EVIDENCE OF COVERAGE

A complete explanation of your plan

Medicare Coordination Of Benefits

HMO (Plan 2G6) EOCID:193612

For University of California Medicare members in Fresno, Madera, Nevada or Ventura Counties
Effective 1/1/2008

Important benefit information – please read

Health Net®
A BETTER DECISION

Dear Health Net Member:

This is your new Health Net Evidence of Coverage.

This document is the most up-to-date version. To avoid confusion, please discard any versions you may have previously received.

Thank you for choosing Health Net.

About This Booklet

Please read the following information so you will know from whom or what group of providers health care may be obtained.

Method of Provider Reimbursement

Health Net uses financial incentives and various risk sharing arrangements when paying providers. You may request more information about our payment methods by contacting the Member Services Department at the telephone number on your Health Net ID Card, your Physician Group or your Primary Care Physician.

Summary of Plan

This Evidence of Coverage constitutes only a summary of the health Plan. The health Plan contract must be consulted to determine the exact terms and conditions of coverage.

Please read this Evidence of Coverage carefully.

Schedule changes in 2008

This page is not an official statement of benefits. Your benefits are described in detail in the *Evidence of Coverage*. We have also edited and clarified language throughout the *Evidence of Coverage* in addition to the items listed below.

Changes to this Plan

Schedule of Benefits and Copayments

- Amended text to show **"Routine Exams"** at $0, under the **"Preventive Care Services "** section (2008 benefit change).
- Amended text to show **"Outpatient Mental Health and Substance Abuse "** at $15 copay, and **"Group Therapy"** at $7.50 copay under the **"Outpatient Services"** section (2008 benefit change).
- Amended text for **"Sexual Dysfunction Drugs,"** to 50% coinsurance, under the **"Retail Pharmacy (up to a 30 day supply)"** section, under the **"Prescription Drug Benefits"** section (2008 benefit change).

Use of Special Words

Special words used in this Evidence of Coverage (EOC) to explain your Plan have their first letter capitalized and appear in "Definitions," Section 900.

The following words are used frequently:

- **"You"** refers to anyone in your family who is covered; that is, anyone who is eligible for coverage in this Plan and who has been enrolled.
- **"Employee"** has the same meaning as the word "you" above.
- **"We" or "Our"** refers to Health Net.
- **"Subscriber"** means the primary covered person, generally an Employee of a Group.
- **"Physician Group" or "Participating Physician Group (PPG)"** means the medical group the individual Member selected as the source of all covered medical care.
- **"Primary Care Physician"** is the individual Physician each Member selected who will provide or authorize all covered medical care.
- **"Group"** is the business entity (usually an employer or Trust) that contracts with Health Net to provide this coverage to you.
- **"Plan" and "EOC"** have similar meanings. You may think of these as meaning your Health Net benefits.

University of California
Eligibility, Enrollment, Termination and Plan Administration Provisions
January 1, 2008

The following information applies to the University of California plan and supersedes any corresponding information that may be contained elsewhere in the document to which this insert is attached. The University establishes its own medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations ("Regulations") and any corresponding Administrative Supplements. Portions of these Regulations are summarized below.

ELIGIBILITY

The following individuals are eligible to enroll in this Plan. If the Plan is a Health Maintenance Organization (HMO) or Exclusive Provider Organization (EPO) Plan, they are only eligible to enroll in the plan if they meet the Plan's geographic service area criteria. Anyone enrolled in a non-University Medicare Advantage Managed Care contract or enrolled in a non-University Medicare Part D Prescription Drug Plan will be deenrolled from this health plan.

Subscriber

Employee: You are eligible if you are appointed to work at least 50% time for twelve months or more or are appointed at 100% time for three months or more or have accumulated 1,000***** hours while on pay status in a twelve-month period. To remain eligible, you must maintain an average regular paid time****** of at least 17.5 hours per week and continue in an eligible appointment. If your appointment is at least 50% time, your appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

* Lecturers - see your benefits office for eligibility.

** Average Regular Paid Time - For any month, the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked in the preceding twelve (12) month period. Average regular paid time does not include full or partial months of zero paid hours when an employee works less than 43.75% of the regular paid hours available in the month due to furlough, leave without pay or initial employment.

Retiree: A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan.

You may continue University medical plan coverage as a Retiree when you start collecting retirement or disability benefits from a University-sponsored defined benefit plan. You must also meet the following requirements:

(a) you meet the University's service credit requirements for Retiree medical eligibility;

(b) the effective date of your Retiree status is within 120 calendar days of the date employment ends (or the date of the (c)Employee/Retiree's death for a Survivor); and
(c) you elect to continue medical coverage at the time of retirement.

A **Survivor**—a deceased Employee's or Retiree's Family Member receiving monthly benefits from a University-sponsored defined benefit plan—may be eligible to continue coverage as set forth in the University's Group Insurance Regulations. For more information, see the UC *Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members*.

If you are eligible for Medicare, you must follow UC's Medicare Rules. See "Effect of Medicare on Retiree Enrollment" below.

Eligible Dependents (Family Members)

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the eligibility requirements outlined below. The University and/or the Plan reserves the right to periodically request documentation to verify eligibility of Family Members including any who are required to be your tax dependent(s). Documentation could include a marriage certificate, birth certificate(s), adoption records, Federal Income Tax Return, or other official documentation.

Spouse: Your legal spouse.

Child: All eligible children must be under the limiting age (18 for legal wards, 23 for all others), unmarried, and may not be emancipated minors. The following categories are eligible:
(a) your natural or legally adopted children;
(b) your stepchildren (natural or legally adopted children of your spouse) if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;
(c) grandchildren of you or your spouse if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;
(d) children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental disability may continue to be covered past age 23 provided:
- the incapacity began before age 23, the child was enrolled in a group medical plan before age 23 and coverage is continuous;

- the child is claimed as your dependent for income tax purposes or is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment which may offset the Social Security or Supplemental Security Income; and
- the child lives with you if he or she is not your or your spouse's natural or adopted child.

Application must be made to the Plan at least 31 days before the child's 23rd birthday and is subject to approval by the Plan. The Plan may periodically request proof of continued disability. Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If you are a newly hired Employee with an incapacitated child, you may also apply for coverage for that child. The child must have had continuous group medical coverage since age 23, and you must apply for University coverage during your Period of Initial Eligibility.

Other Eligible Dependents (Family Members): You may enroll a same-sex domestic partner (and the same-sex domestic partner's children/grandchildren/stepchildren) as set forth in the University of California Group Insurance Regulations.

The University will recognize an opposite-sex domestic partner as a family member that is eligible for coverage in UC-sponsored benefits if the employee/retiree or domestic partner is age 62 or older and eligible to receive Social Security benefits and both the employee/retiree and domestic partner are at least 18 years of age.

An adult dependent relative is no longer eligible for coverage. Only an adult dependent relative who was enrolled as an eligible dependent as of December 31, 2003 may continue coverage in UC-sponsored plans.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, a Retiree, a Survivor or a Family Member, but not under any combination of these. If an Employee and the Employee's spouse or domestic partner are both eligible Subscribers, each may enroll separately or one may cover the other as a Family Member. If they enroll separately, neither may enroll the other as a Family Member. Eligible children may be enrolled under either parent's or eligible domestic partner's coverage but not under both. Additionally, a child who is also eligible as an Employee may not have dual coverage through two University-sponsored medical plans.

More Information

For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's Customer Service Center. You may also access eligibility factsheets on the web site: http://atyourservice.ucop.edu.

Enrollment

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. If you are a Retiree, contact the University's Customer Service Center. Enrollment transactions may be completed by paper form or electronically, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office or by the University's Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by midnight of the last day of the enrollment period.

During a Period of Initial Eligibility (PIE)

A PIE ends 31 days after it begins.

If you are an Employee, you may enroll yourself and any eligible Family Members during your PIE. Your PIE starts the day you become an eligible Employee.

You may enroll any newly eligible Family Member during his or her PIE. The Family Member's PIE starts the day your Family Member becomes eligible, as described below. During this PIE you may also enroll yourself and/or any other eligible Family Member if not enrolled during your own or their own PIE. You must enroll yourself in order to enroll any eligible Family Member. Family members are only eligible for the same plan in which you are enrolled.

(a) For a spouse, on the date of marriage.

(b) For a natural child, on the child's date of birth.

(c) For an adopted child, the earlier of:

  (i) the date you or your Spouse has the legal right to control the child's health care, or

  (ii) the date the child is placed in your physical custody. If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.

(d) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you decline enrollment for yourself or your eligible Family Members because of other group medical plan coverage and you lose that coverage involuntarily (or if the employer stops contributing toward the other coverage for you or your Family Members), you may be able to enroll yourself and those eligible Family Members during a PIE that starts on the day the other coverage is no longer in effect.

If you are in an HMO, POS or EPO Plan and you move or are transferred out of that Plan's service area, or will be away from the Plan's service area for more than two months, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan. Your PIE starts with the effective date of the move or the date you leave the Plan's service area.

At Other Times For Employees And Retirees

You and your eligible Family Members may also enroll during a group open enrollment period established by the University.

If you are an Employee and opt out of medical coverage or fail to enroll yourself during a PIE or open enrollment period, you may enroll yourself at any other time upon completion of a 90 consecutive calendar day waiting period.

If you are an Employee or Retiree and fail to enroll your eligible Family Members during a PIE or open enrollment period, you may enroll your eligible Family Members at any other time upon completion of a 90 consecutive calendar day waiting period.

The 90-day waiting period starts on the date the enrollment form is received by the local Accounting or Benefits office and ends 90 consecutive calendar days later.

If you have one or more children enrolled in the Plan, you may add a newly eligible Child at any time. See "Effective Date".

If you are an Employee or a Retiree and there is a lifetime maximum for all benefits under this plan, and you or a Family Member reaches that maximum, you and your eligible Family Members may be eligible to enroll in another UC-sponsored medical plan. Contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

If you are a Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan (or its Medicare version) you were enrolled in immediately before retiring. You must elect to continue enrollment for yourself and enrolled Family Members before the effective date of retirement (or the date disability or survivor benefits begin).

If you are a Survivor, you may not enroll your legal spouse or domestic partner.

Effective Date

The following effective dates apply provided the appropriate enrollment transaction (paper form or electronic) has been completed within the applicable enrollment period.

If you enroll during a PIE, coverage for you and your Family Members is effective the date the PIE starts.

If you are a Retiree continuing enrollment in conjunction with retirement, coverage for you and your Family Members is effective on the first of the month following the first full calendar month of retirement income.

The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.

For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment transaction is completed.

An Employee or Retiree already enrolled in adult plus child(ren) or family coverage may add additional children, if eligible, at any time after their PIE. Retroactive coverage is limited to the later of:

(a) the date the Child becomes eligible, or

(b) a maximum of 60 days prior to the date your Child's enrollment transaction is completed.

Change in Coverage

In order to change from single to adult plus child(ren) coverage, or two adult coverage, or family coverage, or to add another Child to existing family coverage, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Effect of Medicare on Retiree Enrollment

If you are a Retiree and you and/or an enrolled Family Member is or becomes eligible for premium-free Medicare Part A (Hospital Insurance) as primary coverage, then that individual must also enroll in and remain in Medicare Part B (Medical Insurance). Once Medicare coverage is established, coverage in both Part A and Part B must be continuous. This includes anyone who is entitled to Medicare benefits through their own or their spouse's employment. Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this plan.

Retirees or their Family Member(s) who become eligible for premium-free Medicare Part A on or after
January 1, 2004 and do not enroll in Part B will permanently lose their UC-sponsored medical coverage.

Retirees and their Family Members who were eligible for premium-free Medicare Part A prior to January 1, 2004, but declined to enroll in Part B of Medicare, are assessed a monthly offset fee by the University to cover increased costs. The offset fee may increase annually, but will stop when the Retiree or Family Member becomes covered under Part B.

Retirees or Family Members who are not eligible for premium-free Part A will not be required to enroll in Part B, they will not be assessed an offset fee, nor will they lose their UC-sponsored medical coverage. Documentation attesting to their ineligibility for Medicare Part A will be

required. (Retirees/Family Members who are not entitled to Social Security and premium-free Medicare Part A will not be required to enroll in Part B.)

An exception to the above rules applies to Retirees or Family Members in the following categories who will be eligible for the non-Medicare premium applicable to this plan and will also be eligible for the benefits of this plan without regard to Medicare:

(a) Individuals who were eligible for premium-free Part A, but not enrolled in Medicare Part B prior to July 1, 1991.

(b) Individuals who are not eligible for premium-free Part A.

You should contact Social Security three months before your or your Family Member's 65th birthday to inquire about your eligibility and how to enroll in the Hospital (Part A) and Medical (Part B) portions of Medicare. If you qualify for disability income benefits from Social Security, contact a Social Security office for information about when you will be eligible for Medicare enrollment.

Upon Medicare eligibility, you or your Family Member must complete a University of California Medicare Declaration form, as well as submit a copy of your Medicare card. This notifies the University that you are covered by Part A and Part B of Medicare. The University's Medicare Declaration form is available through the University's Customer Service Center or from the web site: http://atyourservice.ucop.edu. Completed forms should be returned to University of California, Human Resources and Benefits, Health & Welfare Administration-Retiree Insurance Program, Post Office Box 24570, Oakland, CA 94623-9911.

Any individual enrolled in a University-sponsored Medicare Advantage Managed Care Contract must assign his/her Medicare benefit to that plan or lose UC-sponsored medical coverage. Anyone enrolled in a non-University Medicare Advantage Managed Care contract or enrolled in a non-University Medicare Part D Prescription Drug Plan will be deenrolled from this health plan.

Medicare Secondary Payer Law (MSP)

The Medicare Secondary Payer (MSP) Law affects the order in which claims are paid by Medicare and an employer group health plan. UC Retirees re-hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to MSP. For Employees or their spouses who are age 65 or older and eligible for a group health plan due to employment, MSP indicates that Medicare becomes the secondary payer and the employer plan becomes the primary payer. You should carefully consider the impact on your health benefits and premiums should you decide to return to work after you retire.

Medicare Private Contracting Provision and Providers Who do Not Accept Medicare

Federal Legislation allows physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services **(that would otherwise be covered by Medicare)** from these physicians or practitioners will need to enter into written "private contracts" with these physicians or practitioners. These private agreements will require the beneficiary to be responsible for all payments to such medical providers. Since services provided under such "private contracts" are not covered by Medicare or this Plan, the Medicare limiting charge will not apply.

Some physicians or practitioners have **never** participated in Medicare. Their services (that would be covered by Medicare if they participated) will not be covered by Medicare or this Plan, and the Medicare limiting charge will not apply.

If you are classified as a Retiree by the University (or otherwise have Medicare as a primary coverage), are enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement as described above with one or more physicians or practitioners, or if you choose to obtain services from a provider who does not participate in Medicare, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. In either case, no benefits will be paid by this Plan for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered. Therefore, it is important that you confirm that your provider takes Medicare prior to obtaining services for which you wish the Plan to pay.

However, even if you do sign a private contract or obtain services from a provider who does not participate in Medicare, you may still see other providers who have not opted out of Medicare and receive the benefits of this Plan for those services.

TERMINATION OF COVERAGE

The termination of coverage provisions that are established by the University of California in accordance with its Regulations are described below. Additional Plan provisions apply and are described elsewhere in the document.

Deenrollment Due to Loss of Eligible Status

If you are an Employee and lose eligibility, your coverage and that of any enrolled Family Member stops at the end of the last month in which premiums are taken from earnings based on an eligible appointment.

If you are a Retiree or Survivor and your annuity terminates, your coverage and that of any enrolled Family Member stops at the end of the last month in which you are eligible for an annuity.

If your Family Member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Family Member is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. For information on deenrollment procedures, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Deenrollment Due to Fraud

Coverage for you or your Family Members may be terminated for fraud or deception in the use of the services of the Plan, or for knowingly permitting such fraud or deception by another. Such termination shall be effective upon the mailing of written notice to the Subscriber (and to the University if notice is given by the Plan). A Family Member who commits fraud or deception will be permanently deenrolled while any other Family Member and the Subscriber will be deenrolled for 12 months. If a Subscriber commits fraud or deception, the Subscriber and any Family Members will be deenrolled for 12 months.

Leave of Absence, Layoff or Retirement

Contact your local Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, layoff or retirement.

