The listed services will continue to be covered at the cost-sharing amounts shown in this Medical Benefits Chart for the specific service. For Medicare-covered medical supplies including cast and splints, you pay the applicable cost-sharing amount where the specific service is provided. For example, if these medical supplies were used during a visit to an emergency room, then they would be included as part of the emergency room visit copayment.

Services that are covered for you	What you must pay when you get these services
• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes, including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	
Acute care detoxification You are covered for unlimited days.	*Prior authorization (approval in advance) may be required.* There is no copayment for Medicare-covered acute care detoxification services.
Skilled Nursing Facility (SNF) care (For a definition of "Skilled Nursing Facility (SNF) Care," see "Definitions of important words" in this booklet. Skilled nursing facilities are sometimes called "SNFs.") You are covered for 100 days per benefit period. No prior hospital stay is required prior to SNF admission. Covered services include, but are not limited to: • 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	*Prior authorization (approval in advance) may be required.* A referral may be required. There is no copayment for Medicare-covered services in a Skilled Nursing Facility. You pay all costs for each day after day 100 in the benefit period. A benefit period begins the first day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Services that are covered for you	What you must pay when you get these services
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	
Home health agency care Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. 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	*Prior authorization (approval in advance) may be required.* A referral may be required. There is no copayment for Medicare-covered home health visits.

Services that are covered for you	What you must pay when you get these services
Home infusion therapy (HIT) Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to an individual at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but are not limited to: • Professional services, including nursing services, furnished in accordance with the plan of care • Patient training and education not otherwise covered under the durable medical equipment benefit • Remote monitoring • Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	You pay a $0 copay for professional services, including nursing services, training and education, remote monitoring and monitoring services. Home infusion equipment and supplies are covered under your Durable Medical Equipment (DME) benefit. Please see the DME row for cost-sharing information. Home infusion drugs are covered under your Medicare Part B Drugs benefit. Please see the Medicare Part B Drugs row for cost-sharing information.
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 For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal prognosis: 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. For services that are covered by Medicare Part A or B and	A referral may be required. 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 the plan. You pay $15 for a one time consultation visit before you select hospice.

Services that are covered for you	What you must pay when you get these services
are not related to your terminal prognosis: 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: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services • If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare) 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 condition. 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. **Hospice Consultation Services*** Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	
Outpatient Services	
Physician/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 PCP or specialist, if your doctor orders it to see if you	You pay $15 for each Medicare-covered primary care doctor office visit or medically-necessary surgery services furnished in a physician's office. *Prior authorization (approval in advance) may be required.* A referral may be required.

Services that are covered for you	What you must pay when you get these services
need medical treatment • Certain telehealth services, including: primary care, specialist and other health care professional services, and outpatient mental health specialty services, including psychiatric care. o You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service by telehealth. o Contact your provider's office to see if they offer telehealth services and for information on how to access those services. • Some telehealth services including consultation, diagnosis, and treatment by a physician or practitioner, • Telehealth service for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home. • Telehealth services to diagnose, evaluate or treat symptoms of a stroke • Brief virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes **if**: o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment. • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours **if:** o You're not a new patient **and** o The check-in isn't related to an office visit in the past 7 days **and** o The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment. • Consultation your doctor has with other doctors by telephone, internet, or electronic health record **if** you're not a new patient	You pay $15 for each Medicare-covered specialist visit or medically-necessary surgery services furnished in a specialist's office. You pay $15 for each physician visit to your home. Cost-shares for covered additional telehealth services are the same as the standard cost-sharing for those services in an office setting. 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.

Services that are covered for you	What you must pay when you get these services
• Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) Additional copayments may be required depending on services rendered.	
Outpatient hospital services We cover medically-necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include but are not limited to: • Services in an emergency department or outpatient clinic, such as observation or outpatient surgery • Laboratory and diagnostic tests billed by the hospital • Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it • X-rays and other radiology services billed by the hospital • Medical supplies, such as splints and casts • Certain drugs and biologicals that you can't give yourself **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	*Prior authorization (approval in advance) may be required.* A referral may be required. You pay the applicable 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 visit copayment.

Services that are covered for you	What you must pay when you get these services
You Have Medicare – Ask!" This fact sheet is available on the Web at: www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.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.	
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **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: www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.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.	*Prior authorization (approval in advance) may be required.* A referral may be required. You pay a $0 copay for each Medicare-covered observation service during an outpatient hospital facility visit. You pay a $20 copay for each Medicare-covered observation service during an emergency room visit.

Services that are covered for you	What you must pay when you get these services
Chiropractic services	
Covered services include: • Manual manipulation of the spine to correct subluxation (Medicare-covered) • Routine Chiropractic care (non-Medicare covered).◈ ◈The amounts you pay for these services do not count towards your maximum out-of-pocket amount. Refer to the "Additional Benefit Information" section later in this chapter for more information.	*Prior authorization (approval in advance) may be required.* A referral may be required. You pay $15 for each Medicare-covered chiropractic visit for (manual manipulation of the spine to correct subluxation). You pay $5 per visit when using our Chiropractic Network (up to 20 medically necessary visits per plan year).◈

Services that are covered for you	What you must pay when you get these services
Acupuncture for chronic low back pain Covered services include: Up to 12 visits in 90 days are covered for Medicare beneficiaries under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • Lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious, etc. disease); • not associated with surgery; and • not associated with pregnancy. An additional eight sessions will be covered for those patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. **Routine Acupuncture Services** In addition to the Medicare-covered acupuncture services, • Routine Acupuncture services (non-Medicare Covered).◈ ◈The amounts you pay for these services do not count toward your maximum out-of-pocket amount. Refer to the "Additional Benefit Information" portion later in this section for more information.	*Prior authorization (approval in advance) may be required* You pay a $15 copay for each Medicare-covered acupuncture visit up to 20 medically necessary visits per plan year. You pay $15 for each visit, up to 20 medically necessary visits every plan year.◈ For Medicare-covered acupuncture services received outside of a stand-alone acupuncturist's office, you pay the applicable cost-sharing amount where the specific service is provided.

Services that are covered for you	What you must pay when you get these services
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 • Routine foot care (Non-Medicare covered). Care is limited to one visit per calendar month. Additional visits or referrals must be arranged and approved by your PCP.	*Prior authorization (approval in advance) may be required.* A referral may be required. You pay $15 for each Medicare-covered visit (medically necessary foot care). You pay $15 for each routine (Non-Medicare covered) visit.
Outpatient mental health care 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.	*Prior authorization (approval in advance) may be required.* You pay $15 for each Medicare-covered individual therapy visit. You pay $15 for each Medicare-covered group therapy session.
Partial hospitalization services "Partial hospitalization" is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	*Prior authorization (approval in advance) may be required.* There is no copayment for Medicare-covered partial hospitalization.
Outpatient substance abuse 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.	*Prior authorization (approval in advance) may be required.* A referral may be required. You pay $15 for each Medicare-covered individual therapy visit. You pay $15 for each Medicare-covered group therapy session.

Services that are covered for you	What you must pay when you get these services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **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."	*Prior authorization (approval in advance) may be required.* A referral may be required. There is no copayment for Medicare-covered visit to an ambulatory surgical center. There is no copayment for Medicare-covered visit to an outpatient hospital facility.
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care 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.	*Prior authorization (approval in advance) may be required.* There is no copayment for Medicare-covered ground ambulance services. There is no copayment for Medicare-covered air ambulance services.

Services that are covered for you	What you must pay when you get these services
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 $20 for each Medicare-covered emergency room visit. You do not pay this amount if you are directly admitted to the hospital. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.
Urgently needed services	
Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical services. 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.	You pay $20 for each Medicare-covered urgently needed services visit. You do not pay this amount if you are directly admitted to the hospital.

Services that are covered for you	What you must pay when you get these services
• 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 the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.	
Opioid treatment program services Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable • Substance use counseling • Individual and group therapy • Toxicology testing	*Prior authorization may be required.* A referral may be required. You pay $15 for each Medicare-covered opioid treatment in an individual setting. You pay $15 for each Medicare-covered opioid treatment in a group setting.

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

Services that are covered for you	What you must pay when you get these services
Durable medical equipment (DME) and related supplies (For a definition of "Durable Medical Equipment," see the "Definitions of important words"chapter of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds, ordered by a provider for use in home, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at healthnet.com.	*Prior authorization (approval in advance) may be required.* There is no copayment for Medicare-covered durable medical equipment and related supplies.
Prosthetic devices and related supplies • 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 chapter for more detail. • Medicare-covered parenteral and enteral nutrition (PEN): Covers related supplies and nutrients. Does not cover baby food and other regular grocery products that can be blenderized and used with the enteral system or any additional nutritional supplementation (such as those for daily protein or caloric intake).	*Prior authorization (approval in advance) may be required.* There is no copayment for Medicare-covered prosthetic devices and related supplies.

Services that are covered for you	What you must pay when you get these services
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but are not limited to: • X-rays • Therapeutic radiological services (radiation therapy, radium, and isotope) including technician material and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • Laboratory services (includes blood tests, urinalysis, and some screening tests) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used • Other diagnostic tests • EKG tests • Diagnostic radiological service (includes complex tests such as CT, MRI, MRA, SPECT)	*Prior authorization (approval in advance) may be required.* A referral may be required. There is no copayment for the Medicare-covered services listed. **COVID-19 coverage** You pay a $0 copay for laboratory and diagnostic procedures and tests related to COVID-19 at any location. You pay a $0 copay for an EKG following the “Welcome to Medicare” Preventive Visit. If the doctor provides you services in addition to outpatient diagnostic procedures, tests, and lab services, separate cost-sharing may apply. 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
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 copayment for worldwide emergency/urgent coverage received outside of the United States[1].
Preventive Services	
For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. The plan only covers this screening if you 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.	*Prior authorization (approval in advance) may be required.* A referral may be required. There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.