Optional Continuation of Coverage

If your coverage or that of a Family Member ends, you and/or your Family Member may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, and if that continued coverage ends, specified individuals may be eligible for further continuation under California law. The terms of these continuation provisions are contained in the University of California notice "Continuation of Group Insurance Coverage", available from the University's "At Your Service" website (http://atyourservice.ucop.edu). The notice is also available from the person in your department who handles benefits and from the University's Customer Service Center. You may also direct questions about these provisions to your local Benefits Office or to the University's Customer Service Center if you are a Retiree.

PLAN ADMINISTRATION

By authority of the Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the Group Hospital and Professional Service Agreement. What is written in this document does not constitute a guarantee of plan coverage or benefits--particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

This section describes how the Plan is administered and what your rights are.

Sponsorship and Administration of the Plan

The University of California is the Plan sponsor and administrator for the Plan described in this booklet. If you have a question, you may direct it to:

University of California
Human Resources and Benefits
Health & Welfare Administration
300 Lakeside Drive, 12th Floor
Oakland, CA 94612
(800) 888-8267

Retirees may also direct questions to the University's Customer Service Center at the above phone number.

Claims under the Plan are processed by Health Net at the following address and phone number:

Health Net Medicare HMO COB
P.O. Box 14703
Lexington, KY 40512
1-800-539-4072

Group Contract Number

The Group Contract Number for this Plan is: 5047RC, 5047RG, 5047RM, 5047RR, 5047RV, 5047RZ, 5047SD, 5047SJ, 5047SN, 5047SS, 5047SW, 5047TB, 5047TC, 5047TH, 5047TM, 5047TS, 5047TX, 5047UC, 5047UG, 5047UM, 5047UT, 5047UY, 5047VC, 5047VH.

University of California
Eligibility, Enrollment, Termination and Plan Administration Provisions
January 1, 2008

Type of Plan

This Plan is a health and welfare plan that provides group medical care benefits. This Plan is one of the benefits offered under the University of California's employee health and welfare benefits program.

Plan Year

The plan year is January 1 through December 31.

Continuation of the Plan

The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. Plan benefits are not accrued or vested benefit entitlements. The right to terminate or amend applies to all Employees, Retirees and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums and what portion of the premiums the University will pay. The portion of the premiums that University pays is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation.

Financial Arrangements

The benefits under the Plan are provided by Health Net under a Group Service Agreement.

The plan costs are currently shared between you and the University of California.

Agent for Serving of Legal Process

Legal process may be served on Health Net at the address listed above.

Your Rights under the Plan

As a participant in a University of California medical plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and other specified sites, all Plan documents, including the Group Service Agreement, at a time and location mutually convenient to the participant and the Plan Administrator.
- Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Claims under the Plan

To file a claim or to appeal a denied claim, refer to page 77 of this document.

Nondiscrimination Statement

In conformance with applicable law and University policy, the University of California is an affirmative action/equal opportunity employer.

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director of Diversity and Employee Programs, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Director of Academic Affirmative Action, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

Table of Contents

INTRODUCTION TO HEALTH NET

How to Obtain Care

When you enroll in this Plan, you must select a contracting Physician Group where you want to receive all of your medical care. That Physician Group will provide or authorize all medical care. Call your Physician Group directly to make an appointment. For contact information on your Physician Group, please call the Member Services Department at the telephone number on your Health Net ID card.

Some Hospitals and other providers do not provide one or more of the following services that may be covered under your Evidence of Coverage and that you or your Family Member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; Infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association or clinic or the Member Services Department at 1-800-539-4072 to ensure that you can obtain the health care services that you need.

Transition of Care For New Enrollees

You may request continued care from a provider, including a Hospital, that does not contract with Health Net if, at the time of enrollment with Health Net, you were receiving care from such a provider for any of the following conditions:

- An Acute Condition;
- A Serious Chronic Condition not to exceed twelve months from your Effective Date of coverage under this Plan;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- A newborn up to 36 months of age not to exceed twelve months from your Effective Date of coverage under this Plan;
- A Terminal Illness (for the duration of the Terminal Illness); or
- A surgery or other procedure that has been authorized by your prior health plan as part of a documented course of treatment.

For definitions of Acute Condition, Serious Chronic Condition and Terminal Illness see "Definitions," Section 900.

Health Net may provide coverage for completion of services from such a provider, subject to applicable Copayments and any exclusions and limitations of this Plan. You must request the coverage within 60 days of your Group's effective date unless you can show that it was not reasonably possible to make the request within 60 days of your Group's effective date, and you make the request as soon as reasonably possible. The non-participating provider must be willing to accept the same contract terms applicable to providers currently contracted with Health Net, who are not capitated and who practice in the same or similar geographic region. If the provider does not accept such terms, Health Net is not obligated to provide coverage with that provider.

If you would like more information on how to request continued care, or request a copy of our continuity of care policy, please contact the Member Services Department at the telephone number on your Health Net ID Card.

Selecting a Contracting Physician Group

Family Members may select different contracting Physician Groups. However, each person must select a contracting Physician Group close enough to his or her residence or place of work to allow reasonable access to medical care. If you choose a Physician Group based on its proximity to the Subscriber's work address, you will need to travel to that Physician Group for any non-emergency or non-urgent care that you receive. Additionally, some Physician Groups may decline to accept assignment of a Member whose home or work address is not close enough to the Physician Group to allow reasonable access to care. Please call the Member Services Department at the number shown on your Health Net ID Card if you need a provider directory or if you have questions involving reasonable access to care. The provider directory is also available on the Health Net website at www.healthnet.com/uc.

Selecting a Primary Care Physician

In addition to selecting a contracting Physician Group, you must choose a Primary Care Physician at the contracting Physician Group. A Primary Care Physician provides and coordinates your medical care.

Specialists and Referral Care

Sometimes, you may need care that the Primary Care Physician cannot provide. At such times, you will be referred to a Specialist or other health care provider for that care.

THE CONTINUED PARTICIPATION OF ANY ONE PHYSICIAN, HOSPITAL OR OTHER PROVIDER CANNOT BE GUARANTEED.

THE FACT THAT A PHYSICIAN OR OTHER PROVIDER MAY PERFORM, PRESCRIBE, ORDER, RECOMMEND OR APPROVE A SERVICE, SUPPLY OR HOSPITALIZATION DOES NOT, IN ITSELF, MAKE IT MEDICALLY NECESSARY OR MAKE IT A COVERED SERVICE.

Standing Referral to Specialty Care

A standing referral is a referral to a participating Specialist for more than one visit without your Primary Care Physician having to provide a specific referral for each visit. You may receive a standing referral to a Specialist if your continuing care and recommended treatment plan is determined necessary by your Primary Care Physician, in consultation with the Specialist, Health Net's Medical Director and you. The treatment plan may limit the number of visits to the Specialist, the period of time that the visits are authorized or require that the Specialist provide your Primary Care Physician with regular reports on the health care provided. Extended access to a participating Specialist is available to Members who have a life threatening, degenerative or disabling condition (for example, Members with HIV/AIDS). To request a standing referral ask your Primary Care Physician or Specialist.

Changing Contracting Physician Groups

You may transfer to another contracting Physician Group, but only according to the conditions explained in the "Transferring to Another Contracting Physician Group" portion of "Eligibility, Enrollment and Termination," Section 400.

Your Financial Responsibility

Your Physician Group will authorize and coordinate all your care, providing you with medical services or supplies. You are financially responsible only for any required Copayment described in "Schedule of Benefits and Copayments," Section 200.

However, you are completely financially responsible for medical care that the contracting Physician Group does not provide or authorize except for Medically Necessary care provided in a legitimate emergency. You are also financially responsible for care that this Plan does not cover.

Questions

Call the Member Services Department with questions about this Plan at the number shown on your Health Net ID Card.

Emergency and Urgently Needed Care

WHAT TO DO WHEN YOU NEED MEDICAL CARE IMMEDIATELY

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

If your situation is not so severe: Call your Primary Care Physician or Physician Group or, if you cannot call them or you need medical care right away, go to the nearest medical center or Hospital.

If you are unsure of whether an emergency medical condition exists, you may call your Physician Group or Primary Care Physician for assistance.

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

Except in an emergency or other urgent medical circumstances, the covered services of this Plan must be performed by your Physician Group or authorized by them to be performed by others. You may use other providers outside your Physician Group only when you are referred to them by your Physician Group.

Urgently Needed Care within a 30-mile radius of your Physician Group and all Non-Emergency Care must be performed by your Physician Group or authorized by them in order to be covered. These services, if performed by others outside your Physician Group, will not be covered unless they are authorized by your Physician Group.

Urgently Needed Care outside a 30-mile radius of your Physician Group and all Emergency Care (including care outside of California) may be performed by your Physician Group or another provider when your circumstances require it. Services by other providers will be covered if the facts demonstrate that you required Emergency or Urgently Needed Care. Authorization is not mandatory to secure coverage. See "Definitions Related to Emergency and Urgently Needed Care" section below for the definition of Urgently Needed Care.

It is critical that you contact your Physician Group as soon as you can after receiving emergency services from others outside your Physician Group. Your Physician Group will evaluate your circumstances and make all necessary arrangements to assume responsibility for your continuing care. They will also advise you about how to obtain reimbursement for charges you may have paid.

Always present your Health Net ID Card to the health care provider regardless of where you are. It will help them understand the type of coverage you have and they may be able to assist you in contacting your Physician Group.

After your medical problem (including Severe Mental Illness and Serious Emotional Disturbances of a Child) no longer requires Urgently Needed Care or ceases to be an emergency and your condition is stable, any additional care you receive is considered Follow-Up Care.

Follow-Up Care services must be performed or authorized by your Physician Group (medical) or the Behavioral Health Administrator (Mental Disorders and Substance Abuse) or it will not be covered.

Definitions Related To Emergency And Urgently Needed Care

The following terms are located in "Definitions," Section 900, but they are being repeated here for your convenience.

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

His or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger);

His or her bodily functions, organs or parts would become seriously damaged; or

His or her bodily organs or parts would seriously malfunction.

Emergency Care includes paramedic, ambulance, and ambulance transport services provided through the 911 emergency response system.

Emergency Care also includes treatment of severe Pain or active labor. Active labor means labor at the time that either of the following would occur:

- There is inadequate time to effect safe transfer to another Hospital prior to delivery; or
- A transfer poses a threat to the health and safety of the Member or unborn child.

Emergency Care will also include additional screening, examination and evaluation by a Physician (or other health care provider acting within the scope of his or her license) to determine if a psychiatric emergency medical condition exists and the care and treatment necessary to relieve or eliminate such condition, within the capability of the facility.

Health Net will make any final decisions about Emergency Care. See "Independent Medical Review of Grievances Involving a Disputed Health Care Service" under "General Provisions" for the procedure to request Independent Medical Review of a Plan denial of coverage for Emergency Care.

Urgently Needed Care is any otherwise covered medical service that a reasonable person with an average knowledge of health and medicine would seek for treatment of an injury, unexpected illness or complication of an existing condition, including pregnancy to prevent the serious deterioration of his or her health, but which does not qualify as Emergency Care, as defined in this section. This may include services for which a person should reasonably have known an emergency did not exist.

SCHEDULE OF BENEFITS AND COPAYMENTS

Health Net's Medicare Coordination of Benefits (COB) plan is offered to Medicare eligible retirees. To be eligible, retirees must reside within the Health Net HMO service area (see Section 400, Eligibility, Enrollment and Termination). The Medicare COB plan works just like a traditional HMO plan, but coordinates the cost of care with Medicare as the primary payor. On the Medicare COB plan, you do not assign your Medicare Part A & B to Health Net, preserving the portability of your basic Medicare benefits. With the exception of emergency care, Medicare deductibles and coinsurance are not covered by Health Net when utilizing out-of-network services, or services not coordinated through your Primary Care Physician."

The following schedule shows the Copayments that you must pay for this Plan's covered services and supplies.

Percentages shown below are based on amounts agreed to in advance by Health Net and the Member's Physician Group or other health care provider.

You must pay the stated Copayments when you receive the services.

There is a limit to the amount of Copayments you must pay in a Calendar Year. Refer to "Out-of-Pocket Maximum,"Section 300, for more information.

Emergency or Urgently Needed Care in an Emergency Room or Urgent Care Center

	Copayment
Use of emergency room (facility and professional services)	$50
Use of urgent care center (facility and professional services)	$50

Copayment Exceptions

- If you are admitted to a Hospital as an inpatient directly from the emergency room or urgent care center, the emergency room or urgent care center Copayment will not apply.
- If you receive care from an urgent care center owned and operated by your Physician Group, the urgent care Copayment will not apply. (But a visit to one of its facilities will be considered an office visit, and any Copayment required for office visits will apply.)

Office Visits

	Copayment
(See "Non-Severe Mental Disorders and Substance Abuse Benefits" in this section for the applicable Copayments.)	
Visit to Physician, Physician Assistant or Nurse Practitioner at a contracting Physician Group	$15
Visit to Physician, Physician Assistant or Nurse Practitioner at a contracting Physician Group for treatment of Severe Mental Illness or Serious Emotional Disturbances of a Child (who is eligible under this Medicare COB plan)	$15
Specialist consultation	$15
Physician visit to Member's home (at the discretion of the Physician in accordance with the rules and criteria established by Health Net)	$15

Periodic health evaluation, including well-baby care (for a child who is eligible under this Medicare COB plan)	$0
Annual routine physical examination	$0
Vision or hearing examination	$15

Note

Self-referrals are allowed for Obstetrician and Gynecological services. (Refer to "Obstetrician and Gynecologist (OB/GYN) Self-Referral" portion of "Covered Services and Supplies," Section 500.)

Hospital Visits by Physician

	Copayment
Physician visit to Hospital or Skilled Nursing Facility	$0

Allergy, Immunizations and Injections

	Copayment
Allergy testing	$15
Allergy injection services	$15
Allergy serum	$0
Immunizations for occupational purposes or foreign travel	20%
Other immunizations	$0
Office based injectable medications (per dose)	$15
All other injections	$0

Rehabilitation Therapy

	Copayment
Physical therapy	$15
Occupational therapy	$15
Speech therapy	$15
Pulmonary rehabilitation therapy	$15
Cardiac rehabilitation therapy	$15

Note

These services will be covered when Medically Necessary.

Coverage for physical, occupational and speech rehabilitation therapy services is subject to certain limitations as described under the heading "Rehabilitation Therapy" of "Exclusions and Limitations," Section 600.

Care for Conditions of Pregnancy

	Copayment
Prenatal or postnatal office visit	$0
Newborn care office visit (birth through 30 days)	$0
Physician visit to the mother or newborn at a Hospital	$0
Normal delivery, including cesarean section	$0
Complications of pregnancy, including Medically Necessary abortions	$0
Elective abortion in Contracting Physician Group's office	$15

Elective abortions in Hospital $0
Genetic testing of fetus $0
Circumcision of newborn (birth through 30 days) $0

Note

The above Copayments apply to professional services only. Services that are rendered in a Hospital are also subject to the Hospital services Copayment. Look under "Inpatient Hospital Services" and "Outpatient Hospital Services" headings to determine any additional Copayments that may apply.

Family Planning

	Copayment
Sterilization of females in Contracting Physician Group's office	$15
Sterilization of females in Hospital	$0
Sterilization of males in Contracting Physician Group's office	$15
Sterilization of males in Hospital	$0
Contraceptive devices	Not covered
Injectable contraceptives (including but not limited to Depo Provera)	$0
Removal of implantable contraceptive devices (including but not limited to Norplant)	
Medically necessary removal	$60
Voluntary removal (requested by Member)	$60

Note

The above Copayments apply to professional services only. Services that are rendered in a Hospital are also subject to the Hospital services Copayment. Look under "Inpatient Hospital Services" and "Outpatient Hospital Services" headings to determine any additional Copayments that may apply.

Other Professional Services

	Copayment
Surgery in Hospital	$0
Assistance at surgery	$0
Transgender surgery	$0
Administration of anesthetics	$0
Chemotherapy	$0
Laboratory and diagnostic imaging (including x-ray) services	$0
Medical social services	$0
Patient education	$0
Nuclear medicine (use of radioactive materials)	$0
Renal dialysis	$0
Organ, tissue, or bone marrow transplants	$0
Podiatry services (determined Medically Necessary by the contracting Physician Group)	$15

Note

Surgery includes surgical reconstruction of a breast incident to a mastectomy, including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema.