Services that are covered for you	What you must pay when you get these services
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.	*Prior authorization (approval in advance) may be required.* A referral may be required. There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results. 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.	*Prior authorization (approval in advance) may be required.* A referral may be required. There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.

Services that are covered for you	What you must pay when you get these services
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, the following is covered: • 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.	*Prior authorization (approval in advance) may be required.* A referral may be required. There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.

Services that are covered for you	What you must pay when you get these services
Breast cancer screening (mammograms) Covered services include: • One baseline exam 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.	A referral may be required. There is no coinsurance, copayment, or deductible for covered screening mammograms.
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 or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months 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.	A referral may be required. There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Prostate cancer screening exam For men age 50 and older, covered services include the following - once every 12 months:	*Prior authorization (approval in advance) may be required.* A referral may be required.

Services that are covered for you	What you must pay when you get these services
• 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 digital rectal exam. There is no coinsurance, copayment, or deductible for an annual PSA test.
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary • 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* Other immunizations: • Immunizations for foreign travel/occupational purposes. 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.	*Prior authorization (approval in advance) may be required.* A referral may be required. There is no coinsurance, copayment, or deductible for the Medicare-covered pneumonia, influenza, and Hepatitis B vaccines. There is no copayment for other Medicare-covered vaccines if you are at risk and they meet Medicare Part B coverage rules. You pay 20% coinsurance for immunizations for foreign travel/occupational purposes.

Services that are covered for you	What you must pay when you get these services
Cardiovascular disease testing Blood tests for the early 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 copayment or coinsurance will apply for the care received for the existing medical condition.	*Prior authorization (approval in advance) may be required.* A referral may be required. There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
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 healthy. 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.	A referral may be required. There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
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/or 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	A referral may be required. 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
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.	
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.	A referral may be required. There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
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 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.	A referral may be required. There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

Services that are covered for you	What you must pay when you get these services
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. *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 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.	*Prior authorization (approval in advance) may be required.* A referral may be required. There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision making visit or for the LDCT.
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.	*Prior authorization (approval in advance) may be required.* A referral may be required. There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs

Services that are covered for you	What you must pay when you get these services
preventive benefit. 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.	
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.	*Prior authorization (approval in advance) may be required.* A referral may be required. There is no copayment for fasting plasma glucose tests for persons at risk of diabetes. There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a transplant when referred by your doctor. We cover 3 hours of one-on-one counseling services during	*Prior authorization (approval in advance) may be required.* A referral may be required. There is no coinsurance,

Services that are covered for you	What you must pay when you get these services
your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into the next plan 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.	copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) <u>If you use tobacco, but do not have signs or symptoms of tobacco-related disease:</u> We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. <u>If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:</u> We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable 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. Members receive an in-depth assessment and personalized plan to quit smoking. This includes up to 5 proactive, one-on-one coaching calls, and unlimited toll free access to a quit coach. Refer to "Decision Power®: Health and Wellness" under "Additional Benefit Information" later in this chapter for more information on this benefit.	*Prior authorization (approval in advance) may be required.* A referral may be required. There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

Services that are covered for you	What you must pay when you get these services
For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30-60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication • Be conducted in a hospital outpatient setting or a physician's office • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	*Prior authorization (approval in advance) may be required.* A referral may be required. There is no coinsurance, copayment, or deductible for each Medicare-covered Supervised Exercise Therapy (SET) visit.

" 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 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.

A referral may be required.

There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.

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 exam 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 visit 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.

A referral may be required.

There is no coinsurance, copayment, or deductible for the annual wellness visit.

Other Services

Services to treat kidney disease

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. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in the "Using the plan's coverage for your medical services" chapter of this booklet) • 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 "Prescription drugs" section.	*Prior authorization (approval in advance) may be required.* A referral may be required. There is no copayment for Medicare-covered renal dialysis (kidney) services. There is no copayment for Medicare-covered kidney disease education services.

Physical exam

Routine annual physical exam, limited to one exam each year	There is no copayment for each routine physical exam.

Medicare Diabetes Prevention Program (MDPP)

MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change,	*Prior authorization (approval in advance) may be required.* A referral may be required.

increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle. 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 MDPP benefit.
Prescription drugs **Medicare Part B prescription drugs** These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs that may be subject to step therapy include: • Drugs that are usually not self-administered by the patient and are injected while receiving physician services • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by Health Net • 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 treatment of	*Prior authorization (approval in advance), including step therapy, may be required.* There is no copayment for Medicare-covered Part B Drugs.

primary immune deficiency diseases in your home The following link will take you to a list of Part B Drugs that may be subject to Step Therapy: https://ca.healthnetadvantage.com/steptherapyb We also cover some vaccines under our Part B prescription drug benefit.	

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: • 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	*Prior authorization (approval in advance) may be required.* A referral may be required. There is no copayment for Medicare-covered dental services.

Hearing services

• Diagnostic hearing and balance evaluations performed by your PCP or provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider • Routine (Non-Medicare-covered) hearing tests, limited to one test per year	*Prior authorization (approval in advance) may be required.* A referral may be required. You pay $15 for each Medicare-covered hearing test. You pay $15 for each routine hearing test. You pay 100% for hearing aids.

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, we will pay one glaucoma screening each year. People at high risk of glaucoma include: 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. • For people with diabetes, screening for diabetic retinopathy is covered once per year. • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • Routine (non-Medicare covered) vision exams, once per year	*Prior authorization (approval in advance) may be required.* A referral may be required. You pay $15 for each Medicare-covered eye exam (diagnosis and treatment of diseases and injuries of the eye). There is no copayment for Medicare-covered glaucoma screening. You pay $15 for Medicare-covered diabetic retinopathy screening. There is no copayment for Medicare-covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery). You pay $15 for each routine eye exam, limited to 1 exam every year.
Fitness Benefit (The Silver&Fit® Healthy Aging and Exercise Program)	There is no coinsurance, copayment, or deductible for the Fitness benefit. Refer to the "Additional Benefit Information" section later in this chapter for more Fitness information.

Health and wellness education programs[◈] **Nurse Advice Line:** Toll-free telephonic coaching and nurse advice from trained clinicians. The nurse advice line is available 24 hours a day, 7 days a week for assistance with health-related questions. The nurse advice line phone number is located on your member ID card or you can call member services and be transferred. **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.	There is no copayment 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.

[◈]The amounts you pay for these services do not count towards your maximum out-of-pocket amount.

What types of services are not covered by the plan?

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 the "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)" section of the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter in this booklet.)

All exclusions or limitations on services are described in the Medical 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 the "How are your medical services covered when you are in a "clinical research study"?" section of the "Using the plan's coverage for your medical services" chapter 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 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

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
		improvement of the functioning of a malformed body member. • Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Non-routine dental care.		✓ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.
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.
Reversal of sterilization procedures and/or non-prescription contraceptive supplies.	✓	
Naturopath services (uses natural or alternative treatments).	✓	
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.
Prenatal, maternity or post-partum care for a non-Health	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Net Seniority Plus Employer (HMO) Member acting as a surrogate.		
Services related to educational and professional purposes are not covered, including ancillary services such as: Vocational rehabilitation; Employment counseling, training or educational therapy for learning disabilities; Investigations required for employment; Education for obtaining or maintaining employment, or for professional certification; Education for personal or professional growth, development or training; or Academic education during residential treatment.	✓	
Services that do not meet national standards for professional medical or mental health practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy, sleep therapy, biofeedback, hypnotherapy and crystal healing therapy are not covered.	✓	
Services that you get without a referral from your PCP or Medical Group, when a referral from your PCP or Medical Group is required for getting that service.	✓	
Stem cell harvesting and storage not associated with an approved transplant.	✓	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Therapy intended to change behavior by inducing a dislike for the behavior through association with a noxious stimulus is not covered.	✓	
Private duty nurses.	✓	
Routine dental care such as cleaning, fillings or dentures.	✓	
Hearing aids, or exams to fit hearing aids.	✓	
Eyeglasses, radial keratotomy, LASIK surgery, and other low vision aids.		✓ One pair of eyeglasses (or contact lenses) are covered for people after cataract surgery.
Outpatient prescription drugs, including drugs for treatment of sexual dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.	✓	

*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.

Chiropractic Services Exclusions and Limitations

See the exclusions and limitations as listed under “Chiropractic Services” later in this chapter.

Silver & Fit Exclusions and Limitations

See the exclusions and limitations as listed under “The Silver&Fit® Program” later in this chapter.

Acupuncture Services Exclusions and Limitations

See the exclusions and limitations as listed under “Acupuncture Services” later in this chapter.

Additional Benefit Information

Chiropractic Services

American Specialty Health Plans of California, Inc. (ASH Plans) will provide access to covered Chiropractic Services for you. You may access any ASH Plans Contracted Chiropractor without a physician referral, including without a Referral from your Primary Care Physician ("PCP"). All covered Chiropractic Services must be Medically Necessary and may require verification of Medical Necessity through an authorization process by ASH Plans, except as listed below. The ASH Plans Contracted Chiropractor you select will provide the initial examination and will contact ASH Plans for any required verification of medical necessity of the treatment plan he/she develops for you. For a list of ASH Plans Contracted Chiropractors, please call ASH Plans at **1-800-678-9133** (or **TTY**: **711**), Monday through Friday, 5:00 a.m. to 8:00 p.m., Pacific Time.

Chiropractic Services are covered up to the maximum of 20 medically necessary visits per Plan Year. You may receive covered Chiropractic Services from any ASH Plans Contracted Chiropractor at any time, and you are not required to pre-designate the ASH Plans Contracted Chiropractor from whom you will receive covered Chiropractic Services. You must receive covered Chiropractic Services from an ASH Plans Contracted Chiropractor, except that:

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

The following Chiropractic Services do not require medical necessity verification by ASH Plans:

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

♦Please refer to the Chiropractic Covered Services section for the ASH Plans benefit definition as it pertains to chiropractic services.

Chiropractic Covered Services:

- You are required to pay a copayment for each office visit to an ASH Plans Contracted Chiropractor, as described below. A maximum number of visits per plan year will apply to each Member. All Chiropractic Services, except for the initial evaluation, and urgent/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 to assess the need to initiate, continue, extend, or change a Course of Treatment. The established patient exam may require verification of Medical Necessity.
- Adjunctive modalities and procedures such as rehabilitative exercise, traction, ultrasound, electrical muscle stimulation, and other therapies are covered only when provided during the same Course of Treatment and in support of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.
- Follow-up office visits may include manipulation of the spine, joints and/or musculoskeletal soft tissue, a re-evaluation, and/or other services, in various combinations.
- X-rays and clinical laboratory tests are payable in full when provided by or referred by an ASH Plans Contracted Chiropractor and verified by ASH Plans as being Medically Necessary. Radiological consultations are a covered benefit when verified by ASH Plans as being Medically Necessary Services and when provided by a licensed chiropractic radiologist, medical radiologist, radiology group, or hospital that has contracted with ASH Plans to provide those services.
- Chiropractic Supports and Appliances ◄ are covered up to a maximum of $50 per year when verified by ASH Plans as being Medically Necessary for the treatment of either Musculoskeletal and Related Disorders, Pain Syndromes or both.
- Urgent Services ▲.
- Emergency Services ▼.

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

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

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

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

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

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

Chiropractic Services Exclusions and Limitations

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

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

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

How to File a Claim for Chiropractic Services

In most cases your Chiropractic service practitioner will submit your claims to ASH Plans. To file a claim you may have, please send us a letter or complete an ASH Plans claim form. If you need a claim form, contact ASH Plans at **1-800-678-9133** (or **TTY**: **711**), Monday through Friday, 5:00 a.m. to 8:00 p.m.

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

American Specialty Health Plans of California, Inc.
Claims Department
P.O. Box 509001
San Diego, CA 92150-9001

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

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

When receiving Emergency Care or Urgent Care from a non-Contracted Practitioner, you should request that the practitioner bill ASH Plans directly for services. If the practitioner bills you directly, ASH Plans will reimburse you charges paid for emergency services and out-of-area urgent care services less any applicable copayments. To receive reimbursement, you should submit an itemized bill and completed claim form to ASH Plans. A claim form can be obtained by contacting ASH Plans at **1-800-678-9133** (or **TTY**: **711**), Monday through Friday, 5:00 a.m. to 8:00 p.m., Pacific Time.

Completed claim forms should be submitted to:

American Specialty Health Plans of California, Inc.
Claims Department
P.O. Box 509001
San Diego, CA 92150-9001

QUESTIONS?

For up-to-date practitioner information, please contact ASH Plans at **1-800-678-9133** (or **TTY: 711**), Monday through Friday, 5:00 a.m. to 8:00 p.m., Pacific Time.

Grievance Procedures

If you have a complaint about the Chiropractic program or services you received, call Customer Service at **1-800-275-4737** (TTY: **711**) 8:00 a.m. to 8:00 p.m., seven days a week. See the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter of this booklet for more information.

Medicare Appeals Procedure

You have the right to appeal (request a reconsideration) if you (or your ASH Plans Contracted Chiropractor) request authorization of chiropractic services that you believe are covered under the plan, and ASH Plans denies your request; or if ASH Plans denies payment of emergency or urgent chiropractic services you received from a non-Contracted Practitioner. See the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter of this booklet for more information.

Acupuncture Services

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

Acupuncture for chronic low back pain is now covered up to 12 visits within a 90 day period under the following circumstances: You have chronic low back pain lasting 12 weeks or longer, having no identifiable systemic cause and not associated with surgery or pregnancy.

An additional eight sessions may be covered after the initial 90 days for patients demonstrating improvement. A clinical review of your progress is required before the additional 8 visits may be covered. Your provider will manage any necessary review. No more than 20 acupuncture treatments may be administered annually.

Treatment must be discontinued if you are not improving or you are regressing.

Routine (non-Medicare Covered) Acupuncture Services are covered up to the maximum of 20 medically necessary visits per Plan Year. You may receive covered Acupuncture Services from any ASH Plans Contracted Acupuncturist at any time, and you are not required to pre-designate, at any time, the ASH Plans Contracted Acupuncturist from whom you will receive covered Acupuncture Services. You must receive covered Acupuncture Services from an ASH Plans Contracted Acupuncturist except that:

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

The following Acupuncture Services do not require verification of medical necessity by ASH Plans:

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

♥ Please refer to Acupuncture Covered Services for ASH Plans benefit description as it applies to acupuncture services.

Acupuncture Covered Services

- You are required to pay a copayment for each office visit to a Contracted Acupuncturist. A maximum number of visits per plan year will apply to each Member. All Acupuncture Services, except for the initial evaluation, may require verification of Medical Necessity.
- A new patient exam, or an established patient exam for the initial evaluation of a patient with a new condition or new episode, to determine the appropriateness of Acupuncture Services. A new patient is one who has not received any professional services from the practitioner, or another practitioner of the same specialty who belongs to the same group practice, within the past three years. 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 to assess the need to initiate, continue, extend, or change a Course of Treatment. The established patient exam is only covered when used to determine the appropriateness of Acupuncture Services. The established patient exam may require verification of Medical Necessity.
- Adjunctive Therapies or Modalities 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
- Follow-up office visits may include the provision of Acupuncture Services and/or a re-evaluation.
- All Acupuncture Services, except for the initial evaluation, must be verified by ASH Plans as being Medically Necessary for the treatment of Musculoskeletal and Related Disorders, Nausea, Pain or pain syndromes.
- Urgent Services ♣.
- Emergency Services ♠.

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

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

Second Opinion

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

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

Acupuncture Services Exclusions and Limitations

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

- Services rendered in excess of visit or benefit maximums.
- Auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders, and telephones compatible with hearing aids.
- Services, exams (other than an initial examination to determine the appropriateness of Acupuncture Services) and/or treatments for conditions other than Musculoskeletal and Related Disorders, Nausea, Pain or pain syndromes.
- Services or treatments delivered by a Non-Contracted Practitioner, except for (a) Emergency Services; (b) Urgent Services; (c) services that are provided pursuant to a continuity of care plan approved by ASH Plans; or (d) services that are provided upon referral by ASH Plans in situations where such services are not available and accessible to you from a Contracted Acupuncturist within the Service Area.
- Services and other treatments that are classified as Experimental or Investigational.
- Prescription drugs or medicines, including a non-legend or proprietary medicine or medication not requiring a prescription order.
- Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances or durable medical equipment.
- Educational programs, non-medical lifestyle or self-help, or self-help physical exercise training or any related diagnostic testing.
- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services or other related services.
- Services or treatments for pre-employment physicals or vocational rehabilitation.
- Hypnotherapy, sleep therapy, behavior training, and weight programs are not covered.
- Services provided by an acupuncturist practicing outside California, except for Urgent Services or Emergency Services.
- Transportation costs, including local ambulance charges.
- Any services or treatments for conditions caused by, or arising out of, the course of employment or covered under workers' compensation or similar laws.
- Adjunctive therapy not associated with acupuncture.
- Dietary and nutritional supplements, including vitamins, minerals, herbs, herbals and herbal products, injectable supplements and injection services, or other similar products.
- Thermography, magnets used for diagnostic or therapeutic use, ion cord devices, manipulation or adjustments of the joints, physical therapy services, iridology, hormone replacement products, acupuncture point or trigger-point injections (including injectable substances), laser/laser biostim, colorpuncture, NAET diagnosis and/or treatment, and direct moxibustion. Any service or supply that is not permitted by state law with respect to the practitioner's scope of practice.

How to File a Claim for Acupuncture Services

In most cases your Acupuncture service practitioner will submit your claims to ASH Plans. To file a claim you may have, please send us a letter or complete an ASH Plans claim form. If you need a claim form, contact ASH Plans at **1-800-678-9133** (or **TTY**: **711**), Monday through Friday, 5:00 a.m. to 8:00 p.m., Pacific Time.

Attach your itemized bill to the claim form or letter. Mail the itemized bill, completed claim form or letter to:
American Specialty Health Plans of California, Inc.
Claims Department
P.O. Box 509001
San Diego, CA 92150-9001

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

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

When receiving Emergency Care or Urgent Care from a non-Contracted Practitioner, you should request that the practitioner bill ASH Plans directly for services. If the practitioner bills you directly, ASH Plans will reimburse you charges paid for emergency services and out-of-area urgent care services less any applicable copayments. To receive reimbursement, you should submit an itemized bill and completed claim form to ASH Plans. A claim form can be obtained by contacting ASH Plans at **1-800-678-9133** (or **TTY**: **711**), Monday through Friday, 5:00 a.m. to 8:00 p.m., Pacific Time.

Completed claim forms should be submitted to:

American Specialty Health Plans of California, Inc.
Claims Department
P.O. Box 509001
San Diego, CA 92150-9001

QUESTIONS?