Transgender surgery requires prior authorization from Health Net. Transgender surgery and services related to the surgery, that are authorized by Health Net are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member. Reasonable travel, lodging and meal costs, as determined by Health Net, for a Member to undergo an authorized transgender surgery are included within the lifetime benefit maximum.

Routine podiatry services (cutting/removal of corns or calluses, trimming of nails, preventive maintenance care) are limited to 1 visit each calendar month. Medically necessary podiatry services covered by Medicare are covered with no limit.

Medical Supplies

	Copayment
Durable Medical Equipment, nebulizers (including face masks and tubing)	$0
Orthotics (such as bracing, supports and casts)	$0
Diabetic supplies	$0
Diabetic footwear	$0
Corrective footwear (for the treatment of conditions not related to diabetes)*	$0
Prostheses (internal or external)	$0
Blood or blood products	$0
Hearing aids (2 standard Hearing Aids every 36 months)	$0

Notes

Diabetic equipment and orthotics which are covered under the medical benefit include blood glucose monitors, insulin pumps and corrective footwear. Please see "Diabetic Equipment" in "Covered Services and Supplies," Section 500.

A standard Hearing Aid is one that restores adequate hearing to the Member and is determined to be Medically Necessary and authorized by the Members Physician Group.

*Corrective footwear for the management and treatment of diabetes are covered under the "Diabetic Equipment" benefit as Medically Necessary.

Home Health Care Services

	Copayment
Home health visits	$0
Home IV therapy	$0

Hospice Services

	Copayment
Hospice care (when you enroll in a Medicare-certified Hospice, your hospice services are paid by Medicare).	$0

Ambulance Services

	Copayment
Ground ambulance	$0
Air ambulance	$0

Inpatient Hospital Services

Copayment

(See "Non-Severe Mental Disorders and Substance Abuse Benefits" in this section for the applicable Copayments.)

Room and board in a semi-private room or special care unit including ancillary (additional) services $250

Room and board in a semi-private room or special care unit including ancillary (additional) services for treatment of Severe Mental Illness or Serious Emotional Disturbances of a Child (who is eligible under this Medicare COB plan) $250

Note

Hospital Copayments are required for the first three admissions in each calendar year. Once the requirement is met, no copayment is required for further admissions in the same calendar year.

Inpatient Hospital Services for transgender surgery and services related to the surgery require prior authorization by Health Net and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member.

Outpatient Hospital Services

Copayment

Outpatient facility services (other than surgery) $0

Outpatient surgery (Hospital or Outpatient Surgical Center charges only) $0

Note

Other professional services performed in the outpatient department of a Hospital, such as a visit to a Physician (office visit), laboratory and x-ray services, physical therapy, etc., are subject to the same Copayment which is required when these services are performed at your Physician's office.

Look under the headings for the various services such as office visits, neuromuscular rehabilitation and other professional services to determine any additional Copayments that may apply.

Diagnostic endoscopic procedures, such as diagnostic colonoscopy, performed in an outpatient facility require the Copayment applicable for outpatient facility services. If, during the course of a diagnostic endoscopic procedure performed in a Hospital or Outpatient Surgical Center, a therapeutic (surgical) procedure is performed, then the Copayment applicable for outpatient surgery will be required instead of the Copayment for outpatient facility services.

Use of a Hospital emergency room appears in the first item at the beginning of this section.

Outpatient Hospital Services for transgender surgery and services related to the surgery require Prior Authorization by Health Net and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member.

Skilled Nursing Facility Services

Copayment

Room and board in a semi-private room with ancillary (additional) services $0

Limitation

Skilled Nursing Facility services are covered for up to a maximum of 100 days a Calendar Year for each Member.

Chiropractic Services and Supplies

Office Visits	***Copayment***
New patient examination	$15
Each subsequent visit	$15
Re-examination visit	$15
Second opinion	$15

Note

If the re-examination occurs during a subsequent visit, only one Copayment will be required.

Limitations

Up to 20 office visits to a Contracted Chiropractor during a Calendar Year are covered.

Diagnostic Services	***Copayment***
X-rays	$0
Laboratory test	$0

Chiropractic Appliances	***Copayment***
For each appliance	$0

Limitation

Up to a maximum of $50 is covered for each Member during a Calendar Year for covered Chiropractic Appliances.

Eyewear Schedule

	Eyewear Allowance
Frames (one pair of Frames during a 24-month period)	Health Net Vision pays the first $100 then the Member pays 80% of the remaining balance, if applicable.

Standard Plastic Eyeglass Lenses (one pair every 24 months*):

Single vision	Health Net Vision pays in full
Bifocal	Health Net Vision pays in full
Trifocal	Health Net Vision pays in full
Lenticular or aphakic monofocal	Member receives a 20% discount.
Lenticular or aphakic multifocal	Member receives a 20% discount.

Eyeglass Lens Options (for one pair every 24 months*):

Tint Pink or Rose #1 or #2 (only)	Health Net Vision pays in full

Contact Lenses (in lieu of Eyeglass Lenses; includes fit, follow-up and materials):

Conventional/Cosmetic Contact Lenses (one pair every 24 months*)	Health Net Vision pays the first $100, then the Member pays 85% of the remaining balance, if applicable.
Disposable/Cosmetic Contact Lenses (If disposable Contact Lenses are used, you need to purchase enough pairs of disposable contact Lenses to reach the allowable amount shown in "Eyewear Schedule" at one visit. If you do not use the full $100 allowed amount during the initial purchase, the remaining balance will not carry over)	Health Net Vision pays the first $100, Member pays the remaining balance.
Medically Necessary Contact Lenses** (one pair every 24 months*)	
- Conventional or Disposable	Health Net Vision pays the first $250, Member pays the remaining balance.

* An additional pair of Eyeglass Lenses or Contact Lenses (whether cosmetic or Medically Necessary) may be covered at the applicable cost sharing amount (please refer to the Eyewear Schedule for cost sharing amounts), if, after 12 consecutive months from the date the Lenses are dispensed, one of the following occurs:

- There is a change in diopter of at least 0.50 in one eye, or if the change occurs in both eyes, the total for both is 0.50.
- There is a shift in axis of astigmatism of greater than 15 degrees.
- There is a change in vertical prism greater than 1 prism diopter.
- The Physician or Optometrist prescribes either a change in Lens type, or a change from Eyeglasses to Contact Lenses or from Contact Lenses to Eyeglasses.

** Contact Lenses are defined as Medically Necessary if the individual is diagnosed with one of the following conditions:

- Keratoconus where the patient is not correctable to 20/30 in either or both eyes using standard spectacle Lenses.
- High Ametropia exceeding -12 D or +9 D in spherical equivalent.
- Anisometropia of 3 D or more.
- Patients whose vision can be corrected two (2) lines of improvement on the visual acuity chart when compared to best corrected standard spectacle Lenses.

If the Member is diagnosed with a medically necessary condition, the Health Net Vision provider will submit a request for pre-authorization to EyeMed. The EyeMed Medical Director reviews all requests for Medically Necessary Contact Lenses. If approved, the individual will be covered for Medically Necessary Contact Lenses up to the amounts shown under Eyewear Allowance.

Non-Severe Mental Disorders and Substance Abuse Benefits

	Copayment
Professional Services	
Office visit for Non-Severe Mental Disorders (unlimited visits each Calendar Year)	$15
Office visit for Substance Abuse (unlimited visits each Calendar Year)	$15
Outpatient group therapy sessions for Non-Severe Mental Disorders	$7.50
Outpatient group therapy sessions for Substance Abuse	$7.50
Physician inpatient visit	$0

Note

Each group therapy session counts as one half of a private office visit for each Member participating in the session. In addition, each group therapy session requires only one half of a private office visit Copayment.

Facility Services

	Copayment
Inpatient Hospital Services for Non-Severe Mental Disorders (unlimited days each Calendar Year)	$250
Residential Substance Abuse program (unlimited days each Calendar Year)	$250
Detoxification (unlimited days each Calendar Year)	$250
Outpatient Hospital Services for Non-Severe Mental Disorders	$15
Outpatient Hospital Services for Non-Severe Mental Disorders Group Therapy	$7.50
Outpatient Hospital Services for Substance Abuse	$15
Outpatient Hospital Services for Substance Abuse Group Therapy	$7.50

Exceptions

If two or more Members in the same family attend the same outpatient treatment session, only one Copayment will be applied.

The Mental Disorder Copayments and day or visit limits will not apply for Severe Mental Illness or Serious Emotional Disturbances of a Child. Services for these mental conditions, as defined in "Definitions," Section 900, require whatever Copayment would be required if the services were provided for a medical condition. Look under the headings for the various services such as office visits, outpatient services and inpatient Hospital services to determine the applicable Copayment. All other Mental Disorders will be subject to the Copayments and limits shown above.

Note

The above Copayment is applicable for each admission. Hospital Copayments are required for the first three admissions in each calendar year. Once the requirement is met, no copayment is required for further admissions in the same calendar year.

Prescription Drugs

Prescription Drugs are covered as described in the Medicare Prescription Drug Plan Evidence of Coverage immediately following this Medicare Coordination of Benefit HMO Evidence of Coverage.

OUT-OF-POCKET MAXIMUM

The Out-of-Pocket Maximum (OOPM) amounts below are the maximum amounts you must pay for covered services during a particular Calendar Year, except as described in "Exceptions to OOPM" below.

Once the total amount of all Copayments you pay for covered services under this Evidence of Coverage in any one Calendar Year equals "Out-of-Pocket Maximum" amount, no payment for covered services and benefits may be imposed on any Member, except as described in "Exceptions to OOPM" below.

The OOPM amounts for this Plan are:

One Member..... $1000

Two Members..... $2000

Family (three or more Members)..... $3000

Exceptions to OOPM

Your payments for services or supplies that this Plan does not cover will not be applied to the OOPM amount.

The following Copayments or expenses paid by you for covered services or supplies under this Plan will not be applied to the OOPM amount:

Copayments for self-injectable drugs, which are covered under the medical benefit, will also be applied to the OOPM amount.

You are required to continue to pay these Copayments listed by the bullets above after the OOPM has been reached.

How the OOPM Works

Keep a record of your payment for covered medical services and supplies. When the total in a Calendar Year reaches the OOPM amount shown above, contact the Member Services Department at the telephone number shown on your Health Net ID Card for instructions.

- If an individual Member pays amounts for covered services in a Calendar Year that equal the OOPM amount shown above for an individual Member, no further payment is required for that Member for the remainder of the Calendar Year.
- Once an individual Member in a Family satisfies the individual OOPM, the remaining enrolled Family Members must continue to pay the Copayments until either (a) the aggregate of such Copayments paid by the Family reaches the Family OOPM or (b) each enrolled Family Member individually satisfies the individual OOPM.
- If amounts for covered services paid for all enrolled Members equal the OOPM amount shown for a family, no further payment is required from any enrolled Member of that family for the remainder of the Calendar Year for those services.

- Only amounts that are applied to the individual Member's OOPM amount may be applied to the family's OOPM amount. Any amount you pay for covered services for yourself that would otherwise apply to your individual OOPM but exceeds the above stated OOPM amount for one Member will be refunded to you by Health Net, and will not apply toward your family's OOPM. Individual Members cannot contribute more than their individual OOPM amount to the Family OOPM.

You must notify Health Net when the OOPM amount has been reached. Please keep a copy of all receipts and canceled checks for payments for Covered Services as proof of Copayments made.

ELIGIBILITY, ENROLLMENT AND TERMINATION

Who Is Eligible for Coverage

The covered services and supplies of this Plan are available to the following people as long as they live in the continental United States, either work or live in the Health Net Service Area, and meet any additional eligibility requirements of the Group and this Evidence of Coverage:

The University of California establishes its own medical plan criteria for employees and retirees based on the University of California Group Insurance Regulations ("Regulation") and any corresponding Administrative Supplements. Portions of those regulations are summarized below.

Subscriber

Employee
You are eligible if you are appointed to work at least 50% time for twelve months or more or are appointed at 100% time for three months or more or have accumulated 1,000* hours while on pay status in a twelve-month period. To remain eligible, you must maintain an average regular paid time** of at least 17.5 hours per week and continue in an eligible appointment. If your appointment is at least 50% time, your appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

* Lecturers - see your benefits office for eligibility.

** Average Regular Paid Time - For any month, the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked in the preceding twelve (12) month period. Average regular paid time does not include full or partial months of zero paid hours when an employee works less than 43.75% of the regular paid hours available in the month due to furlough, leave without pay or initial employment.

Retiree
A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan.

You may continue University medical plan coverage as a Retiree when you start collecting retirement or disability benefits from a University-sponsored defined benefit plan. You must also meet the following requirements:

(a) you meet the University's service credit requirements for Retiree medical eligibility;

(b) the Effective Date of your Retiree status is within 120 calendar days of the date employment ends (or the date of the Employee/Retiree's death for a Survivor); and

(c) you elect to continue medical coverage at the time of retirement.

Survivor
A deceased Employee's or Retiree's Family Member receiving monthly benefits from a University-sponsored defined benefit plan—may be eligible to continue coverage as set forth in the University's Group Insurance Regulations. For more information, see the UC Group Insurance Eligibility Fact Sheet for Retirees and Eligible Family Members.

If you are eligible for Medicare, you must follow UC's Medicare Rules. See "Effect of Medicare on Retiree Enrollment" below.

Eligible Dependents (Family Members)

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the eligibility requirements outlined below. The University and/or the Plan reserves the right to periodically request documentation to verify eligibility of Family Members including any who are required to be your tax dependent(s). Documentation could include a marriage certificate, birth certificate(s), adoption records, Federal Income Tax Return, or other official documentation.

Spouse
Your legal spouse

Child
All eligible children must be under the limiting age (18 for legal wards, 23 for all others), unmarried, and may not be emancipated minors. The following categories are eligible:

(a) your natural or legally adopted children;

(b) your stepchildren (natural or legally adopted children of your spouse) if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;

(c) grandchildren of you or your spouse if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;

(d) children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental disability may continue to be covered past age 23 provided:

- the incapacity began before age 23, the child was enrolled in a group medical plan before age 23 and coverage is continuous;
- the child is claimed as your dependent for income tax purposes or is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment which may offset the Social Security or Supplemental Security Income; and
- the child lives with you if he or she is not your or your spouse's natural or adopted child.

Application must be made to the Plan at least 31 days before the child's 23rd birthday and is subject to approval by the Plan. The Plan may periodically request proof of continued disability. Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If you are a newly hired Employee with an incapacitated child, you may also apply for coverage for that child. The child must have had continuous group medical coverage since age 23, and you must apply for University coverage during your Period of Initial Eligibility.

Other Eligible Dependents (Family Members)
You may enroll a same-sex Domestic Partner (and the same-sex Domestic Partner's children/grandchildren/stepchildren) as set forth in the University of California Group Insurance Regulations.

The University recognizes an opposite-sex Domestic Partner as a family Member that is eligible for coverage in UC-sponsored benefits if the employee/retiree or Domestic Partner is age 62 or older and eligible to receive Social Security benefits and both the employee/retiree and Domestic Partner are at least 18 years of age.

An adult dependent relative is no longer eligible for coverage. Only an adult dependent relative who was enrolled as an eligible dependent as of December 31, 2003 may continue coverage in UC-sponsored plans.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, a Retiree, a Survivor or a Family Member, but not under any combination of these. If an Employee and the Employee's spouse or Domestic Partner are both eligible Subscribers, only one should enroll; however, each may enroll separately or one may cover the other as a Family Member. Eligible children may be enrolled under either parent's or eligible domestic partner's coverage but not under both. Additionally, a child who is also eligible as an Employee may not have dual coverage through two University-sponsored medical plans.

More Information

For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's Customer Service Center. You may also access eligibility fact sheets on the web site: http://atyourservice.ucop.edu.

How to Enroll for Coverage

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. If you are a Retiree, contact the University's Customer Service Center. Enrollment transactions may be completed by paper form or electronically, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office or by the University's Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by midnight of the last day of the enrollment period.

A Period of Initial Eligibility (PIE)
A PIE ends 31 days after it begins.

Employee
If you are an Employee, you may enroll yourself and any eligible Family Members during your PIE. Your PIE starts the day you become an eligible Employee, and ends 31 days later.