For up-to-date practitioner information, please contact ASH Plans at **1-800-678-9133** (or **711** Monday through Friday, 5:00 a.m. to 8:00 p.m., Pacific Time.

Grievance Procedures

If you have a complaint about the Acupuncture program or services you received, call Customer Service at **1-800-275-4737** (**TTY**: **711**) 8:00 a.m. to 8:00 p.m., seven days a week. See the “What to do if you have a problem or complaint (coverage decisions, appeals, complaints)” chapter of this booklet for more information.

Medicare Appeals Procedure

You have the right to appeal (request a reconsideration) if you (or your ASH Plans Contracted Acupuncturist) request authorization of acupuncture services that you believe are covered under the plan, and ASH Plans denies your request; or if ASH Plans denies payment of emergency or urgent acupuncture services you received from a non-plan acupuncturist. See the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter of this booklet for more information.

The Silver&Fit® Program

The Silver&Fit program is a Healthy Aging and Exercise Program which provides a no-cost fitness center membership at participating Silver&Fit fitness centers or select YMCAs from a broad network, and membership in the Silver&Fit Home Fitness Program for members who are unable to visit a fitness center or prefer to work out at home. The Silver&Fit program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). 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 center or select YMCA online at SilverandFit.com or call Silver&Fit customer service at **1-888-797-7757** or **TTY users call 711**, Monday – Friday, 5:00 a.m. – 6:00 p.m., Pacific Time, excluding holidays to choose a center. Once you have chosen a fitness center or YMCA, take your enrollment flier, to the participating fitness center of your choice. You may be required by the fitness center you choose to sign a membership agreement. The membership agreement that you may be required to sign at the fitness center is for a no-cost "standard fitness center membership," which includes the covered services available through the program, described below. If you choose to access fitness center services otherwise available by the center at an additional fee, then the agreement may reflect costs associated with those non-Silver&Fit related services.

If you wish to enroll in the Silver&Fit Home Fitness program, and choose up to two home fitness kits to workout at home, you can enroll online at www.SilverandFit.com or by calling Silver&Fit customer service at **1-888-797-7757** (TTY users call 711), 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 center membership?”)

Fitness Centers

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

- Cardiovascular and strength training 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 center services that typically require an additional fee.

Exercise Centers

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

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

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

Home Fitness Kits (pick up to two per benefit year)

- Aquatic Exercise
- Athletic Conditioning
- Barre Fitness
- Barre Fitness for All Levels
- Cardio & Strength
- Cardio Blast
- Cardio Pump
- Cardio Quick Fix
- Chair Aerobics
- Chair Boxing
- Chair Dancing
- Chair Dancing Celebration

- Chair Pilates
- Chair Resistance Band
- Chair Tai Chi
- Chair Yoga
- Circuit Burn
- Diabetes Workout
- Exercises for the Bedridden
- High Energy Cardio
- High Intensity Bootcamp
- Lean Body Circuits
- Signature Series I: Explore
- Signature Series II: Experience
- Signature Series III: Excel
- Strength & Stamina
- Stress Management
- Tai Chi
- Tai Chi for Balance
- Total Body Workout
- Upper & Lower Body Workouts
- Walking
- Yoga
- Your Best Body

The Silver&Fit Home Fitness Program kits may include:

- A DVD
- A booklet with general information about the topic
- A “Quick Start” guide that explains how to start using the items in the kit.

Stay Fit Kits (limit one per benefit year)

- Garmin® or Fitbit® Wearable Fitness Tracker
- Gaiam Yoga Kit
- Beginner or Intermediate Strength Kit with exercise bands light dumbbells, and a mat

Services offered through the "Customer Service Hotline"

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

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

- Fitness center nominations

Silver&Fit Website

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

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

Exclusions and limitations

The following services are not offered:

- Services or supplies provided by any person, company or fitness center other than a Silver&Fit participating fitness center or select YMCA
- 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
- Program services or products for individuals other than the member
- Prescription drugs, over-the-counter products, dietary supplements, herbal supplements, vitamins, minerals, weight control products, meal-replacement beverages or powders, or any other types of food or food product, whether or not it is recommended, prescribed, or supplied by a health care provider, fitness center, or program
- All listening devices, including, but not limited to, audiotape and CD players
- Services for members with serious medical conditions for which Silver&Fit services are not appropriate.
- Fitness devices and applications that require a fee are not reimbursable by the Silver&Fit program.

The benefits included in this chapter are subject to the same appeals process as any other benefits. See the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter of this booklet for more information.

* Home Kits and Rewards are subject to change.

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 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 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, exercise, and healthy diet. Each program is designed to include 6 weeks of instruction.

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. The areas of focus are weight management, healthy eating, exercise, stress management and tobacco cessation. The wellness health coaching provides up to 6 months of telephonic and online support.

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 healthnet.com to get started.

Valuable tools that put health information in reach

Nurse Advice Line
Toll-free telephonic advice from licensed clinicians is available 24 hours a day, 7 days a week. Health Net's nurse advice line provides real time support to help the member determine the level of care needed at the moment. The nurse advice line phone number is located on your member ID card or you can call member services and be transferred.

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 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 line.

ASKING US TO PAY OUR SHARE OF A BILL YOU HAVE RECEIVED FOR COVERED MEDICAL SERVICES

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

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

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

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

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

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

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

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

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

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

- 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 the "Our plan does not allow providers to 'balance bill' you" section of the "Medical Benefits Chart (what is covered and what you pay)" chapter in this booklet.
- 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. The "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter of this booklet has information about how to make an appeal.

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

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 (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.)

For **medical services**, mail your request for payment together with any bills or receipts to us at this address:

Medical Claims:
Health Net
PO Box 9030
Farmington, MO 63640

You must submit your claim to us within 12 months of the date you received the service or item.

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

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

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 decide whether to pay it 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 (The "Using the plan's coverage for your medical services" chapter of this booklet 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 reimburse you. 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.

If we tell you that we will not pay for 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, see the “What to do if you have a problem or complaint (coverage decisions, appeals, complaints)” chapter of this booklet. 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 the “A guide to the basics of coverage decisions and appeals” section in this chapter. This introduction explains the process for coverage decisions and appeals and gives definitions of terms such as “appeal.” Then after you have read the “A guide to the basics of coverage decisions and appeals” section, you can go to the chapter “What to do if you have a problem or complaint (coverage decisions, appeals, complaints)” that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, see the “What to do if you have a problem or complaint (coverage decisions, appeals, complaints)” chapter of this booklet.

YOUR RIGHTS AND RESPONSIBILITIES

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

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 interpreter services available to answer questions from disabled and non-English speaking members. This information is available for free in other languages. We can also give you information in audio, in large print, or other alternate formats at no cost if you need it. We are required to give you information about the plan's benefits in a format that is accessible and appropriate for you at no cost if you need it. To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet) or contact our Grievance department at the same number.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Services (phone numbers are printed on the back cover of this booklet). You may also file a complaint with Medicare by calling 1-800-MEDICARE (1-800-633-4227) (TTY: 1-877-486-2048), 24 hours a day, 7 days a week, or directly with the Office of Civil Rights. Contact information is included in this Evidence of Coverage or with this mailing, or you may contact Member Services for additional information.

我們必須以您瞭解的方式（以英語以外的語言、錄音版、大字版或其他格式等）提供資訊。

如需以您瞭解的方式向我們取得資訊，請致電會員服務部 (電話號碼列印於本手冊封底)。

本計畫有服務人員並提供免費口譯服務，可回答殘障人士和非英語會員的疑問。本資訊備有其他語言版本，可免費提供。若有需要，我們可以免費提供錄音版、大字版或其他格式的資訊給您。若有需要，我們必須以您能夠使用且適合您的格式免費提供有關本計畫福利的資訊。如需以您瞭解的方式向我們取得資訊，請致電會員服務部 (電話號碼列印於本手冊封底)，您也可以透過同個號碼致電申訴部門。

如果您無法順利取得您能夠使用且適合您的本計畫福利資訊格式，請致電會員服務部進行申訴 (電話號碼列印於本手冊封底)。您也可以致電全年無休的 1-800-MEDICARE (1-800-633-4227) (TTY：1-877-486-2048) 向 Medicare 進行投訴，或直接聯絡民權辦公室。

聯絡資訊附在《承保範圍證明》中，您也可以在本郵件中找到聯絡資訊，或者您也可以聯絡會員服務部取得額外資訊。

Debemos proporcionar la información de una manera que le sirva (en idiomas distintos del inglés, en audio, en letra grande o en otros formatos alternativos, etc.)
Para obtener la información de parte nuestra de una manera que le sirva, llame al Departamento de Servicios al Afiliado (los números de teléfono aparecen en la contraportada de este cuadernillo).

Nuestro plan cuenta con personas y servicios de intérprete gratuitos disponibles para responder las preguntas de los afiliados que presentan una discapacidad y que no hablan inglés. Esta información está disponible en forma gratuita, en otros idiomas. También podemos proporcionarle información en audio, en letra grande o en otros formatos alternativos sin cargo si lo necesita. Se nos exige que le brindemos información sobre los beneficios del plan en un formato que sea accesible y adecuado para usted, sin costo, si fuera necesario. Para obtener la información de parte nuestra de una manera que le sirva, llame al Departamento de Servicios al Afiliado (los números de teléfono aparecen en la contraportada de este cuadernillo) o comuníquese con el Departamento de Quejas Formales al mismo número.

Si tiene dificultades para obtener información de parte de nuestro plan en un formato que sea accesible y adecuado para usted, llame para presentar una queja formal ante el Departamento de Servicios al Afiliado (los números de teléfono aparecen en la contraportada de este cuadernillo). También puede presentar una queja ante Medicare por teléfono al 1-800-MEDICARE (1-800-633-4227), (TTY: 1-877-486-2048), las 24 horas del día, los 7 días de la semana, o directamente ante la Oficina de Derechos Civiles. Se incluye la información de contacto en esta *Evidencia de Cobertura* o en este correo. Para obtener información adicional, puede comunicarse con el Departamento de Servicios al Afiliado.

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

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

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

If you think that you are not getting your medical care within a reasonable amount of time, see the "How to make a complaint about quality of care, waiting times, customer service, or other concerns" section of the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter of this booklet, which tells what you can do. (If we have denied coverage for your medical care and you don't agree with our decision, the "A guide to the basics of coverage decisions and appeals" section of the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter of this booklet, tells what you can do.)

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 Practices," 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 Medicare plan, we are required to give Medicare your health information. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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

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

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

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

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

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

As a member of our plan, you have the right to get several kinds of information from us. This includes information about Health Net, its services, its providers and member rights and responsibilities. (As explained above in the "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.)" section above, you have the right to get information from us in a way that works for you. This includes getting the information 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 Advantage 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, call member services or go online to healthnet.com.
  - For a list of the providers in the plan's network, see the *Provider Directory*.
  - For more detailed information about our providers, you can visit our website at https://www.healthnet.com or call Member Services (phone numbers are printed on the back cover of this booklet).
- **Information about your coverage and the rules you must follow when using your coverage.**
  - In the "Using the plan's coverage for your medical services" and "Medical Benefits Chart (what is covered and what you pay)" chapter 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.
  - **Note:** Our plan does not reward practitioners, providers, or employees who perform utilization reviews, including those of delegated entities. Utilization Management (UM) decision making is based only on appropriateness of care and service, and existence of coverage. Additionally, the plan does not specifically

reward practitioners or other individuals for issuing denials of coverage. Financial incentives for UM decision makers do not encourage decisions that result in underutilization.
    - 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 the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (The "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter 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 the "Asking us to pay our share of a bill you have received for covered medical services" chapter of this booklet.

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. The "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter 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.
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that Health Net, a doctor or hospital did not follow the instructions in it, you may file a complaint with the Center for Health Care Quality.

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

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.

Evaluation of new technologies

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

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

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

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

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

Is it about something else?

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

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, see the "Important phone numbers and resources" chapter of this booklet.
- 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.

How to get more information about your rights

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

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

- You can **call the SHIP**. For details about this organization and how to contact it, see the "Important phone numbers and resources" chapter of this booklet.
- You can contact **Medicare**.
    - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." The publication is available at: www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.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.

You have some responsibilities as a member of the plan

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.
    - The "Using the plan's coverage for your medical services" and "Medical Benefits Chart (what is covered and what you pay)" chapter give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
- ***If you have any other health insurance coverage in addition to our plan, or separate prescription drug coverage, you are required to tell us.*** Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).
    - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves coordinating the health benefits you get from our plan with any other benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to the "How other insurance works with our plan" section of the "Getting started as a member" chapter of this booklet.)
- ***Tell your doctor and other health care providers that you are enrolled in our plan.*** Show your plan membership card whenever you get your medical care.
- ***Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.***
    - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems, give them the information they need about you and your health, and work with them to develop mutually agreed upon goals. Follow the treatment plans and instructions that you and your doctors agree upon.

  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.
- ***Be considerate.*** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- ***Pay what you owe.*** As a plan member, you are responsible for these payments:
  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of the plan.
  - For most 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). The "Medical Benefits Chart (what is covered and what you pay)" chapter of this booklet 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 the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter 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.** (The "Getting started as a member" chapter 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 the "Important phone numbers and resources" chapter of this booklet.
- ***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 the “Important phone numbers and resources” chapter of this booklet.

WHAT TO DO IF YOU HAVE A PROBLEM OR COMPLAINT (COVERAGE DECISIONS, APPEALS, COMPLAINTS)

Introduction

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 the "To deal with your problem, which process should you use?" section will help you identify the right process to use.

For information on Appeals procedures for your Employer-Sponsored Benefits (benefits beyond the basic Medicare-covered benefits), please refer to the "Appeals Procedures for your Employer-Sponsored Benefits" section later in this chapter.

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," or "at-risk 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.

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

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 the "Important phone numbers and resources" chapter 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).

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

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 is covered or not, the way in which they are covered, and problems related to payment for medical care.)

Yes. My problem is about benefits or coverage.

Go on to the section **"A guide to 'the basics' of coverage decisions and appeals."**

No. My problem is not about benefits or coverage.

Skip ahead to section: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

COVERAGE DECISIONS AND APPEALS

A guide to 'the basics' of coverage decisions and appeals

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

If we say no to all or part of your Level 1 Appeal, your case will automatically go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

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).
- You **can get free help from** your State Health Insurance Assistance Program (see the "You can get help from government organizations that are not connected with us" section of this chapter).
- **Your doctor or other provider can make a request for you.**
- For medical care, a doctor can make a request for you. 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 or on our website at https://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.

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 separately. Please refer to the following sections s of this chapter for more information:

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

If you're still not sure which section of this chapter you should be using, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your SHIP (the section "Important phone numbers and resources" of this booklet has the phone numbers for this program).

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

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

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 the "Medical Benefits Chart (what is covered and what you pay)" chapter of this booklet. To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this chapter, instead of repeating "medical care or treatment or services" every time. The term "medical care" includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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 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 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:

        - The "*How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon*" section of the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter of this booklet.
        - The "*How to ask us to keep covering certain medical services if you think your coverage is ending too soon*" section of the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter of the booklet tells about three services only: home health care, skilled nursing facility care, and CORF services.

    - For *all other* situations that involve being told that medical care you have been getting will be stopped, use this section ("Your medical care: How to ask for a coverage decision or make an appeal") of this chapter 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:
To find out whether we will cover the medical care you want.	You can ask us to make a coverage decision for you. Go to the next section of this chapter, "**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)"**.
If 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 the "**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)"** section of this chapter.
If you want to ask us to pay you back for medical care you have already received and paid for.	You can send us the bill. Skip ahead to the **"What if you are asking us to pay you for our share of a bill you have received for medical care?"** section of this chapter.

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

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

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

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

How to request coverage for the medical care you want

- Start by calling, or writing 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, see the "Important phone numbers and resources" chapter in of this booklet, 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 **for a medical item or service**. If your request is for a **Medicare Part B prescription drug, we will give you an answer within 72 hours** after we receive your request.

- **However,** for a request for a **medical item or service 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. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- 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 the "How to make a complaint about quality of care, waiting times, customer service, or other concerns" section 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 if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours.**
  - **However,** for a request for a **medical item or service 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. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - 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 the "How to make a complaint about quality of care, waiting times, customer service, or other concerns" section 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 ask for 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 the "How to make a complaint about quality of care, waiting times, customer service, or other concerns" section of this chapter.)

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

Deadlines for a "fast coverage decision"

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 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. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - 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 the "How to make a complaint about quality of care, waiting times, customer service, or other concerns" section 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), or 24 hours if your request is for a Part B prescription drug, you have the right to appeal. Section "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)" below tells how to make an appeal.
- **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 on a request for a medical item or service, we will give you our answer **within 14 calendar days of receiving your request.** If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.
  - For a request for a medical item or service, 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. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - 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 the "How to make a complaint about quality of care, waiting times, customer service, or other concerns" section 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), or 72 hours if your request is for Part B prescription drug, you have the right to appeal. The "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)" section below tells how to make an appeal.

- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

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

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

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

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

What to do

- **To start an appeal you, your doctor or your representative, must contact our plan.** For details on how to reach us for any purpose related to your appeal, see the "Important phone numbers and resources" chapter of this booklet.
- **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 www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at 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 the "Important phone numbers and resources" chapter of this booklet.
- **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, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
  - You have the right to ask us for a copy of the information regarding your appeal.
  - If you wish, you and your doctor may give us additional information to support your appeal.

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

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

- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this chapter.)
- 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 your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
    - 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 Review Organization. Later in this chapter, 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 automatically send 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 on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug, we will give you our answer **within 7 calendar days** after we receive your appeal if your appeal is about coverage for a Part B prescription drug you have not yet received, we will give you our answer **within 7 calendar days** after we receive your appeal. 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 your request is for a medical item or service**.** If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

  - 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 the "How to make a complaint about quality of care, waiting times, customer service, or other concerns" section of this chapter.)
  - If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this chapter, 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 if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Medicare Part B prescription drug.
- **If our answer is no to part or all of what you requested**, we will automatically send 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.

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

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

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

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- 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 your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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. If your request is for a medical item or service, the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of when it receives your appeal.
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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 a request for a medical item or service,** 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 we receive the decision from the review organization for expedited requests.

- **If the review organization says yes to part or all of a request for a Medicare Part B prescription drug**, we must authorize or provide the Part B prescription drug under dispute within **72 hours** after we receive the decision from the review organization for **standard requests** or within **24 hours** from the date we receive 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 get after your Level 2 Appeal.
- The Level 3 Appeal is handled by an Administrative Law Judge or attorney adjudicator. The "Taking your appeal to Level 3 and beyond" section in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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 our plan for payment for medical care, start by reading the "Asking us to pay our share of a bill you have received for covered medical services" chapter of this booklet. This section 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 the "Asking for coverage decisions and making appeals: the big picture" section 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 the "Medical Benefits Chart (what is covered and what you pay)" chapter of this booklet). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in the "Using the plan's coverage for your medical services" chapter of this booklet).