Newly Acquired Dependents
You may enroll any newly eligible Family Member during his or her PIE. The Family Member's PIE starts the day your Family Member becomes eligible, as described below. During this PIE you may also enroll yourself and/or any other eligible Family Member if not enrolled during your own or their own PIE. You must enroll yourself in order to enroll any eligible Family Member. Family Members are only eligible for the same plan you are enrolled in.

Spouse: On the date of Marriage.

Natural Child: For a natural child, on the child's date of birth.

Newborn Child: A child newly born to the Subscriber or his or her spouse is automatically covered from the moment of birth through the 31st day of life. In order for coverage to continue beyond the 30th day of life, the Subscriber must enroll the newborn child through the employer within the Period of Initial Eligibility. The newborn's Period of Initial Eligibility begins on the date of birth and ends on the last working day within the 31 day period following that date.

If the mother is the Subscriber's spouse and an enrolled Member, the child will be assigned to the mother's Physician Group and may not transfer to another Physician Group until the first day of the calendar month following the birth. If the mother is not enrolled, the child will be automatically assigned to the Subscriber's Physician Group. If you want to choose another Physician Group for that child, the transfer will take effect only as stated in the "Transferring to Another Contracting Physician Group" portion of this section.

Adopted Child: For an Adopted Child, the earlier of:

(i) the date you or your Spouse has the legal right to control the child's health care; or
(ii) the date the child is placed in your physical custody. If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.
(iii) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you decline enrollment for yourself or your eligible Family Members because of other group medical plan coverage and you lose that coverage involuntarily (or if the employer stops contributing toward the other coverage for you or your Family Members), you may be able to enroll yourself and those eligible Family Members during a PIE that starts on the day the other coverage is no longer in effect.

If you are in an HMO, POS or EPO Plan and you move or are transferred out of that Plan's service area, or will be away from the Plan's service area for more than two months, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan. Your PIE starts with the Effective Date of the move or the date you leave the Plan's service area.

Enrollment At Other Times For Employees And Retirees

You and your eligible Family Members may also enroll during a group Open Enrollment Period established by the University.

If you are an Employee and opt out of medical coverage or fail to enroll yourself during a PIE or Open Enrollment Period, you may enroll yourself at any other time upon completion of a 90 consecutive calendar day waiting period.

If you are an Employee or Retiree and fail to enroll Your eligible Family Members during a PIE or Open Enrollment Period, you may enroll your eligible Family Members at any other time upon completion of a 90 consecutive calendar day waiting period.

The 90-day waiting period starts on the date the enrollment form is received by the local Accounting or Benefits office and ends 90 consecutive calendar days later.

If you have one or more children enrolled in the Plan, you may add a newly eligible Child at any time. See "Effective Date".

If you are an Employee or a Retiree and there is a lifetime maximum for all benefits under this Plan, and you or a Family Member reaches that maximum, you and your eligible Family Members may be eligible to enroll in another UC-sponsored medical plan. Contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

If you are a Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan (or its Medicare version) you were enrolled in immediately before retiring as long as your Family Members are eligible for coverage. You must elect to continue enrollment for yourself and enrolled Family Members before the Effective Date of retirement (or the date disability or survivor benefits begin).

If you are a Survivor, you may not enroll your legal spouse or Domestic Partner.

Effective Date

The following effective dates for coverage apply provided the appropriate enrollment transaction (paper form or electronic) has been completed within the applicable enrollment period.

If you enroll during a PIE, coverage for you and your Family Members is effective the date the PIE starts.

If you are a Retiree continuing enrollment in conjunction with retirement, coverage for you and your Family Members is effective on the first of the month following the first full calendar month of retirement income.

The Effective Date of coverage for enrollment during an Open Enrollment Period is the date announced by the University.

For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment transaction is completed.

An Employee or Retiree who is already enrolled in adult-plus-child(ren) or family coverage may add additional children, if eligible, at any time after their PIE. Retroactive coverage is limited to the later of:

(a) the date the Child becomes eligible, or

(b) a maximum of 60 days prior to the date your Child’s enrollment transaction is completed.

Change in Coverage

In order to change from single to adult-plus-child(ren) coverage, or two adult coverage, or family coverage, or to add another Child to existing family coverage, you should contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Effect of Medicare on Retiree Enrollment

If you are a Retiree and you and/or an enrolled Family Member is or becomes eligible for premium-free Medicare Part A (Hospital Insurance) as primary coverage, then the individual who is eligible for Part A, must also enroll in and remain in Medicare Part B (Medical Insurance). Once Medicare coverage is established, coverage in both Part A and Part B must be continuous to maintain eligibility in this plan. This rule includes anyone who is entitled to Medicare benefits through their own or their spouse's employment. Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this Plan.

Retirees or their eligible Family Member(s) who become eligible for premium-free Medicare Part A, on or after January 1, 2004, and do not enroll in Part B, will permanently lose their UC-sponsored medical coverage.

In order to cover increased costs, the University will assess a monthly offset fee on Retirees and their Family Members who were eligible for premium-free Medicare Part A prior to January 1, 2004, but declined to enroll in Part B of Medicare. The offset fee may increase annually, but will stop when the Retiree or Family Member becomes covered under Part B.

Retirees or Family Members who are not eligible for premium-free Part A will not be required to enroll in Part B, therefore, they will not be assessed an offset fee, nor will they lose their UC-sponsored medical coverage. Documentation attesting to their ineligibility for Medicare Part A will be required. (Retirees/Family Members who are not entitled to Social Security and premium-free Medicare Part A will not be required to enroll in Part B.)

An exception to the above rules applies to certain Retirees or Family Members who will be eligible for the non-Medicare premium applicable to this Plan and will also be eligible for the benefits of this Plan without regard to Medicare if they are in one of the following groups:

(a) Individuals who were eligible for premium-free Part A, but not enrolled in Medicare Part B prior to July 1, 1991.

(b) Individuals who are not eligible for premium-free Part A.

You should contact Social Security three months before your or your Family Member's 65th birthday to inquire about your eligibility and how you enroll in the Hospital (Part A) and Medical (Part B) portions of Medicare. If you qualify for disability income benefits from Social Security, contact a Social Security office for information about when you will be eligible for Medicare enrollment.

Upon Medicare eligibility, you or your Family Member must complete a University of California Medicare Declaration form, as well as submit a copy of your Medicare card. This notifies the University that you are covered by Part A and Part B of Medicare. The University's Medicare Declaration form is available through the University's Customer Service Center, or from the website: http://atyourservice.ucop.edu. Completed forms should be returned to University of California, Human Resources and Benefits, Health & Welfare Administration-Retiree Insurance Program, Post Office Box 24570, Oakland, CA 94623-9911.

Any individual enrolled in a University-sponsored Medicare Advantage Managed Care Contract must assign his/her Medicare benefit to that plan or lose UC-sponsored medical coverage. Anyone enrolled in a non-University Medicare Advantage Managed Care contract or enrolled in a non-University Medicare Part D Prescription Drug Plan will be deenrolled from this health Plan.

Medicare Secondary Payer Law (MSP)

The Medicare Secondary Payer (MSP) Law affects the order in which claims are paid by Medicare and an employer group health plan. UC Retirees re-hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to MSP. For Employees or their spouses who are age 65 or older and eligible for a group health plan due to employment, the law requires that Medicare becomes the secondary payer and the employer plan becomes the primary payer for your health coverage. You should carefully consider the impact on your health benefits and premiums should you decide to return to work after you retire.

Medicare Private Contracting Provision and Providers Who do Not Accept Medicare

Federal Legislation allows Physicians or practitioners to opt out of Medicare. If you wish to continue to obtain services (that would otherwise be covered by Medicare) from these Physicians or practitioners you will need to enter into written "private contracts" with these Physicians or practitioners. These private agreements will require you to be responsible for all payments to such medical providers. Since services provided under such "private contracts" are not covered by Medicare or this Plan, the Medicare limiting charge will not apply.

Some Physicians or practitioners have never participated in Medicare. Their services (that would be covered by Medicare if they participated) will not be covered by Medicare or this Plan, and the Medicare limiting charge will not apply.

If you are classified as a Retiree by the University (or otherwise have Medicare as a primary coverage), are enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement as described above with one or more Physicians or practitioners, or if you choose to obtain services from a provider who does not participate in Medicare, under the law you have in effect "opted out" of Medicare for the services provided by these Physicians or other practitioners. In either case, no benefits will be paid by this Plan for services rendered by these Physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered. Therefore, it is important that you confirm that your provider takes Medicare prior to obtaining services for which you wish the Plan to pay.

However, even if you do sign a private contract or obtain services from a provider who does not participate in Medicare, you may still see other providers who have not opted out of Medicare and receive the benefits of this Plan for those services.

Special Reinstatement Rule For Reservists Returning From Active Duty

Reservists ordered to active duty on or after January 1, 2007 who were covered under this Plan at the time they were ordered to active duty and their eligible dependents will be reinstated without waiting periods or exclusion of coverage for pre-existing conditions. A reservist means a member of the U.S. Military Reserve or California National Guard called to active duty as a result of the Iraq conflict pursuant to Public Law 107-243 or the Afghanistan conflict pursuant to Presidential Order No. 13239. Please notify the Group when you return to employment if you want to reinstate your coverage under the Plan.

Special Reinstatement Rule Under USERRA

USERRA, a federal law, provides service members returning from a period of uniformed service who meet certain criteria with reemployment rights, including the right to reinstate their coverage without pre-existing exclusions or waiting periods, subject to certain restrictions. Please check with your Group to determine if you are eligible.

Transferring to Another Contracting Physician Group

As stated in the "Selecting a Contracting Physician Group" portion of "Introduction to Health Net," Section 100, each person must select a contracting Physician Group close enough to his or her residence or place of work to allow reasonable access to care. Please call the Member Services Department at the telephone number on your Health Net ID Card if you have questions involving reasonable access to care.

Any individual Member may change Physician Groups, that is, transfer from one to another:

- When the Group's Open Enrollment Period occurs;
- When the Member moves to a new address (notify Health Net within 30 days of the change);
- When the Member's employment work-site changes (notify Health Net within 30 days of the change);
- When determined necessary by Health Net; or
- When the Member exercises the once-a-month transfer option.

Exceptions
Health Net will not permit a once-a-month transfer at the Member's option, if the Member is confined to a Hospital. However, if you believe you should be allowed to transfer to another contracting Physician Group because of unusual or serious circumstances, and you would like Health Net to give special consideration to your needs, please contact the Member Services Department at the telephone number on your Health Net ID Card for prompt review of your request.

Effective Date of Transfer
If we receive your request for a transfer on or before the 15th day of the month, the transfer will occur on the first day of the following month. (Example: Request received March 12, transfer effective April 1.)

If we receive your request for a transfer on or after the 16th day of the month, the transfer will occur on the first day of the second following month. (Example: Request received March 17, transfer effective May 1.)

If your request for a transfer is not allowed because of a pregnancy, illness, injury, hospitalization, or surgery, and you still wish to transfer after the medical condition or treatment for it has ended, please call the Member Services Department to process the transfer request. The transfer in a case like this will take effect on the first day of the calendar month following:

- The date the pregnancy ends.
- The date the treatment for the condition causing the delay ends.

For a newly eligible child who has been automatically assigned to a Contracting Physician Group, the transfer will not take effect until the first day of the calendar month following the date the child first becomes eligible. (Automatic assignment takes place with newborn and adopted children, and is described in the "How to Enroll for Coverage" provision earlier in this section.)

Changes made during the Open Enrollment Period would be effective on the following January 1. However, any transfer which requires Health Net's approval of a health status questionnaire will not take effect until the first day of the calendar month following the date of such approval.

Effect of Medicare
If you are eligible for Medicare, you must enroll in Medicare according to UC's Medicare Rules. Employees should contact the local benefits office and Retirees should contact the University's Customer Service Center to transfer to the portion of your plan for Medicare enrollees.

Termination of Coverage

The termination of coverage provisions that are established by the University of California in accordance with its Regulations are described below. Additional Plan provisions apply and are described elsewhere in the document.

Deenrollment Due to Loss of Eligible Status
If you are an Employee and lose eligibility for any reason, your coverage and that of any enrolled Family Member will stop at the end of the last month in which premiums are taken from earnings based on an eligible appointment.

If you are a Retiree or Survivor and your annuity terminates, your coverage and that of any enrolled Family Member will stop at the end of the last month in which you are eligible for an annuity.

If your Family Member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Family Member is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. For information on deenrollment procedures, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Deenrollment Due to Fraud
Coverage for you or your Family Members may be terminated for fraud or deception in the use of the services of the Plan, or for knowingly permitting such fraud or deception by another. Such termination shall be effective upon the mailing of written notice to the Subscriber (and to the University if notice is given by the Plan). A Family Member who commits fraud or deception will be permanently deenrolled while you and any other Family Member will be deenrolled for 12 months. If you commit fraud or deception, you and any Family Members will be deenrolled for 12 months.

Leave of Absence, Layoff or Retirement
You need to contact your local Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, layoff or retirement.

Individual Members that Establish Residency Outside the Health Net Service Area
You will become ineligible if you establish your primary residency outside the Health Net Service Area and do not work inside that area.

However, a child subject to a Medical Child Support Order, according to state or federal law, who moves out of the Health Net 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 Care.

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 upon the date the notice of termination is mailed 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 upon 15 days prior written notice 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 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 Health Net conversion plan, 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. The termination is effective immediately on the date Health Net mails the notice of termination, unless Health Net has specified a later date in that notice.

Health Net will conduct a fair investigation of the facts before any termination transfer 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 Managed Health Care.

Optional Continuation of Coverage
If your coverage or that of a Family Member ends, you and/or your Family Member may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, and if that continued coverage ends, specified individuals may be eligible for further continuation under California law. The terms of these continuation provisions are contained in the University of California notice "Continuation of Group Insurance Coverage," available from the University "At Your Service" website (http://atyourservice.ucop.edu). The notice is also available from the person in your department who handles benefits and from the University's Customer Service Center. You may also direct questions about these provisions to your local Benefits Office or to the University's Customer Service Center if you are a Retiree.

Extension of Benefits

When Benefits May Be Extended
Benefits may be extended beyond the date coverage would ordinarily end if;

- You lose your Health Net coverage because the UC Standardized Contract is discontinued, and you are totally disabled at that time; or
- You lose your coverage for any reason other than discontinuance of the UC Standardized Contract and you are a registered bed patient in a Hospital or Skilled Nursing Facility when coverage ends, and the hospitalization was covered by this Plan.

When benefits are extended, you will not be required to pay subscription charges. However, the Copayments shown in "Schedule of Benefits and Copayments," Section 200, will continue to apply.

Benefits will only be extended for the condition you were hospitalized for or the condition that caused you to become totally disabled. Benefits will not be extended for other medical conditions.

Benefits will not be extended if coverage was terminated for cause as stated in "Termination for Cause" provision of "Eligibility, Enrollment and Termination," Section 400.

"Totally disabled" has a different meaning for different Family Members.

- For the Subscriber it means that because of an illness or injury, the Subscriber is unable to engage in employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience; furthermore, the Subscriber must not be employed for wage or profit.
- For a Family Member it means that because of an illness or injury, that person is prevented from performing substantially all regular and customary activities usual for a person of his or her age and family status.

How to Obtain an Extension
MEMBER IS CONFINED TO A HOSPITAL

If you are confined to a Hospital or Skilled Nursing Facility when your coverage ends, benefits will be extended to you automatically. You do not have to do anything to make it happen.

When you are discharged from a Hospital or Skilled Nursing Facility, no further extension is available, unless your coverage ended because the UC Standardized Contract ended.

If your coverage ended because the UC Standardized Contract between Health Net and the Group was terminated, and you are totally disabled and want to continue to have extended benefits, you must send a written request to Health Net within 90 days of the discharge date. The request must include your Physician Group’s written certification that you are totally disabled.

MEMBER IS NOT CONFINED TO A HOSPITAL

If a Member is totally disabled and not confined to a Hospital or Skilled Nursing Facility when the Agreement ends, send a written request to Health Net within 90 days of the date the Agreement terminates. The request must include written certification by the Member's Physician Group that the Member is totally disabled.