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 the "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)" section 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.

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 the "Medical Benefits Chart (what is covered and what you pay)" chapter of this booklet.

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.

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 your right to know who will pay for it.
    - Where to report any concerns you have about the 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. (The "Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date" section below tells how to make this appeal and tells you how you can request an immediate review.)

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

   - You or someone who is acting on your behalf will be asked to sign the notice. (The "A guide to the basics of coverage decisions and appeals" section 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 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 the notice online at www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html

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 the "You can get help from government organizations that are not connected with us" section 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 the "You can get help from government organizations that are not connected with us" section in the "Important phone numbers and resources" chapter 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 midnight the day of your discharge.** (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, and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see the "What if you miss the deadline for making your Level 1 Appeal?" section of this chapter.

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 get a sample notice online at 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 the "Medical Benefits Chart (what is covered and what you pay)" chapter 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.

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 when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended.

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

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

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

If the review organization says yes:

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

If the review organization says no:

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

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 an Administrative Law Judge or attorney adjudicator.
- The "Taking your appeal to Level 3 and beyond" section in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

You can appeal to us instead

As explained above in the "Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date" section, 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, whichever comes first.) 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, see the "Important phone numbers and resources" chapter of this booklet, 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

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. The "How to make a complaint about quality of care, waiting times, customer service, or other concerns" section 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 an Administrative Law Judge or attorney adjudicator.

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.
- The "Taking your appeal to Level 3 and beyond" section in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

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 the "Definitions of important words" chapter in this booklet.)
- **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 the "Definitions of important words" chapter in this booklet.)

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 the "Medical Benefits Chart (what is covered and what you pay)" chapter in this booklet.

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.

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

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, 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.

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. (The "Step-by-Step: How to make a Level 1 Alternate Appeal" section below tells how you can request a fast-track appeal.)

The written notice is called the "**Notice of Medicare Non-Coverage."**

2. **You will be asked to sign the written notice to show that you received it.**

    - You or someone who is acting on your behalf will be asked to sign the notice. (The "A guide to 'the basics' of coverage decisions and appeals" section 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 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.

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. The "How to make a complaint about quality of care, waiting times, customer service, or other concerns" section 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 the "You can get help from government organizations that are not connected with us" section of this chapter).

If you ask for a Level 1 Appeal on time, 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 the "Important phone numbers and resources" chapter 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 by *noon of the day* before the effective date on the Notice of Medicare Non-Coverage.
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see the "What if you miss the deadline for making your Level 1 Appeal?" section of this chapter.

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 that the reviewers inform us of your appeal, you will also get a written notice from us that explains in detail our reasons for wanting to end our coverage for your services.

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

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

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see the "Medical Benefits Chart (what is covered and what you pay)" chapter 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, 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.

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, 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 an Administrative Law Judge or attorney adjudicator.

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 an Administrative Law Judge or attorney adjudicator.
- The "Taking your appeal to Level 3 and beyond" section of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

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

You can appeal to us instead

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

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

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

Here are the steps for a Level 1 Alternate Appeal:

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

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

- For details on how to contact us, go to the *"How to contact our plan's Member Services"* section of the chapter called "Important phone numbers and resources."

- **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

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. The "How to make a complaint about quality of care, waiting times, customer service, or other concerns" section 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 an Administrative Law Judge or attorney adjudicator.
- The "Taking your appeal to Level 3 and beyond" section of this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Taking your appeal to Level 3 and beyond

Appeal Levels 3, 4 and 5 for Medical Service Requests

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 **(called an Administrative Law Judge) or an attorney adjudicator who works for the Federal government** will review your appeal and give you an answer.

- **If the Administrative Law Judge or attorney adjudicator 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 Administrative Law Judge's or attorney adjudicator'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 or attorney adjudicator 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 or attorney adjudicator says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal: The Medicare **Appeals Council** (Council) will review your appeal and give you an answer. The Council is part of the Federal government.

- **If the answer is yes, or if the 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 the value of the item or medical service meets the required dollar value.
  - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the 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 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 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 appeals process.

MAKING COMPLAINTS

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 the section on "A guide to 'the basics' of coverage decisions and appeals".

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, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan? • Examples include waiting too long on the phone, in the waiting room, when getting a prescription, 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 the following sections: • "A guide to 'the basics' of coverage decisions and appeals" • "Your medical care: How to ask for a coverage decision or make an appeal" • "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon" • "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" • "Taking your appeal to Level 3 and beyond" 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 or drugs, 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.

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."**

Step-by-step: Making a complaint

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

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. 1-800-275-4737. Hours of Operation: 8:00 a.m. to 8:00 p.m., seven days a week. TTY 711.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.
- If you ask for a written response, file a written complaint (grievance), or if your complaint is related to quality of care, we will respond to you in writing. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaint. We call this the Grievance Procedure.** To make a complaint, or if you have questions about this procedure, please call Member Services at the phone number above. Or, you may mail or fax us a written request to the address or fax number listed under *Appeals for Medical Care* or *Complaints about Medical Care* in the "Important phone numbers and resources" chapter of this booklet.
    - You need to file your complaint within 60 calendar days after the event. You can submit your complaint, formally, in writing or via fax at the address or fax number listed under *Appeals for Medical Care* or *Complaints about Medical Care*, in the "Important phone numbers and resources" chapter of this booklet.
    - We must notify you of our decision about your complaint (grievance) 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 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 the "Important phone numbers and resources" chapter 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."**

<u>Step 2:</u> 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 within 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.

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 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 the "Important phone numbers and resources" chapter 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.

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.

Appeals Procedures for your Employer-Sponsored Benefits

There is a special type of **Appeal** that applies only to Employer-Sponsored Benefits. Employer-Sponsored Benefits are covered benefits that are beyond the basic Medicare-covered benefits. If you make this type of Appeal, you must follow the steps outlined below. They are different from the Appeal process that is set by the Medicare program.

This section of this chapter explains what you can do if you have problems getting Employer-Sponsored Benefits you believe we should provide. The word "provide" includes

such things as authorizing care, paying for it, or arranging for someone to provide it. There are 4 possible steps for requesting care or payment of Employer-Sponsored Benefits.

STEP 1: The Initial Decision

The starting point is when we make an Initial Decision about your care or about paying for care you have already received. When we make an Initial Decision, we are giving our interpretation of how the benefits and services that are covered for members of the plan apply to your specific situation.

STEP 2: Appealing the Initial Decision

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an "**Appeal.**" You can file the Appeal by calling Health Net Member Services Department at **1-800-275-4737** (**TTY: 711**) 8:00 a.m. to 8:00 p.m., seven days a week or by sending information to:

Medical Only
Appeals & Grievances
Medicare Operations
PO Box 10450
Van Nuys, CA 91410-0450

We will:

- Review your complaint and inform you of our decision in writing within 30 days from the receipt of the Appeal. For conditions where there is an immediate and serious threat to your health, including severe Pain, or the potential for loss of life, limb or major bodily function exists, we must notify you of the status of your grievance no later than three days from receipt of the grievance.
- Inform you if additional time is necessary to complete our investigation.

You must file your Appeal with Health Net within 365 calendar days after we notify you of the Initial Decision. Please include all information from your Health Net Identification Card and the details of the concern or problem. After reviewing your Appeal, we will decide whether to stay with our original decision, or change this decision and give you some or all of the care or payment you want.

STEP 3: Review of your request by an Independent Review Organization

If you are not satisfied with the outcome of your Appeal in Step 2, you can request for an independent review organization to review your case. This organization will review your request and make a decision about whether we must give you the care or payment you want. You may call Health Net Member Services Department at **1-800-275-4737** (**TTY: 711**) 8:00 a.m. to 8:00 p.m., seven days a week to request the independent review or by sending the request to:

Medical Only
Appeals & Grievances
Medicare Operations
PO Box 10450
Van Nuys, CA 91410-0450

The review is conducted by an independent Physician reviewer with appropriate expertise in the area of medicine in question who has no connection to us. The independent review organization will provide its decision within 30 days after receiving the request for review and the supporting documents. If there is an immediate and serious threat to your health, an expedited review will be completed within 72 hours, or sooner if medically indicated.

We will accept the determination made by the independent review organization. You will not have to pay for this review. Your medical records and review materials are kept confidential. You may have access, upon request, to any relevant policy used to make this determination. You may also have access, upon request, to the independent reviewer's determination.

STEP 4: Binding Arbitration

If you continue to be dissatisfied after the independent review process in Step 3 has been completed, you may then initiate binding arbitration as described in the "Legal Notices" chapter of this *Evidence of Coverage*. Binding arbitration is generally the final process to resolve disputes concerning Employer-Sponsored Benefits.

ENDING YOUR MEMBERSHIP IN THE PLAN

Introduction

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. The "When can you end your membership in our plan?" section of this chapter 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. The "How do you end your membership in our plan?" section of this chapter 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. The "We must end your membership in the plan in certain situations" section of this chapter 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.

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 Medicare Advantage Open Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

You can end your membership during the Annual Enrollment Period

In general, there are only certain times during the year when you may voluntarily end your membership in our plan.

- Please contact your employer's or union's benefit administrator for information regarding other plan options and/or questions about your employer's or union's open enrollment season.
- From October 15 through December 7, during the Annual Open Enrollment Period, anyone with Medicare may enroll in, make changes to, or disenroll from their existing Medicare plan for the following year. Your change will take effect on January 1.
- There may be other limited times during which you may make changes. For more information about these times and the options available to you, please refer to the "Medicare & You"

handbook you receive each fall. You may 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, or visit www.medicare.gov to learn more about your options.