If benefits are extended because of total disability, provide Health Net with proof of total disability at least once every 90 days during the extension. The Member must ensure that Health Net receives this proof before the end of each 90-day period.

When the Extension Ends
The Extension of Benefits will end on the earliest of the following dates:

1. For extensions provided only because of Hospital confinement: If the Agreement between Health Net and the Group has not been terminated, then the Extension of Benefits will end on the earliest of the following dates:
   (a) On the date the Member is discharged from the Hospital or Skilled Nursing Facility, even if the total disability continues;
   (b) On the date the Member becomes covered by another private or group health insurance policy or plan; or
   (c) On the date that available benefits are exhausted.
2. For extensions provided because of total disability which may or may not involve hospitalization: If the Agreement between Health Net and the Group has been terminated, then the extension of benefits will end on the earliest of the following dates:
   (a) On the date the Member is no longer totally disabled;
   (b) On the date the Member becomes covered by a replacement health policy or plan obtained by the Group, and this coverage has no limitation for the disabling condition;
   (c) On the date that available benefits are exhausted; or

On the last day of the 12-month period following the date the extension began, unless the Member is confined in a Hospital or Skilled Nursing Facility on that date for the disabling condition.

Other Coverage Affects Extension of Benefits

Other Group Coverage

Extended benefits will end as stated in #1 and #2 in the section immediately above titled “When the Extension Ends.”

If other group coverage exists that does not cause the extension of benefits to end, such as coverage through a new job or coverage that existed before the loss of Health Net coverage, Health Net will obtain reimbursement from the other Plan through the Coordination of Benefits process.

Also, when another health maintenance organization provides that coverage, Health Net may arrange for that HMO to be responsible for continuing medical care.

- **COBRA CONTINUATION COVERAGE**
  If your Health Net coverage continues because you were eligible for and obtained federal COBRA continuation coverage, you have not yet lost your Health Net coverage. If you are still totally disabled when the COBRA continuation coverage ends, you may try to obtain an extension as described above in the section titled "How to Obtain an Extension."

- **CONVERSION COVERAGE**
  Conversion coverage affects extension of benefits when:

  1. You receive an extension of the benefits of this Plan and
  2. You have also elected conversion coverage and it is in force.

  Whichever coverage provides the higher benefits will be applied toward the disabling condition. Refer to the "Conversion Privilege" section immediately below.

Conversion Privilege

Who Is Eligible for Conversion Coverage
Except as specified below, if you lose coverage in this Plan, you have the right to purchase individual coverage through the Health Net conversion plan without being required to complete a health statement.

You must pay the cost of conversion coverage (called subscription charges). Please note, however, that the benefits, as well as the subscription charges, will not be the same as coverage through this Group Plan.

Who Is Not Eligible for Conversion Coverage
The following people are not eligible for conversion coverage:

1. Anyone who lives outside the continental United States and who does not either live or work inside the Health Net Service Area;
2. Anyone whose coverage was terminated for cause as stated in "Termination for Cause" portion of this section;
3. Anyone who is covered by another group or individual health plan; or
4. Anyone who was not covered by this Plan.

How to Apply for Conversion Coverage
Request an application from Health Net. You must complete the application form and send it to Health Net within 63 days of the last day of coverage.

Anyone eligible to enroll in the Health Net conversion plan who does not enroll when Group coverage ends will not be allowed to do so at a later date.

Conversion coverage must become effective immediately following the date Group coverage ends. There can be no lapse in coverage.

COVERED SERVICES AND SUPPLIES

You are entitled to receive Medically Necessary services and supplies described below when they are authorized according to procedures Health Net and the contracting Physician Group have established. The fact that a Physician or other provider may perform, prescribe, order, recommend or approve a service, supply or hospitalization does not, in itself, make it Medically Necessary or make it a covered service.

Any covered service or supply may require a Copayment or have a benefit maximum. Please refer to "Schedule of Benefits and Copayments," Section 200, for details.

Certain limitations may apply. Be sure you read the section entitled "Exclusions and Limitations," Section 600, before obtaining care.

Medical Services and Supplies

Office Visits
Office visits for services by a Physician are covered. Also covered are office visits for services by other health care professionals when you are referred by your Primary Care Physician.

Health Evaluations
For preventive health purposes, a periodic health evaluation and diagnostic preventive procedures are covered, based on recommendations published by the U.S. Preventive Services Task Force. In addition, a covered annual cervical cancer screening test includes a Pap test, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA.

Vision and Hearing Examinations
Eye and ear examinations to determine the need for correction of vision and hearing are covered.

Hearing Aids
Standard hearing devices inserted in or affixed to the outer ear to restore adequate hearing to the Member and are determined to be Medically Necessary are covered. This includes repair and maintenance (but not replacement batteries). Please refer to "Schedule of Benefits and Copayments," Section 200 for more information.

Obstetrician and Gynecologist (OB/GYN) Self-Referral
If you are a female Member you may obtain OB/GYN Physician services without first contacting your Primary Care Physician.

If you need OB/GYN preventive care, are pregnant or have a gynecology ailment, you may go directly to an OB/GYN Specialist or a Physician who provides such services in your Physician Group.

If such services are not available in your Physician Group, you may go to one of the contracting Physician Group’s referral Physicians who provides OB/GYN services. (Each contracting Physician Group can identify its referral Physicians.)

The OB/GYN Physician will consult with the Member’s Primary Care Physician regarding the Member’s condition, treatment and any need for Follow-Up Care.

Copayment requirements may differ depending on the service provided. Refer to "Schedule of Benefits and Copayments," Section 200.

Immunizations and Injections
Immunizations and injections, professional services to inject the medications, and the medications that are injected are covered as shown in "Schedule of Benefits and Copayments," Section 200. This includes allergy serum.

Member Physicians will provide immunizations that are recommended by guidelines published by the Advisory Committee on Immunization Practices (ACIP) of the U.S. Public Health Service or the American Academy of Pediatrics (AAP).

In addition, injectable medications (including Glucagon) approved by the FDA are covered for the Medically Necessary treatment of medical conditions when prescribed by the Member's Primary Care Physician and authorized by Health Net.

Self-injectable Drugs (other than insulin), needles and syringes used with these self-injectable drugs must be obtained through Health Net's contracted Specialty Pharmacy Vendor when Prior Authorization is obtained from Health Net. Upon approval, Health Net will arrange for the distribution of drugs, needles and syringes from the appropriate Specialty Pharmacy Vendor. The Specialty Pharmacy Vendor may contact you directly to coordinate the delivery of your medications.

The Specialty Pharmacy Vendor will charge you for the appropriate Copayment or Coinsurance shown in "Schedule of Benefits and Copayments," Section 200.

Surgical Services
Services by a surgeon, assistant surgeon, anesthetist or anesthesiologist are covered.

Laboratory and Diagnostic Imaging (including X-ray) Services
Laboratory and diagnostic imaging (including x-ray) services and materials are covered.

Home Visit
Visits by a Member Physician to a Member's home are covered at the Physician's discretion in accordance with the rules and criteria set by Health Net, and if the Physician concludes that the visit is medically and otherwise reasonably indicated.

Rehabilitation Therapy
Rehabilitation therapy services (physical, speech, and occupational therapy) are covered when Medically Necessary, except as stated in "Exclusions and Limitations," Section 600.

Cardiac Rehabilitation Therapy
Rehabilitation therapy services provided in connection with the treatment of heart disease is covered when Medically Necessary.

Pulmonary Rehabilitation Therapy
Rehabilitation therapy services provided in connection with the treatment of chronic respiratory impairment is covered when Medically Necessary.

Clinical Trials
Routine patient care costs for patients diagnosed with cancer who are accepted into phase I, II, III or IV clinical trials are covered when Medically Necessary, recommended by the Member's treating Physician and authorized by Health Net. The Physician must determine that participation has a meaningful potential to benefit the Member and the trial has therapeutic intent. Services rendered as part of a clinical trial may be provided by a non-Participating or Participating Provider subject to the reimbursement guidelines as specified in the law. Coverage for routine patient care shall be provided in a clinical trial that involves either a drug that is exempt from federal regulation in relation to a new drug application or is approved by one of the following:

- The National Institutes of Health;
- The FDA as an Investigational new drug application;
- The Department of Defense; or
- The Veterans' Administration.

The following definition applies to the terms mentioned in the above provision only.

"Routine patient care costs" are the costs associated with the standard provisions of Health Net, including drugs, items, devices and services that would normally be covered under this Evidence of Coverage, if they were not provided in connection with a clinical trials program.

Please refer to "All Services and Supplies" portion of "Exclusions and Limitations," Section 600, for more information.

Pregnancy
The coverage described below meets requirements for Hospital length of stay under the Newborns' and Mothers' Health Protection Act of 1996.

Hospital and professional services for conditions of pregnancy are covered, including prenatal and postnatal care, delivery and newborn care. In cases of identified high-risk pregnancy, prenatal diagnostic procedures and genetic testing of the fetus are also covered. Please refer to "Schedule of Benefits and Copayments," Section 200, for Copayment requirements.

When you give birth to a child in a Hospital, you are entitled to coverage of at least 48 hours of care following a vaginal delivery or at least 96 hours following a cesarean section delivery.

Your Physician will not be required to obtain authorization for a Hospital stay that is equal to or less than 48 hours following vaginal delivery or 96 hours following cesarean section. Longer stays in the Hospital will require authorization. Also the performance of cesarean sections must be authorized.

You may be discharged earlier only if you and your Physician agree to it.

If you are discharged earlier, your Physician may decide, at his or her discretion, that you should be seen at home or in the office, within 48 hours of the discharge, by a licensed health care provider whose scope of practice includes postpartum care and newborn care. Your Physician will not be required to obtain authorization for this visit.

Abortions
Abortions (surgical or drug) are covered by this Plan whether they are elective or Medically Necessary.

Copayment requirements may differ between the two. Refer to "Schedule of Benefits and Copayments," Section 200.

The contracting Physician Group and Health Net will determine whether an abortion is Medically Necessary or elective.

Family Planning
Counseling, planning and other services for problems of fertility are covered.

Included in these other services are:

- Fitting examination for a vaginal contraceptive device (diaphragm and cervical cap).
- Inserting an intrauterine device (IUD).

Please refer to "Schedule of Benefits and Copayments," Section 200, under the heading "Family Planning" for information regarding contraceptives covered under the medical benefit.

Medical Social Services
Hospital discharge planning and social service counseling are covered. In some instances, a medical social service worker may refer you to other providers for additional services. These services are covered only when authorized by your Physician Group and not otherwise excluded under this Plan.

Patient Education
Patient education programs on how to prevent illness or injury and how to maintain good health, including diabetes management programs and asthma management programs are covered. Your Physician Group will coordinate access to these services.

Home Health Care Services
The services of a Home Health Care Agency in the Member's home are covered when provided by a registered nurse or licensed vocational nurse and /or licensed physical, occupational, speech therapist or respiratory therapist. These services are in the form of visits that may include, but are not limited to, skilled nursing services, medical social services, rehabilitation therapy (including physical, speech and occupational), pulmonary rehabilitation therapy and cardiac rehabilitation therapy.

Home Health Care Services must be ordered by your Physician, approved by your Physician Group or Health Plan and provided under a treatment plan describing the length, type and frequency of the visits to be provided. The following conditions must be met in order to receive Home Health Care Services:

- The skilled nursing care is appropriate for the medical treatment of a condition, illness, disease or injury;
- The Member is home bound because of illness or injury (this means that the Member is normally unable to leave home unassisted, and, when the Member does leave home, it must be to obtain medical care, or for short, infrequent non-medical reasons such as a trip to get a haircut, or to attend religious services or adult day care);

- The Home Health Care Services are part-time and intermittent in nature; a visit lasts up to 4 hours in duration in every 24 hours; and
- The services are in place of a continued hospitalization, confinement in a Skilled Nursing Facility, or outpatient services provided outside of the Member's home.

Additionally, Home Infusion Therapy is also covered. A provider of infusion therapy must be a licensed pharmacy. Home nursing services are also provided to ensure proper patient education, training, and monitoring of the administration of prescribed home treatments. Home treatments may be provided directly by infusion pharmacy nursing staff or by a qualified home health agency. The patient does not need to be homebound to be eligible to receive Home Infusion Therapy. See “Definitions,” Section 900. Note: Diabetic supplies covered under medical supplies include blood glucose monitors and insulin pumps.

Custodial Care services and Private Duty Nursing, as described in "Definitions," Section 900 and any other types of services primarily for the comfort or convenience of the Member, are not covered even if they are available through a Home Health Care Agency. Home Health Care Services do not include Private Duty Nursing or shift care. Private Duty Nursing (or shift care) is not a covered benefit under this plan even if it is available through a Home Health Care Agency or is determined to be Medically Necessary. See “Definitions,” Section 900.

Ambulance Services
Air and ground ambulance services are covered.

The contracting Physician Group may order the ambulance themselves when they know of your need in advance. If circumstances result in you or others ordering an ambulance, your Physician Group must still be contacted as soon as possible and they must authorize the services. All paramedic, ambulance, and ambulance transport services provided as a result of a 911 emergency response system call will be covered, when the criteria for Emergency Care, as defined in this Evidence of Coverage, have been met.

Hospice Care
"Hospice" is a special way of caring for people who are terminally ill, and for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a Hospice facility, a Hospital, or a nursing home. Care from a Hospice is meant to help patients make the most of the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

Hospice care includes Physician services, counseling, medications, other necessary services and supplies and homemaker services. The Member Physician will develop a plan of care for a Member who elects Hospice care.

In addition, up to five consecutive days of inpatient care for the Member may be authorized to provide relief for relatives or others caring for the Member.

Corrective Footwear
Corrective footwear for conditions not related to diabetes is covered. Corrective footwear for the management and treatment of diabetes is covered under the "Diabetic Equipment" benefit as Medically Necessary.

Corrective footwear for the management and treatment of diabetes are covered as described under the "Diabetic Equipment" provision in this section.

Durable Medical Equipment
Durable Medical Equipment, which includes but is not limited to wheelchairs, crutches, bracing, supports, casts, nebulizers (including face masks and tubing) and Hospital beds, is covered and will be repaired or replaced when necessary. However, repair or replacement for loss or misuse is not covered. Health Net will decide whether to repair or replace an item. Some Durable Medical Equipment may have specific quantity limits or may not be covered as they are considered primarily for non-medical use. Nebulizers (including face masks and tubing) and orthotics are not subject to such quantity limits.

Diabetic Equipment
Equipment and supplies for the management and treatment of diabetes are covered, as Medically Necessary, including:

- Insulin pumps and all related necessary supplies
- Corrective footwear to prevent or treat diabetes-related complications
- Blood glucose monitors designed to assist the visually impaired
- Visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin are provided through the prostheses benefit (see the "Prostheses" portion of this section).
- Glucagon is provided through the self-injectables benefit (see the "Immunization and Injections" portion of this section).
- Self-management training, education and medical nutrition therapy will be covered, only when provided by licensed health care professionals with expertise in the management or treatment of diabetes. Please refer to the "Patient Education" portion of this section for more information.

These following items are covered under your Medicare Part D Prescription Drug benefits issued to you in a separate Evidence of Coverage:

- Insulin and Prescription Drugs for the treatment and management of diabetes
- Specific brands of blood glucose monitors and blood glucose testing strips
- Ketone urine testing strips
- Lancets and lancet puncture devices
- Specific brands of pen delivery systems for the administration of insulin, including pen needles
- Specific brands of disposable insulin needles and syringes

Bariatric (Weight Loss) Surgery
Bariatric surgery provided for the treatment of morbid obesity is covered when Medically Necessary, authorized by Health Net and performed at a Health Net designated bariatric surgical center.

Health Net has a designated network of bariatric surgical centers to perform weight loss surgery. Your Member Physician can provide you with information about these centers. You will be directed to a Health Net designated bariatric surgical center at the time authorization is obtained. If you live 50 miles or more from the nearest Health Net designated bariatric surgical center, you are eligible to receive travel expense reimbursement. All requests for travel expense reimbursement must be prior approved by Health Net. Approved travel-related expenses will be reimbursed as follows:

- Transportation for the Member to and from the designated bariatric surgical center up to $130 per trip for a maximum of three (3) trips (one pre-surgical visit, the initial surgery and one follow-up visit).
- Transportation for one companion (whether or not an enrolled Member) to and from the designated bariatric surgical center up to $130 per trip for a maximum of two (2) trips (the initial surgery and one follow-up visit).
- Hotel accommodations for the Member and one companion not to exceed $100 per day for the pre-surgical visit and the follow-up visit, up to two (2) days per trip or as Medically Necessary. Limited to one room, double occupancy.
- Hotel accommodations for one companion not to exceed $100 per day for the duration of the Member's initial surgery stay, up to four (4) days. Limited to one room, double occupancy.
- Other reasonable expenses not to exceed $25 per day, up to four (4) days per trip. Expenses for tobacco, alcohol, drugs, telephone, television, delivery, and recreation are specifically excluded.

Submission of adequate documentation including receipts is required to receive travel expense reimbursement from Health Net.

Organ, Tissue and Bone Marrow Transplants
Organ, tissue and bone marrow transplants that are not Experimental or Investigational are covered, only if the transplant is authorized by Health Net and performed at a Health Net designated transplant center.

Health Net has a specific network of Transplant Centers to perform organ, tissue and bone marrow transplants. Your Member Physician can provide you with information about those Transplant Centers. You will be directed to a designated Health Net Transplant Center at the time authorization is obtained.

Medical services, in connection with an organ, bone marrow or tissue transplant are covered as follows:

- For the enrolled Member who receives the transplant; and
- For the donor (whether or not an enrolled Member). Benefits are reduced by any amounts paid or payable by the donor's own coverage.

Organ donation extends and enhances lives and is an option that you may want to consider. For more information on organ donations, including how to elect to be an organ donor, please contact the Member Services Department at the telephone number on your Health Net ID Card, or visit the Department of Health and Human Services organ donation website at www.organdonor.gov.

Renal Dialysis
Renal dialysis services in your home service area are covered. Dialysis services for Members with end-stage-renal disease (ESRD) who are traveling within the United States are also covered. Outpatient dialysis services within the United States but outside of your home service area must be arranged and authorized by your Physician Group or Health Net in order to be performed by providers in your temporary location. Outpatient dialysis received out of the United States is not a covered service.

Prostheses
Internal and external prostheses required to replace a body part are covered. Examples are artificial legs, surgically implanted hip joints, devices to restore speaking after a laryngectomy and visual aids (excluding eyewear) to assist the visually impaired with proper dosing of insulin.

Also covered are internally implanted devices such as heart pacemakers.

In addition, prostheses to restore symmetry after a Medically Necessary mastectomy are covered.

Health Net or the Member's Physician Group will select the provider or vendor for the items. If two or more types of medically appropriate devices or appliances are available, Health Net or the Physician Group will determine which device or appliance will be covered. The device must be among those that the Food and Drug Administration has approved for general use.

Prostheses will be replaced when no longer functional. However, repair or replacement for loss or misuse is not covered. Health Net will decide whether to replace or repair an item.

Blood
Blood transfusions, including blood processing, the cost of blood, unreplaced blood and blood products, are covered. However, self-donated (autologous) blood transfusions are covered only for a surgery that the contracting Physician Group has authorized and scheduled.

Inpatient Hospital Confinement
Care in a room of two or more beds or in a licensed special treatment unit is covered. Benefits for a private room are limited to the Hospital's most common charge for a two-bed room, unless a private room is determined to be Medically Necessary.

Outpatient Hospital Services
Professional services, outpatient Hospital facility services and outpatient surgery performed in a Hospital or Outpatient Surgical Center are covered.

Professional services performed in the outpatient department of a Hospital (including but not limited to a visit to a Physician, rehabilitation therapy, including physical, occupational and speech therapy, pulmonary rehabilitation therapy, cardiac rehabilitation therapy, laboratory tests, x-ray and radiation therapy) are subject to the same Copayment which is required when these services are performed at your Physician’s office.

Copayments for surgery performed in a Hospital or outpatient surgery center may be different than Copayments for professional or outpatient Hospital facility services. Please refer to "Outpatient Hospital Services" in "Schedule of Benefits and Copayments," Section 200 for more information.

Outpatient Hospital Services for transgender surgery and services related to the surgery require Prior Authorization by Health Net and are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member.

Reconstructive Surgery
Reconstructive surgery to restore and achieve symmetry including surgery performed to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors or disease, to do either of the following:

- Improve function; or
- Create a normal appearance to the extent possible, unless the surgery offers only a minimal improvement in the appearance of the Member.

This does not include cosmetic surgery that is performed to alter or reshape normal structures of the body in order to improve appearance or dental services or supplies or treatment for disorders of the jaw except as set out under "Dental Services" and "Disorders of the Jaw" portions of "Exclusions and Limitations," Section 600.

Health Net and the contracting Physician Group determine the feasibility and extent of these services, except that, the length of Hospital stays related to mastectomies and lymph node dissections will be determined solely by the Physician and no Prior Authorization for determining the length of stay is required.

This includes reconstructive surgery to restore and achieve symmetry incident to mastectomy.

This Plan covers transgender surgery and services related to the surgery, including reasonable travel, lodging and meal costs, to change a Member's physical characteristics to those of the opposite gender.

Skilled Nursing Facility
Care in a room of two or more is covered. Benefits for a private room are limited to the Hospital's most common charge for a two-bed room, unless a private room is Medically Necessary.

A Member does not have to have been hospitalized to be eligible for Skilled Nursing Facility care.

Benefits are limited to the number of days of care stated in "Schedule of Benefits and Copayments," Section 200.

Phenylketonuria (PKU)
Coverage for testing and treatment of phenylketonuria (PKU) includes formulas and special food products that are part of a diet prescribed by a Physician and managed by a licensed health care professional in consultation with a Physician who specializes in the treatment of metabolic disease. The diet must be deemed Medically Necessary to prevent the development of serious physical or mental disabilities or to promote normal development or function. Coverage is provided only for those costs which exceed the cost of a normal diet.

"Formula" is an enteral product for use at home that is prescribed by a Physician.

"Special food product" is a food product that is prescribed by a Physician for treatment of PKU and used in place of normal food products, such as grocery store foods. It does not include a food that is naturally low in protein.

Other specialized formulas and nutritional supplements are not covered.

Second Opinion by a Physician
You have the right to request a second opinion when:

- Your Primary Care Physician or a referral Physician gives a diagnosis or recommends a treatment plan that you are not satisfied with;
- You are not satisfied with the result of treatment you have received;
- You are diagnosed with or a treatment plan is recommended for, a condition that threatens loss of life, limb or bodily function or a substantial impairment, including but not limited to a Serious Chronic Condition; or
- Your Primary Care Physician or a referral Physician is unable to diagnose your condition or test results are conflicting;

To request an authorization for a second opinion, contact your Primary Care Physician or the Member Services Department at the telephone number on your Health Net ID card. Physicians at your Physician Group or Health Net will review your request in accordance with Health Net's procedures and timelines as stated in the second opinion policy. You may obtain a copy of this policy from the Member Services Department.

All authorized second opinions must be provided by a Physician who has training and expertise in the illness, disease or condition associated with the request.

Surgically Implanted Drugs
Surgically implanted drugs are covered under the medical benefit when Medically Necessary, and may be provided in an inpatient or outpatient setting.

Transgender Surgery and Services
This Plan covers transgender surgery and services related to the surgery, including reasonable travel, lodging and meal costs, to change a Member's physical characteristics to those of the opposite gender.

Mental Disorders and Substance Abuse

Please read the "Mental Disorders and Substance Abuse" portion of "Exclusions and Limitations," Section 600.
The Mental Health and Substance Abuse benefits are administered by a specialized health care service Plan which contracts with Health Net to underwrite and administer these benefits.

To be covered, the Behavioral Health Administrator must authorize these services and supplies. In an emergency, call 911 or contact the Behavioral Health Administrator at the telephone number shown on your Health Net ID Card before receiving care.

The Behavioral Health Administrator will refer you to a nearby Participating Mental Health Professional or participating independent physician or provider association (IPA) sub-contracted by the Behavioral Health Administrator. That professional or association will evaluate you to determine if additional treatment is necessary. If you need treatment, the Participating Mental Health Professional or IPA will develop a treatment plan and submit that plan to the Behavioral Health Administrator for review. When authorized by the Behavioral Health Administrator or sub-contracted entity thereof, the proposed services will be covered by this Plan.

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

Transition of Care For New Enrollees
If you are receiving ongoing care for an acute, serious or chronic mental health condition from a non-Participating Mental Health Professional at the time you enroll with Health Net, we may temporarily cover services from a provider not affiliated with the Behavioral Health Administrator, subject to applicable Copayments and any other exclusions and limitations of this Plan.

Your non-Participating Mental Health Professional must be willing to accept the Behavioral Health Administrator's standard mental health provider contract terms and conditions and be located in the Plan's service area.

If you would like more information on how to request continued care, or request a copy of our continuity of care policy, please call the Member Services Department at the telephone number on your Health Net ID Card.

The following benefits are provided:

Outpatient Services
Outpatient crisis intervention, short-term evaluation and therapy, longer-term specialized therapy, and any rehabilitative care that is related to Substance Abuse are covered for up to the maximum number of visits shown in "Schedule of Benefits and Copayments," Section 200. Medication management care is also covered when appropriate.

Second Opinion
You may request a second opinion when:

- Your Participating Mental Health Professional renders a diagnosis or recommends a treatment plan that you are not satisfied with;
- You are not satisfied with the result of the treatment you have received;
- You question the reasonableness or necessity of recommended surgical procedures;
- You are diagnosed with, or a treatment plan is recommended for, a condition that threatens loss of life, limb or bodily function or a substantial impairment, including but not limited to a Serious Chronic Condition;
- Your Primary Care Physician or a referral Physician is unable to diagnose your condition or test results are conflicting.
- The treatment plan in progress is not improving your medical condition within an appropriate period of time for the diagnosis and plan of care; or
- If you have attempted to follow the plan of care you consulted with the initial Primary Care Physician or a referral Physician due to serious concerns about the diagnosis or plan of care.

To request an authorization for a second opinion contact the Behavioral Health Administrator. Participating Mental Health Professionals will review your request in accordance with the Behavioral Health Administrator's second opinion policy. When you request a second opinion, you will be responsible for any applicable Copayments.

Second opinions will only be authorized for Participating Mental Health Professionals, unless it is demonstrated that an appropriately qualified Participating Mental Health Professional is not available. The Behavioral Health Administrator will ensure that the provider selected for the second opinion is appropriately licensed and has expertise in the specific clinical area in question.

Any service recommended must be authorized by the Behavioral Health Administrator in order to be covered.

Inpatient Services
Inpatient treatment of a Mental Disorder or Substance Abuse is covered for up to the maximum number of days shown in "Schedule of Benefits and Copayments," Section 200, under "Inpatient Hospital Services" portion.

Covered services and supplies include:

- Accommodations in a room of two or more beds, including special treatment units, such as intensive care units and psychiatric care units, unless a private room is determined to be Medically Necessary.
- Supplies and ancillary services normally provided by the facility, including professional services, laboratory services, drugs and medications dispensed for use during the confinement, psychological testing and individual, family or group therapy or counseling.
- Medically Necessary services in a Residential Treatment Center are covered except as stated in the “Mental Disorders and Substance Abuse” portion of “Exclusions and Limitations,” Section 600.

Detoxification
Inpatient services for acute detoxification and treatment of acute medical conditions relating to Substance Abuse are covered, except as stated in "Mental Disorders and Substance Abuse" portion of "Exclusion and Limitations," Section 600.

Serious Emotional Disturbances of a Child (SED)

The treatment and diagnosis of Serious Emotional Disturbances of a Child under the age of 18 is covered as shown in "Schedule of Benefits and Copayments," Section 200.

Severe Mental Illness

Treatment of Severe Mental Illness is covered as shown in "Schedule of Benefits and Copayments," Section 200. Look under the headings for office visits, outpatient services and inpatient Hospital services to determine the applicable Copayment.

Covered services include treatment of:

- Schizophrenia
- Schizoaffective disorder
- Bipolar disorder (manic-depressive illness)
- Major depressive disorders
    - Panic disorder
    - Obsessive-compulsive disorder
    - Pervasive developmental disorder (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders)
    - Autism
    - Anorexia nervosa
    - Bulimia nervosa

Chiropractic Services and Supplies

Please read the "Chiropractic Services and Supplies" portion of "Exclusions and Limitations," Section 600.

Chiropractic Services are covered up to the maximum number of visits shown in "Schedule of Benefits and Copayments," Section 200.

American Specialty Health Plans of California, Inc. (ASH Plans) will arrange covered Chiropractic Services for you. You may access any Contracted Chiropractor without a referral from a Physician or your Primary Care Physician.

You may receive covered Chiropractic Services from any Contracted Chiropractor at any time and you are not required to pre-designate, at any time, the Contracted Chiropractor prior to your visit from whom you will receive covered Chiropractic Services. You must receive covered Chiropractic Services from a Contracted Chiropractor, except that:

- You may receive Emergency Chiropractic Services from any chiropractor, including a non-Contracted Chiropractor; and
- If covered Chiropractic Services are not available and accessible to you in the county in which you live, you may obtain covered Chiropractic Services from a non-Contracted Chiropractor who is available and accessible to you in a neighboring county only upon referral by ASH Plans.

All covered Chiropractic Services require pre-approval by ASH Plans except:

- A new patient examination by a Contracted Chiropractor and the provision or commencement, in the new patient examination, of Medically/Clinically Necessary services that are covered Chiropractic Services, to the extent consistent with professionally recognized standards of practice; and
- Emergency Chiropractic Services including, without limitation, any referral for x-ray services, radiological consultations, or laboratory services.

When ASH Plans approves a treatment plan, the approved services for the subsequent office visits covered by the approved treatment plan include not only the approved services but also a re-examination, in each subsequent office visit, if deemed necessary by the Contracted Chiropractor, without additional approval by ASH Plans.

The following benefits are provided for Chiropractic Services:

Office Visits

- A new patient examination is performed by a Contracted Chiropractor to determine the nature of your problem, to provide or commence, in the new patient examination, Medically/Clinically Necessary Chiropractic Services that are covered services, to the extent consistent with professionally recognized standards of practice and to prepare a treatment plan of services to be furnished. A new patient examination will be provided to you if you seek services from a Contracted Chiropractor for any injury, illness, disease, functional disorder or condition with regard to which you are not, at that time, receiving services from the Contracted Chiropractor. A Copayment will be required.
- Subsequent office visits, as set forth in a treatment plan approved by ASH Plans, may involve an adjustment, a re-examination and other services, in various combinations. A Copayment will be required for each visit to the office.
- Adjunctive therapy, as set forth in a treatment plan approved by ASH Plans, may involve therapies such as ultrasound, hot packs, cold packs, electrical muscle stimulation and other therapies. If adjunctive therapy is provided separately from an office visit, a Copayment will be required.
- A re-examination may be performed by the Contracted Chiropractor to assess the need to continue, extend or change a treatment plan approved by ASH Plans. A re-examination may be performed during a subsequent office visit or separately. If performed separately, a Copayment will be required.

Second Opinion
If you would like a second opinion with regard to covered services provided by a Contracted Chiropractor, you will have direct access to any other Contracted Chiropractor. Your visit to a Contracted Chiropractor for purposes of obtaining a second opinion 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 Contracted Chiropractor.

However, a visit to a second Contracted Chiropractor to obtain a second opinion will not count as a visit, for purposes of any maximum benefit, if you were referred to the second Contracted Chiropractor by another Contracted Chiropractor (the first Contracted Chiropractor). The visit to the first Contracted Chiropractor will count toward any maximum benefit.

X-ray and Laboratory Tests
X-rays and laboratory tests are payable when prescribed by a Contracted Chiropractor and approved by ASH Plans. Radiological consultations are a covered benefit when approved by ASH Plans as Medically/Clinically 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. A Copayment is not required.

X-ray second opinions are covered only when performed by a radiologist to verify suspected tumors or fractures.

Chiropractic Appliances
Chiropractic Appliances are payable when prescribed by a Contracted Chiropractor and approved by ASH Plans for up to the maximum benefit shown in "Schedule of Benefits and Copayments," Section 200.

Eyewear

Please read the "Eyewear" portion of "Exclusions and Limitations," Section 600.

To obtain Eyewear benefits, you must go to a Participating Eyewear Dispenser.