You can end your membership during the Medicare Advantage Open Enrollment Period

You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **When is the annual Medicare Advantage Open Enrollment Period?** This happens every year from January 1 to March 31.
- **What type of plan can you switch to during the annual Medicare Advantage Open Enrollment Period?** During this time, you can:
  - Switch to another Medicare Advantage plan (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Disenroll from our plan and obtain coverage through Original Medicare. If you choose to switch to Original Medicare, during this period you can also join a separate Medicare prescription drug at that time.
- **When will your membership end?** Your membership will end on the first day of the month after you enroll in a different Medicare Advantage plan or 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.

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 may be 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 Medi-Cal (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 Advantage 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 you enroll in a different Medicare advantage plan or your request to change your plan is received.

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 2021*** 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 (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.

How do you end your membership in our plan?

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 the “When can you end your membership in our plan?” section of 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.

Until your membership ends, you must keep getting your medical services through our plan

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 the "When can you end your membership in our plan?" section of this section 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).

We must end your membership in the plan in certain situations

When must we end your membership in the plan?

We must end your membership in the plan if any of the following happen:

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area
- If you are away from our service area for more than six months.
    - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's service 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 for this reason, Medicare may have your case investigated by the Inspector General.

When Coverage Ends

You must notify your employer's or union's benefits administrator of changes that will affect your eligibility. The employer or union benefits administrator will send the appropriate request to Health Net according to current procedures. Coverage ends on the last day of the month in which the eligible Member(s), cease to be eligible for coverage.

Involuntarily ending your membership due to termination of the Group Policy

All Group Members

All Members of a Group become ineligible for coverage under this Plan at the same time if the Group Hospital and Professional Service Agreement between the Group and Health Net ("Group Service Agreement") is terminated, including termination due to nonpayment of subscription charges by the Group.

When the Group Service Agreement between the Group and Health Net is terminated, or the Group determines that a Member is no longer eligible to participate in the Group plan, Health Net has the option to follow one of two procedures to disenroll Members from the current Health Net plan in which the Member is enrolled:

For both of the following options, Health Net must ensure that the Group agrees to the following:

- The Group will provide Health Net with timely notice of termination of the Group Service Agreement or the ineligibility of a Member to participate in the Group sponsored plan. Such notice must be prospective, not retroactive.
- The Group must provide a prospective notice to its Members alerting them of the termination event and of other insurance options that may be available to them through their employer or union.

Health Net will mail your employer a Prospective Notice of Cancellation 30 days before any cancellation of coverage. This Prospective Notice of Cancellation will provide information to the Group regarding the consequences of the Group's failure to pay the subscription charges due within 30 days of the date of mailing of the Prospective Notice of Cancellation.

If Health Net does not receive payment of the delinquent subscription charges from your employer within 30 days of the date of mailing of the Prospective Notice of Cancellation, Health Net will cancel the Group Service Agreement and mail the Subscriber and your employer a Notice Confirming Termination of Coverage, which will provide you and your employer with the following information: (1) that the Group Service Agreement has been canceled for non-payment of subscription charges; and (2) an explanation of your coverage options. The Group or Health Net will also provide you with written notice of disenrollment from the plan no less than 21 days prior to the effective date of the disenrollment.

If coverage through this plan ends for reasons other than non-payment of subscription charges, see the "Coverage Options Following Termination" section below for coverage options.

Subscriber and All Family Members
The Subscriber and all his or her Family Members will become ineligible for coverage at the same time if the Subscriber loses eligibility for this plan.

Individual Members – Termination for Loss of Eligibility
Individual Members become ineligible on the last day of the month from the date any of the following occurs:

- The Member no longer meets the eligibility requirements established by the Group and Health Net. This will include a child subject to a Medical Child Support Order, according to state or federal law, who becomes ineligible on the earlier of:

  1. The date established by the order.
  2. The date the order expired.

- The Member establishes primary residency outside the continental United States.
- The Member establishes primary residency outside the Health Net Service Area.

  However, a child subject to a Medical Child Support Order, according to state or federal law, who moves out of the Health Net plan service area, does not cease to be eligible for this plan. But, while that child may continue to be enrolled, coverage of care received outside the Health Net Service Area will be limited to services provided in connection with Emergency Care or Urgently Needed Service.

  Follow-Up Care, routine care and all other benefits of this plan are covered only when authorized by the contracting Physician Group (medical) or MHN Services (Mental Disorders and Chemical Dependency).

- The Subscriber's marriage or domestic partnership ends by divorce, annulment or some other form of dissolution. Eligibility for the Subscriber's enrolled spouse or Domestic Partner (now former spouse or Domestic Partner) and that spouse's or Domestic Partner's enrolled dependents, who were related to the Subscriber only because of the marriage or domestic partnership, will end.

Individual Members - Termination for Cause
Health Net has the right to terminate your coverage from this plan under certain circumstances. The following are examples of circumstances that may result in a termination:

- Disruptive or Threatening Behavior: Your coverage may be terminated effective the first day of the calendar month after the month in which Health Net gives you written notice of the disenrollment, or as provided by the Centers for Medicare & Medicaid Services (CMS), if you threaten the safety of the health care provider, his or her office staff, the contracting Physician Group or Health Net if such behavior does not arise from a diagnosed illness or condition. In addition, your coverage may be terminated effective the first day of the calendar month after the month in which Health Net gives you written notice of the disenrollment, or as provided by the Centers for Medicare & Medicaid Services (CMS), if you repeatedly or materially disrupt the operations of the Physician Group or Health Net to the extent that your behavior substantially impairs Health Net's ability to furnish or arrange services for you or other Health Net Members,

or substantially impairs the Physician's office or contracting Physician Group's ability to provide services to other patients.

- Misrepresentation or Fraud: Your coverage may be terminated effective the first day of the calendar month after the month in which Health Net gives you written notice, if you knowingly omit or misrepresent a meaningful fact on your enrollment form or fraudulently or deceptively use services or facilities of Health Net, its contracting Physician Groups or other contracting providers, (or knowingly allow another person to do so), including altering a prescription.

If coverage is terminated for any of the above reasons, you forfeit all rights to enroll in the COBRA plan or any plan that is owned or operated by Health Net's parent company or its subsidiaries and lose the right to re-enroll in Health Net in the future.

Health Net will conduct a fair investigation of the facts before any termination for any of the above reasons is carried out.

Your health status or requirements for health care services will not determine eligibility for coverage. If you believe that coverage was terminated because of health status or the need for health services, you may request a review of the termination by the Director of the California Department of Public Health.

Coverage Options Following Termination

If coverage through this Plan ends as a result of the Group's non-payment of subscription charges, see the "All Group Members" section of this chapter for coverage options following termination. If coverage through this Plan ends for reasons other than the Group's non-payment of subscription charges, the terminated Member may be eligible for additional coverage.

COBRA Continuation Coverage

Many groups are required to offer continuation coverage by the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA). For most Groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside California. Please check with your employer/union benefits administrator to determine if you and your covered dependents are eligible.

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).

We cannot ask you to leave our plan for any reason related to your health

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

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 the “What to do if you have a problem or complaint (coverage decisions, appeals, complaints)” chapter of this booklet for information about how to make a complaint.

LEGAL NOTICES

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.

Notice about non-discrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. **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 within the service area. 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.

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

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

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:

- 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, audio, 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 Member Services at:1-800-275-4737 (HMO), (TTY: 711). From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to

September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays.

If you believe that Health Net has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by calling the number above and telling them you need help filing a grievance; Health Net's Member Services 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.

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 chapter supersede any State laws.

Recovery of benefits paid by Health Net under your Health Net Seniority Plus Employer (HMO) plan

When you are injured

If you are ever injured, become ill or develop a condition through the actions of another person, company, or yourself (a "responsible party"), our plan will provide benefits for covered services that you receive. However, if you receive money or are entitled to receive money because of your injury, illness or condition, whether through a settlement, judgment, or any other payment associated with your injury, illness or condition, our plan and/or the treating providers retain the right to recover the value of any services provided to you through this Plan in accordance with applicable State law.

As used throughout this provision, the term "responsible party" means any person or entity actually or potentially responsible for your injury, illness or condition. The term responsible party includes the liability or other insurer of the responsible person or entity.

Some examples of how you could be injured, become ill or develop a condition through the actions of a responsible party are:

- You are in a car accident;
- You slip and fall in a store; or
- You are exposed to a dangerous chemical at work.

Our plan's right of recovery applies to any and all amounts you receive from the responsible party, including but not limited to:

- 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 or umbrella coverage;
- Any settlement received from a lawsuit or other legal action;
- Any judgment received from a lawsuit or other legal action; or
- 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 agree that our plan has a first priority right of subrogation and reimbursement that attaches when this Plan has paid benefits for Covered Services that you received 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) assign to our plan your right to recover medical expenses from any coverage available up to the full cost of all Covered Services provided by the Plan in connection with your injury, illness or condition, and (ii) you agree to specifically direct the responsible party to directly reimburse the Plan on your behalf.

By accepting benefits under this Plan, you also give our plan a first priority lien on any recovery, settlement or judgment, or other source of compensation and all reimbursement for the full cost of benefits for Covered Services paid under the Plan that are associated with your injury, illness or condition due to the actions or omissions of a responsible party. This priority applies regardless of whether the amounts are specifically identified as a recovery for medical expenses and regardless of whether you are made whole or fully compensated for your loss. Our plan may recover the full cost of all benefits provided by this Plan without regard to any claim of fault on your part, whether by comparative negligence or otherwise. No attorney fees may be deducted from our plan's recovery, and our plan is not required to pay or contribute to paying court costs or attorneys' fees for the attorney hired to pursue the claim or lawsuit against any responsible party.