Eyewear benefits are provided by Health Net. Health Net contracts with EyeMed Vision Care LLC, a vision services provider panel, to provide and administer Eyewear benefits. EyeMed Vision Care provides benefits for eyewear through a network of dispensing opticians and optometric laboratories. Vision examinations are provided through your Physician Group or you may schedule a vision examination through EyeMed Vision Care. Refer to "Office Visits" in "Schedule of Benefits and Copayments," Section 200, for information on vision examinations.

If you require eyeglasses, a prescription is written, and you are free to purchase eyewear from a list of contracting dispensing opticians in California. The optician will bill EyeMed Vision Care for reimbursement. If you select standard lenses and frames, you will not owe the dispensing optician. But if more costly items are selected, you are required to pay the amount in excess of those specified in "Eyewear Allowance" in "Schedule of Benefits and Copayments," Section 200. Only Eyewear services obtained through contracting providers are covered.

To find a Participating Eyewear Dispenser, contact the Health Net Vision Program at 1-866-392-6058 or visit our website at www.healthnet.com/uc.

Eyewear obtained from nonparticipating dispensers is not covered.

Eyewear benefits are provided by the Health Net Vision Program and are administered by EyeMed Vision Care, LLC.

The following benefits are provided for Eyewear:

Lenses

- One pair of standard plastic eyeglass Lenses are covered during a 24-month period.
- One pair of Medically Necessary Contact Lenses or Contact Lenses chosen for convenience or cosmetic purposes is covered during a 24-month period. The maximum allowable amount is shown in "Schedule of Benefits and Copayments," Section 200. If disposable Contact Lenses are used, you should submit only one claim after the charges for the individual pairs of Lenses reach the allowable amount shown in "Schedule of Benefits and Copayments," Section 200.

An additional pair of Eyeglass Lenses or Contact Lenses (whether cosmetic or Medically Necessary) may be covered if, after 12 consecutive months from the date the Lenses are dispensed, one of the following occurs:

- There is a change in diopter of at least 0.50 in one eye or if the change occurs in both eyes, the total for both is 0.50.
- There is a shift in axis of astigmatism of greater than 15 degrees;
- There is a change in vertical prism greater than 1 prism diopter; or
- The Physician or Optometrist prescribes either a change in Lens type, or a change from Eyeglasses to Contact Lenses or from Contact Lenses to Eyeglasses.

Medically Necessary Contact Lenses
Medically Necessary Contact Lenses are Lenses that meet any of the following specifications:

- They are necessary because of keratoconus, when visual acuity cannot be corrected to 20/40 with the use of spectacles.
- They are prescribed following cataract surgery and the natural lens is not replaced with a lens implant (aphakia).
- They are necessary because of anisometropia 3 diopters or more, provided visual acuity improves to 20/40 or better in the weaker eye.
- They are necessary because of astigmatism of 3 diopters or more.
- They are necessary because of hyperopia of greater than 7 diopters.
- They are necessary because of myopia of greater than 12 diopters.

Tints
Pink or rose tints #1 or #2 are covered in full. Other tints are covered at a 20% discount.

Eyeglass Frames
One set of Frames are covered up to the amount shown in "Schedule of Benefits and Copayments," Section 200.

EXCLUSIONS AND LIMITATIONS

It is extremely important to read this section before you obtain services in order to know what Health Net will and will not cover.

Services and Supplies

The exclusions and limitations in this subsection apply to any category or classification of services and supplies described throughout this Evidence of Coverage.

Health Net does not cover the services or supplies listed below. Also, services or supplies that are excluded from coverage in the Evidence of Coverage, exceed Evidence of Coverage limitations or are Follow-Up Care (or related to Follow-Up Care) to Evidence of Coverage exclusions or limitations, will not be covered. However, the Plan does cover Medically Necessary services for medical conditions directly related to non-covered services when complications exceed routine Follow-Up Care (such as life-threatening complications of cosmetic surgery).

Clinical Trials
Although routine patient care costs for clinical trials are covered, as described in the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 500, coverage for clinical trials does not include the following items:

- Drugs or devices that are not approved by the FDA;
- Services other than health care services, including but not limited to cost of travel or costs of other non-clinical expenses;
- Services provided to satisfy data collection and analysis needs which are not used for clinical management;
- Health care services that are specifically excluded from coverage under this Evidence of Coverage; and
- Items and services provided free of charge by the research sponsors to Members in the trial.

Custodial or Domiciliary Care
This Plan does not cover services and supplies that are provided primarily to assist with the activities of daily living, regardless of where performed.

Custodial Care is not covered even when the patient is under the care of a supervising or attending Physician and services are being ordered and prescribed to support and generally maintain the patient’s condition or provide for the patient’s comforts or ensure the manageability of the patient. Furthermore, Custodial Care is not covered even if ordered and prescribed services and supplies are being provided by a registered nurse, a licensed vocational nurse, a licensed practical nurse, a Physician Assistant or physical therapist.

Disposable Supplies for Home Use
This Plan does not cover disposable supplies for home use.

Experimental or Investigational Services
Experimental or Investigational drugs, devices, procedures or other therapies are only covered when:

- Independent review deems them appropriate, please refer to the "Independent Medical Review of Investigational or Experimental Therapies" portion of "General Provisions," Section 700, for more information; or
- Clinical trials for cancer patients are deemed appropriate according to the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 500.

In addition, benefits will also be provided for services and supplies to treat medical complications caused by Experimental or Investigational services or supplies.

Ineligible Status
This Plan does not cover services or supplies provided before the Effective Date of coverage. Services or supplies provided after coverage through this Plan has ended are not covered, except as specified in "Extension of Benefits" portion of "Eligibility, Enrollment and Termination," Section 400.

A service is considered provided on the day it is performed. A supply is considered provided on the day it is dispensed.

No-Charge Items
This Plan does not cover reimbursement to the Member for services or supplies for which the Member is not legally required to pay the provider or for which the provider pays no charge.

Personal or Comfort Items
This Plan does not cover personal or comfort items.

Unlisted Services
This Plan only covers services or supplies that are specified as covered services or supplies in this Evidence of Coverage, unless coverage is required by state or federal law.

Medical Services and Supplies

In addition to the exclusions and limitations shown in "Services and Supplies" portion of this section, the following exclusions and limitations apply to medical services and supplies:

Blood
Blood transfusions, including blood processing, the cost of blood, unreplaced blood and blood products, are covered. Self-donated (autologous) blood transfusions are covered only for a surgery that the contracting Physician Group or Health Net has authorized and scheduled.

This Plan does not cover treatments which use umbilical cord blood, cord blood stem cells or adult stem cells (nor their collection, preservation and storage) as such treatments are considered to be Experimental or Investigational in nature. See "General Provisions," Section 700, for the procedure to request an Independent Medical Review of a Plan denial of coverage on the basis that it is considered Experimental or Investigational.

Conception by Medical Procedures
Artificial insemination is covered when a female Member or her male partner is infertile (refer to Infertility in "Definitions," Section 900). However, if only the male partner is a Member and the female partner (who is not a member) is infertile, artificial insemination will not be covered. The collection, storage or purchase of sperm is not covered.

Other services or supplies that are intended to impregnate a woman are not covered. Excluded procedures include, but are not limited to:

- In-vitro fertilization (IVF), gamete intrafallopian transfer (GIFT), zygote intrafallopian transfer (ZIFT) or any process that involves harvesting, transplanting or manipulating a human ovum. Also not covered are services or supplies (including injections and injectable medications) which prepare the Member to receive these services.
- Collection, storage or purchase of sperm or ova.

Contraceptives
Injectable contraceptives (which are administered by a Physician) are covered as a medical benefit. If your Physician determines that none of the methods specified as covered by the Plan are medically appropriate, then the Plan will provide coverage for another FDA approved contraceptive method as prescribed by your Physician.

Services related to Norplant are limited to the removal only. Norplant devices are not covered.

Cosmetic Services and Supplies
Cosmetic surgery or services and supplies performed to alter or reshape normal structures of the body solely to improve the physical appearance of a Member are not covered. However, the Plan does cover Medically Necessary services and supplies for complications which exceed routine Follow Up Care that is directly related to cosmetic surgery (such as life-threatening complications). In addition, hair transplantation, hair analysis, hairpieces and wigs, chemical face peels, abrasive procedures of the skin, liposuction or epilation are not covered.

However, when reconstructive surgery is performed to correct or repair abnormal structures of the body caused by, congenital defects, developmental abnormalities, trauma, infection, tumors or disease and such surgery does either of the following:

- Improve function;
- Create a normal appearance to the extent possible;

then

- Surgery to remove or change the size (or appearance) of any part of the body;
- Surgery to reform or reshape skin or bone; or
- Surgery to remove or reduce skin or tissue are covered.

In addition, when a Medically Necessary mastectomy has been performed, the following are covered:

- Breast reconstruction surgery; and
- Surgery performed on either breast to restore or achieve symmetry (balanced proportions) in the breasts.

Health Net and the contracting Physician Group determine the feasibility and extent of these services, except that, the length of Hospital stays related to mastectomies and lymph node dissections will be determined solely by the Physician and no Prior Authorization for determining the length of stay is required.

The coverage described above in relation to a Medically Necessary mastectomy complies with requirements under the Women's Health and Cancer Rights Act of 1998.

This Plan covers transgender surgery and services related to the surgery, including reasonable travel, lodging and meal costs, to change a Member's physical characteristics to those of the opposite gender.

Dental Services
Dental services or supplies are limited to the following situations:

- When immediate Emergency Care to sound natural teeth as a result of an accidental injury is required. Please refer to "Emergency and Urgently Needed Care" portion of "Introduction to Health Net," Section 100, for more information.
- General anesthesia and associated facility services are covered when the clinical status or underlying medical condition of the Member requires that an ordinarily non-covered dental service which would normally be treated in a dentist's office and without general anesthesia must instead be treated in a Hospital or Outpatient Surgical Center. The general anesthesia and associated facility services must be Medically Necessary, are subject to the other exclusions and limitations of this Evidence of Coverage and will only be covered under the following circumstances (a) Members who are under seven years of age or, (b) Members who are developmentally disabled or (c) Members whose health is compromised and general anesthesia is Medically Necessary.
- When dental examinations and treatment of the gingival tissues (gums) are performed for the diagnosis or treatment of a tumor.

The following services are not covered under any circumstances.

- Routine care or treatment of teeth and gums including but not limited to dental abscesses, inflamed tissue or extraction of teeth.
- Spot grinding, restorative or mechanical devices, orthodontics, inlays or onlays, crowns, bridgework, dental splints or orthotics (whether custom fit or not), or other dental appliances and related surgeries to treat dental conditions
- Dental implants (materials implanted into or on bone or soft tissue) and any surgery to prepare the jaw for implants.
- Follow-up treatment of an injury to sound natural teeth as a result of an accidental injury regardless of reason for such services.

Dietary or Nutritional Supplements
Dietary, nutritional supplements and specialized formulas are not covered except when prescribed for the treatment of Phenylketonuria (PKU) (see the "Phenylketonuria" portion of "Covered Services and Supplies," Section 500).

Disorders of the Jaw
Treatment for disorders of the jaw is limited to the following situations:

- Surgical procedures to correct abnormally positioned or improperly developed bones of the upper or lower jaw are covered when such procedures are Medically Necessary. However, spot grinding, restorative or mechanical devices; orthodontics, inlays or onlays, crowns, bridgework, dental splints (whether custom fit or not), dental implants or other dental appliances and related surgeries to treat dental conditions are not covered under any circumstances.

- Custom made oral appliances (intra-oral splint or occlusal splint) and surgical procedures to correct disorders of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders) are covered if they are Medically Necessary. However, spot grinding, restorative or mechanical devices, orthodontics inlays or onlays, crowns, bridgework, dental splints, dental implants or other dental appliances to treat dental conditions related to TMD/TMJ disorders are not covered.
- TMD/TMJ disorders are generally caused when the chewing muscles and jaw joint do not work together correctly and may cause headaches, tenderness in the jaw muscles, tinnitus or facial Pain.

Durable Medical Equipment
Although this Plan covers Durable Medical Equipment, it does not cover the following items:

- Exercise equipment
- Hygienic equipment and supplies (to achieve cleanliness even when related to other covered medical services)
- Stockings, corrective shoes and arch supports
- Surgical dressings other than primary dressings that are applied by your Physician Group or a Hospital to lesions of the skin or surgical incisions.
- Jacuzzis and whirlpools
- Orthotics, unless custom made to fit the Member’s body. (Orthotics are supports, casts or braces for weak or ineffective joints or muscles.)
- Orthodontic appliances to treat dental conditions related to the treatment of the temporomandibular (jaw) joint (also known as TMD or TMJ disorders).
- Corrective footwear (whether or not custom fit) that are not incorporated into cast, splint, brace or strapping of the foot except when Medically Necessary for the management and treatment of diabetes, or when purchased by your Group as a specific benefit for corrective footwear as shown in the "Medical Supplies" portion of "Schedule of Benefits and Copayments," Section 200 and the "Corrective Footwear" portion of "Covered Services and Supplies," Section 500.

The Plan covers Medically Necessary diabetic supplies as shown in "Medical Supplies" portion of "Schedule of Benefits and Copayments," Section 200 and "Diabetic Equipment" portion of "Covered Services and Supplies," Section 500. Visual aids (excluding eyewear) to assist the visually impaired in the proper dosing of insulin are covered as described in the "Prostheses" portion of the "Covered Services and Supplies" Section 500.

Genetic Testing and Diagnostic Procedures
Genetic testing is covered when determined by Health Net to be Medically Necessary. The prescribing Physician must request Prior Authorization for coverage. Genetic testing will not be covered for non-medical reasons or when a Member has no medical indication or family history of a genetic abnormality.

Home Birth
A birth which takes place at home will be covered only when the criteria for Emergency Care, as defined in this Evidence of Coverage, have been met.

Non-eligible Institutions
This Plan only covers services or supplies provided by a legally operated Hospital, Medicare-approved Skilled Nursing Facility or other properly licensed facility specified as covered in this Evidence of Coverage. Any institution that is primarily a place for the aged, a nursing home or a similar institution, regardless of how it is designated, is not an eligible institution. Services or supplies that are provided by such institutions are not covered.

Nonprescription (Over-the-Counter) Drugs, Equipment and Supplies
Medical equipment and supplies (including insulin), that are available without a prescription, are covered only when prescribed by a Physician for the management and treatment of diabetes.

Any other nonprescription or over-the-counter drugs, medical equipment or supplies that can be purchased without a Prescription drug order is not covered even if a Physician writes a Prescription drug order for such drug, equipment or supply unless listed in the Recommended Drug List. However, if a higher dosage form of a nonprescription drug or over-the-counter drug is only available by prescription, that higher dosage drug may be covered when Medically Necessary.

If a drug that was previously available by prescription becomes available in an over-the-counter (OTC) form in the same prescription strength, then Prescription Drugs that are similar agents and have comparable clinical effect(s) will only be covered when Prior Authorization is obtained from Health Net.

Outpatient Prescription Drugs
Outpatient Prescription Drug benefits are not covered under this medical Plan. Please refer to Medicare Part D Prescription Drug benefits.

However, diabetic equipment and supplies for the management and treatment of diabetes are as shown in the "Diabetic Equipment" portion of "Covered Services and Supplies," Section 500.

Physician Self-Treatment
This Plan does not cover Physician self-treatment rendered in a non-emergency. Physician self-treatment occurs when Physicians provide their own medical services, including prescribing their own medication, ordering their own laboratory test and self-referring for their own services. Claims for emergency self-treatment are subject to review by Health Net.

Physicians Treating Immediate Family Members
This Plan does not cover routine or ongoing treatment or consultation provided by the Member's parent, spouse, Domestic Partner, child, stepchild or sibling. Members who receive routine or ongoing care from a member of their immediate family will be reassigned to another Physician.

Private Duty Nursing
This Plan does not cover Private Duty Nursing in the home or for registered bed patients in a Hospital or long-term care facility.

Refractive Eye Surgery
This Plan does not cover eye surgery performed to correct refractive defects of the eye, such as near-sightedness (myopia), far-sightedness (hyperopia) or astigmatism, unless Medically Necessary, recommended by the Member's treating Physician and authorized by Health Net.