Steps you must take

If you are injured, become ill or develop a condition because of a responsible party, you must cooperate with our plan's and/or the treating provider's efforts to recover its expenses, including:

- Telling our plan or the treating provider, as applicable, 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, including a description of how the injury, illness or condition was caused.
- Completing any paperwork that our plan or the treating provider may reasonably require to assist in enforcing the lien or right of recovery.
- Promptly responding to inquiries from our plan or the treating provider about the status of the case or claim and any settlement discussions.
- Notifying our plan immediately upon you or your lawyer receiving any money from the responsible party(s) or any other source.
- Paying the health care lien or Plan recovery amount from any recovery, settlement or judgment, or other source of compensation, including payment of all reimbursement due to our plan for the full cost of benefits paid under the Plan that are associated with your injury, illness or condition 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;
- Doing nothing to prejudice our plan's rights as set forth above. This includes, but is not limited to, refraining from any attempts to reduce or exclude from settlement or recovery the full cost of all benefits paid by the Plan or any attempts to deny our plan its first priority right of recovery or lien.
- Holding any money that you or your lawyer receive from the responsible party(s), or from any other source, in trust, and reimbursing our plan or the treating provider, as applicable, 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.

Membership card

A membership card issued by our plan under this *Evidence of Coverage* is for identification purposes only. Possession of a membership card does not confer any right to services or other benefits under this *Evidence of Coverage*. To be entitled to services or benefits under this *Evidence of Coverage*, the holder of the card must be eligible for coverage and be enrolled as a member under this *Evidence of Coverage*. Any person receiving services to which he or she is not then entitled under this *Evidence of Coverage* will be responsible for payment for those services. A Member must present the plan's membership card, not a Medicare card, at the time of service. Please call Member Services at the number located on the back cover of this booklet if you need your membership card replaced.

Note: Any member knowingly permitting abuse or misuse of the membership card may be disenrolled for cause. Our plan is required to report a disenrollment that results from membership card abuse or misuse to the Office of the Inspector General, which may result in criminal prosecution.

Independent contractors

The relationship between our plan and each participating provider is an independent contractor relationship. Participating providers are not employees or agents of our plan and neither our plan, nor any employee of our plan, is an employee or agent of a participating provider. In no case will our plan be liable for the negligence, wrongful act, or omission of any participating or other health care provider. Participating physicians, and not our plan, maintain the physician-patient relationship with the Member. Our plan is not a provider of health care.

Health care plan fraud

Health care plan fraud is defined as a deception or misrepresentation to the plan 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, for example, filing a claim that contains a false or deceptive statement is guilty of health care plan 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 1-866-685-8664 (TTY: 711). The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

Circumstances beyond the plan's control

To the extent that a natural disaster, war, riot, civil insurrection, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, disability of significant medical group personnel, state of emergency or other similar events not within the control of our plan, results in our plan's facilities or personnel not being available to provide or arrange for services or benefits under this *Evidence of Coverage*, the plan's obligation to provide such services or benefits shall be limited to the requirement that our plan make a good faith effort to provide or arrange for the provision of such services or benefits within the current availability of its facilities or personnel.

Binding Arbitration

This binding arbitration provision does not apply to disputes that are subject to the Medicare appeals process as described in the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)"chapter.

Sometimes disputes or disagreements may arise between you (including your enrolled Family Members, heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of this Evidence of Coverage or regarding other matters relating to or arising out of your Health Net membership. Typically such disputes are handled and resolved through the Health Net

Grievance, Appeal and Independent Medical Review process described above. However, in the event that a dispute is not resolved in that process, Health Net uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, health care providers, or their agents or employees, are also involved. In addition, disputes with Health Net involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

As a condition to becoming a Health Net Member, you agree to submit all disputes you may have with Health Net, except those described below, to final and binding arbitration. Likewise, Health Net agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both you and Health Net are bound to use binding arbitration as the final means of resolving disputes that may arise between the parties, and thereby the parties agree to forego the constitutional right to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by Health Net's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Health Net's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is $200,000 or less, the parties shall, within 30 days of submission of the demand for Arbitration to Health Net, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and who will not have jurisdiction to award more than $200,000. In the event that the total amount of damages is over $200,000, the parties shall, within 30 days of submission of the demand for Arbitration to Health Net, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

If the parties fail to reach an agreement during this time frame, then either party may apply to a Court of Competent Jurisdiction for appointment of the arbitrator(s) to hear and decide the matter.

Arbitration can be initiated by submitting a demand for Arbitration to Health Net at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Health Net of California
Attention: Legal Department
PO Box 4504
Woodland Hills, CA 91365-4504

The arbitrator is required to follow applicable state and federal laws. The arbitrator may interpret this Evidence of Coverage, but will not have any power to change, modify or refuse to enforce any of its terms, nor will the arbitrator have the authority to make any award that would not be available in a court of law. At the conclusion of the arbitration, the arbitrator will issue a written opinion and award setting forth findings of fact and conclusions of law and the reasons for the award. The award will be final and binding on all parties except to the extent that applicable state or federal law provide for judicial review of arbitration proceedings.

The parties will share equally the arbitrator's fees and expenses of administration involved in the arbitration. Each party also will be responsible for their own attorneys' fees. In cases of extreme hardship to a Member, Health Net may assume all or a portion of a Member's share of the fees and expenses of the Arbitration. Upon written notice by the Member requesting a hardship application, Health Net will forward the request to an independent professional dispute resolution organization for a determination. Such request for hardship should be submitted to the Legal Department at the address provided above.

Effective July 1, 2002, Members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations" made by Health Net to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by Health Net to deny, reduce, terminate or not pay for all or a part of a benefit. However, you and Health Net may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

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 payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for an item or service you think you should be able to receive. The "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter in this booklet 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 for services. As a member of our plan you only have to pay the plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" 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. See the "Important phone numbers and resources" chapter of this booklet as it 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 (if applicable to your plan). Coinsurance is usually a percentage (for example, 20%).

Complaint - The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance," in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit or hospital outpatient visit. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services are received. (this is in addition to any applicable plan 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. A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment.

Covered Services – The general term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Deductible – The amount you must pay (if applicable) for health care or prescriptions before our plan begins to pay.

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

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 – A member who has 6 months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from 2 years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

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.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the plan year for in network covered medical services. Amounts you pay for any plan premiums and Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount. See the "Medical Benefits Chart (what is covered and what you pay)" chapter for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See the

"Important phone numbers and resources" chapter in this booklet for information about how to contact Medicaid in your state.

Medical Group - A group of two or more physicians and non-physician practitioners legally organized in a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association in which each physician who is a member of the group provides substantially the full range of services which the physician routinely provides (including medical care, consultation, diagnosis, or treatment) through the joint use of shared office space, facilities, equipment, and personnel.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a PACE plan, or a Medicare Advantage plan.

Medicare Advantage Open Enrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to another Medicare Advantage plan, or obtain coverage through Original Medicare .If you choose to switch to Original Medicare during this period, you can also join a separate Medicare prescription drug plan at that time. The Medicare Advantage Open Enrollment Period is from January 1 until March 31, and is also available for a 3-month period after an individual is first eligible for Medicare.

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 Advantage health plan that is offered in their area.

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.

Medical Group – A group of two or more physicians and non-physician practitioners legally organized in a partnership, professional corporation, foundation, not-for-profit corporation, faculty practice plan, or similar association in which each physician who is a member of the group provides substantially the full range of services which the physician routinely provides (including medical care, consultation, diagnosis, or treatment) through the joint use of shared office space, facilities, equipment, and personnel.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B

"Medigap" (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill "gaps" in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

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 the back cover of this booklet 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, coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this booklet. The "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" chapter in this booklet explains how to ask us for a coverage decision.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care provider 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. Out-of-network providers are paid using Medicare Allowable rates,

or if there is no defined Medicare Allowable rate, 60% of billed charges. Any of your coinsurance cost-sharing will be the coinsurance amounts indicated in the Medical Benefits Chart and will be calculated from the Medicare Allowable Cost or reduced billed charges. Using out-of-network providers or facilities is explained in this booklet in the "Using the plan's coverage for your medical services"chapter.

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".

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See the "You must choose a Primary Care Provider (PCP)" to provide and oversee your medical care" section of the "Using the plan's coverage for your medical services" chapter of this booklet for information about Primary Care Provider.

Prior Authorization – Approval in advance to get services. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Medical Benefits Chart.

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 the "Important phone numbers and resources" chapter of this booklet 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 drug plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

Special Needs Plan – A special type of Medicare Advantage plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Urgently needed services are provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

Health Net Seniority Plus Employer (HMO) Member Services

Method	Member Services – Contact Information
CALL	1-800-275-4737 Calls to this number are free. From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends, and on federal holidays. 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 Calls to this number are free. From October 1 to March 31, you can call us 7 days a week from 8 a.m. to 8 p.m. From April 1 to September 30, you can call us Monday through Friday from 8 a.m. to 8 p.m. A messaging system is used after hours, weekends and on federal holidays.
WRITE	PO Box 10420 Van Nuys, CA 91410-0420
WEBSITE	healthnet.com

Health Insurance Counseling & Advocacy Program (HICAP) (California SHIP)

The Health Insurance Counseling and Advocacy Program (HICAP*)* is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

Method	Health Insurance Counseling & Advocacy Program (HICAP) (California SHIP) – Contact Information
CALL	1-800-434-0222
TTY	711 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	HICAP 505 12th Street Sacramento, CA 95814
WEBSITE	www.hicapservices.net

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