Rehabilitation Therapy
Coverage for rehabilitation therapy is limited to Medically Necessary services provided by a licensed physical, speech or occupational therapist for treatment of conditions resulting from a Defined Disease, injury or surgical procedure. The services must be at a level of complexity that requires the judgment, knowledge and skills of a licensed physical, speech or occupational therapist, be based on a treatment plan and be provided by such therapist or under the therapist's direct supervision. Such services are not covered when medical documentation does not support the Medical Necessity because of the Member's inability to progress toward the treatment plan goals or when a Member has already met the treatment plan goals. See "General Provisions," Section 700, for the procedure to request Independent Medical Review of a Plan denial of coverage on the basis of Medical Necessity.

Reversal of Surgical Sterilization
This Plan does not cover services to reverse voluntary, surgically induced sterility.

Sexual Dysfunction Drugs
Drugs (including injectable medications) prescribed for the treatment of sexual dysfunction are not covered.

Services Not Related To Covered Condition, Illness Or Injury
Any services or supplies not related to the diagnosis or treatment of a covered condition, illness or injury. However, the Plan does cover Medically Necessary services or supplies for medical conditions directly related to non-covered services when complications exceed routine Follow-Up Care (such as life-threatening complications of cosmetic surgery).

Surrogate Pregnancy
This Plan covers services for a surrogate pregnancy when the surrogate is a Health Net Member. When compensation is obtained for the surrogacy, the Plan shall have a lien on such compensation to recover its medical expense. A surrogate pregnancy is one in which a woman has agreed to become pregnant with the intention of surrendering custody of the child to another person.

Treatment of Obesity
Treatment or surgery for obesity, weight reduction or weight control is limited to the treatment of morbid obesity.

Unauthorized Services and Supplies
This Plan only covers medical services or supplies that are authorized by Health Net or the Physician Group according to Health Net's procedures, except for emergency services.

Vision Therapy, Eyeglasses and Contact Lenses
This Plan does not cover vision therapy, eyeglasses or contact lenses. However, this exclusion does not apply to an implanted lens that replaces the organic eye lens.

Chiropractic Services and Supplies

The exclusions and limitations in the "Services and Supplies" and "Medical Services and Supplies" portions of this section apply to Chiropractic Services.

Note: Services or supplies excluded under the chiropractic benefits may be covered under your medical benefits portion of this Evidence of Coverage. Please refer to the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 500, for more information.

Services, laboratory tests and x-rays and other treatment not approved by ASH Plans and documented as Medically/Clinically Necessary as appropriate or classified as Experimental, and/or being in the research

stage, as determined in accordance with professionally recognized standards of practice are not covered. If you have a life threatening or seriously debilitating condition and ASH plans denies coverage based on the determination that the therapy is Experimental, you may be able to request an independent medical review of ASH Plans' determination. You should contact ASH Plans at 1-800-678-9133 for more information.

Additional exclusions and limitations include, but are not limited to, the following:

Anesthesia
Charges for anesthesia are not covered.

Diagnostic Radiology
Coverage is limited to x-rays. No other diagnostic radiology (including magnetic resonance imaging or MRI) is covered.

Drugs
Prescription drugs and over-the-counter drugs are not covered.

Durable Medical Equipment
Durable Medical Equipment is not covered.

Educational Programs
Educational programs, nonmedical self-care, self-help training and related diagnostic testing are not covered.

Experimental or Investigational Chiropractic Services
Chiropractic care that is (a) investigatory; or (b) an unproven chiropractic service that does not meet generally accepted and professionally recognized standards of practice in the chiropractic provider community is not covered. ASH Plans will determine what will be considered Experimental or Investigational.

Hospital Charges
Charges for Hospital confinement and related services are not covered.

Hypnotherapy
Hypnotherapy, behavior training, sleep therapy and weight programs are not covered.

Non-Contracted Providers
Services or treatment rendered by chiropractors who do not contract with ASH Plans are not covered, except with regard to Emergency Chiropractic Services or upon a referral by ASH Plans.

Nonchiropractic Examinations
Examinations or treatments for conditions unrelated to Neuromusculoskeletal Disorders are not covered. This means that physical therapy not associated with spinal, muscle and joint manipulation, is not covered.

Out-of-State Services
Services provided by a chiropractor practicing outside California are not covered, except with regard to Emergency Chiropractic Services.

Services Not Within License
Services that are not within the scope of license of a licensed chiropractor in California.

Thermography
The diagnostic measuring and recording of body heat variations (thermography) are not covered.

Transportation Costs
Transportation costs are not covered, including local ambulance charges.

Medically/Clinically Unnecessary Services
Only Chiropractic Services that are necessary, appropriate, safe, effective and rendered in accordance with professionally recognized, valid, evidence-based standards of practice are covered.

Vitamins
Vitamins, minerals, nutritional supplements or other similar products are not covered.

Eyewear

The exclusions and limitations in the "Services and Supplies" and "Medical Services and Supplies" portions of this section apply to Eyewear.

Note: Services or supplies excluded under the Eyewear benefits may be covered under your medical benefits portion of this Evidence of Coverage. Please refer to the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 500, for more information.

Additional exclusions and limitations:

Refraction Exams
Refraction exams are not covered except as stated in "Medical Services and Supplies," Section 500.

Additional Frames and Lenses
The fitting or dispensing of more than one set of Frames and one pair of Lenses is only covered as specified in "Lenses" provision in "Eyewear Benefits" portion of "Covered Services and Supplies," Section 500.

Aniseikonic Lenses
Lenses that correct the vision defect known as aniseikonia are not covered.

Medical Treatment
Diagnostic services and medical or surgical treatment of the eye are not covered. Please see "Medical Services and Supplies" portion in "Covered Services and Supplies," Section 500, for information.

Nonparticipating Dispensers
Services or supplies provided by a dispenser other than a Participating Eyewear Dispenser are not covered.

Nonprescription Eyewear
Nonprescription vision devices and sunglasses are not covered.

Optional Frames
Additional fitting and measurement charges or special consultation charges due to the purchase of optional Frames, are not covered.

Orthoptics
Orthoptics or vision training are not covered.

Drugs
Prescription drugs or over-the-counter drugs are not covered.

Vision Aids
Vision aids (other than Eyeglasses or Contact Lenses) are not covered.

Progressive Lenses
The Eyewear allowance for Progressive Lenses is the same as for trifocal Lenses. Any difference between that and the retail price is your responsibility.

Mental Disorders and Substance Abuse

The exclusions and limitations in the "Services and Supplies" and "Medical Services and Supplies" portions of this section apply to Mental Disorders and Substance Abuse.

Note: Services or supplies excluded under the Mental Disorders and Substance Abuse benefits may be covered under your medical benefits portion of this Evidence of Coverage. Please refer to the "Medical Services and Supplies" portion of "Covered Services and Supplies," Section 500, for more information.
Mental health care as a condition of parole, probation or court-ordered testing for Mental Disorders is limited to Medically Necessary services and subject to this Plan's day or visit limits as shown in "Schedule of Benefits and Copayments," Section 200.

Services and supplies for treating Mental Disorders and Substance Abuse are covered only as specified in "Mental Disorders and Substance Abuse" portion of "Covered Services and Supplies," Section 500. The treatment and diagnosis of Serious Emotional Disturbances of a Child under the age of 18 is covered as shown in "Schedule of Benefits and Copayments," Section 200. Look under the headings for office visits, outpatient services and inpatient Hospital services to determine the applicable Copayment.

The following exclusions apply specifically to Mental Disorders and Substance Abuse.

Additional exclusions and limitations:

Aversion Therapy
Therapy intended to change behavior by inducing a dislike for the behavior through association with a noxious stimulus is not covered.

For Insurance
Services for obtaining or maintaining insurance are not covered

Educational and Employment Services
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.
- Academic education during residential treatment.

Nonabstinence-Based Treatment
Substance Abuse treatment not based on abstinence is not covered.

Noncontracting Providers or Facilities
Services, treatment or supplies rendered in a non-emergency by a nonparticipating provider or nonparticipating facility, are only covered when authorized by the Behavioral Health Administrator's Medical Director or his/her designee or otherwise provided by the Plan. For information on "Continuity of Care" through a nonparticipating Mental Health Professional, please see the "Mental Disorders and Substance Abuse" portion of "Covered Services and Supplies," Section 500.

This includes, but is not limited to those cases where the Behavioral Health Administrator refers a Member to a noncontracting provider or authorizes Emergency or Urgently Needed Care or a second opinion.

Noncovered Treatments
The following types of treatment are only covered when provided in connection with covered treatment for a Mental Disorder or Substance Abuse:

- Treatment ordered by a court of law.
- Treatment of chronic Pain.
- Treatment for co-dependency.
- Treatment for psychological stress.
- Treatment of marital or family dysfunction.

Treatment for smoking cessation, weight reduction, obesity, stammering, sleeping disorders, stuttering or sexual addiction is not covered under the Mental Disorders and Substance Abuse benefits of this Plan. However, treatment for morbid obesity is covered under the medical benefit as described in "Medical Services and Supplies" in "Covered Services and Supplies," Section 500. Treatment for smoking cessation is covered under the prescription drug benefit as described in the "Prescription Drug" portion of "Covered Services and Supplies", Section 500. Treatment related to judicial or administrative proceedings that is not Medically Necessary is also not covered.

Treatment of Delirium, Dementia, Amnesic Disorders (as defined in the DSM-IV) and Mental Retardation other than Medically Necessary Services for accompanying behavioral or psychological symptoms if amenable to psychotherapeutic or psychiatric treatment, is not covered.

In addition, treatment by Providers who are not within licensing categories that are recognized by the Behavioral Health Administrator as providing Covered Services in accordance with applicable medical community standards is not covered.

Nonstandard Therapies
Services that do not meet national standards for professional mental health practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy applied behavioral analysis and crystal healing therapy are not covered.

Nontreatable Disorders
Mental Disorders or conditions of Substance Abuse that the Behavioral Health Administrator determines are not likely to improve with generally accepted methods of treatment are not covered.

Prescription Drugs
Outpatient Prescription Drugs or over-the-counter drugs are not covered.

Private Duty Nursing
Private Duty Nursing services in the home or in a Hospital are not covered.

Residential Treatment Center
Admissions that are not considered medically appropriate and are not covered include admissions for wilderness center training; for Custodial Care, for a situational or environmental change; or as an alternative to placement in a foster home or halfway house.

State Hospital Treatment
Services in a state Hospital are limited to treatment or confinement as the result of an emergency or Urgently Needed Care as defined in "Definitions," Section 900.

Telephone Consultations
Treatment or consultations provided by telephone are not covered.

Psychological Testing
Psychological testing is only covered, when ordered by a licensed Participating Mental Health Professional and is Medically Necessary to diagnose a Mental Disorder for purposes of developing a mental health treatment plan or when Medically Necessary to treat a Mental Disorder or condition of Substance Abuse.

Treatment by a Relative
Treatment or consultation provided by the Member's parents, siblings, children, current or former spouse or any adults who live in the Member's household, is not covered.

Congenital and Organic Disorders
Treatment of physiological diseases or defects, including but not limited to organic brain disease is not covered. However, some conditions shall be covered as shown in "Schedule of Benefits and Copayments," Section 200, provided that their level of severity meets the criteria described in the definitions of "Serious Emotional Disturbances of a Child" or "Severe Mental Illness."

Learning Disabilities
Testing, screening or treatment for learning disabilities are not covered. However, some conditions shall be covered as shown in "Schedule of Benefits and Copayments," Section 200, provided that their level of severity meets the criteria described in the definitions of "Serious Emotional Disturbances of a Child" or "Severe Mental Illness" and the conditions are treated by Participating Mental Health Professionals.

Detoxification in Newborns
Treatment of detoxification in newborns is not covered. However, these services are covered under the medical benefit (see "Inpatient Hospital Confinement" portion of "Covered Services and Supplies," Section 500).

Excess Services
Services in excess of those authorized by the Behavioral Health Administrator's Medical Director or his/her designee, unless such services are determined to be Medically Necessary.

GENERAL PROVISIONS

When the Plan Ends

The Standardized Contract specifies how long this Plan remains in effect.

If you are hospitalized or totally disabled on the date that the Standardized Contract is terminated, benefits will continue according to "Extension of Benefits" portion of "Eligibility, Enrollment and Termination," Section 400.

When the Plan Changes

Subject to notification and according to the terms of the Standardized Contract, the Group has the right to terminate this Plan or to replace it with another plan with different terms. This may include, but is not limited to, changes or termination of specific benefits, exclusions and eligibility provisions.

Health Net has the right to modify this Plan, including the right to change subscription charges according to the terms of the Standardized Contract. Notice of modification will be sent to the Group. Except as required under "Eligibility, Enrollment and Termination" Section 400, Subsection D, "When Coverage Ends" regarding termination for non-payment, Health Net will not provide notice of such changes to plan Subscribers unless it is required to do so by law. The Group may have obligations under state or federal law to provide notification of these changes to plan Subscribers.

If you are confined in a Hospital when the Standardized Contract is modified, benefits will continue as if the Plan had not been modified, until you are discharged from the Hospital.

Form or Content of the Plan: No agent or employee of Health Net is authorized to change the form or content of this Plan. Any changes can be made only through an endorsement authorized and signed by an officer of Health Net.

Member Services Department Interpreter Services

Health Net’s Member Services Department has bilingual staff and a telephone interpreter service for additional languages to handle Member inquiries. Examples of interpretive services provided include explaining benefits and answering health plan questions in the Member's preferred language. Call the Member Services number on your Health Net ID card for this free service. Health Net discourages the use of family members, friends and minors as interpreters.

Grievance, Appeals, Independent Medical Review and Arbitration

Grievance Procedures
If you are not satisfied with efforts to solve a problem with Health Net or your Physician Group, you must first file a grievance or appeal against Health Net by calling the Member Services Department at 1-800-539-4072 or by submitting a Member Grievance Form through the Health Net website at www.healthnet.com/uc.

You may also file your complaint in writing by sending information to:

Health Net
Member Services Appeals and Grievance Department
P.O. Box 10348
Van Nuys, CA 91410-0348

If your concern involves the Mental Disorders and Substance Abuse program call Managed Health Network (MHN) at 1 888 426-0030, or write to:

Managed Health Network
Attention: Appeals & Grievances
503 Canal Boulevard
Pt. Richmond, CA 94804

You must file your grievance or appeal with Health Net within 365 calendar days following the date of the incident or action that caused your grievance. Please include all information from your Health Net Identification Card and he details of the concern or problem.

We will:

- Confirm in writing within five calendar days that we received your request.
- Review your complaint and inform you of our decision in writing within 30 days from the receipt of the Grievance. 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, Health Net must notify you of the status of your grievance no later than three days from receipt of the grievance. For urgent grievances, Health Net will immediately notify you of the right to contact the Department of Managed Health Care. There is no requirement that you participate in Health Net's grievance or appeals process before requesting IMR for denials based on the Investigational or Experimental nature of the therapy. In such cases you may immediately contact the Department of Managed Health Care to request an IMR of the denial.

If you continue to be dissatisfied after the grievance procedure has been completed, you may contact the Department of Managed Health Care for assistance or to request an independent medical review, or you may initiate binding arbitration, as described below. Binding arbitration is the final process for the resolution of disputes.

Independent Medical Review of Grievances Involving a Disputed Health Care Service
You may request an independent medical review (IMR) of disputed health care services from the Department of Managed Health Care (Department) if you believe that health care services eligible for coverage and payment under your Health Net Plan have been improperly denied, modified or delayed by Health Net or one of its contracting providers. A "Disputed Health Care Service" is any health care service eligible for coverage and payment under your Health Net Plan that has been denied, modified or delayed by Health Net or one of its contracting providers, in whole or in part because the service is not Medically Necessary.

The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of the request for IMR. Health Net will provide you with an IMR application form and Health Net's grievance response letter that states its position on the Disputed Health Care Service. A decision

not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Health Net regarding the Disputed Health Care Service.

Eligibility
Your application for IMR will be reviewed by the Department to confirm that it meets all the eligibility requirements of the law for IMR which are set out below:

1.(A) Your provider has recommended a health care service as Medically Necessary or

(B) You have received urgent or Emergency Care that a provider determined to have been Medically Necessary

(C) In the absence of the provider recommendation described in 1.(A) above, you have been seen by a Health Net Member Physician for the diagnosis or treatment of the medical condition for which you seek IMR;

2. The Disputed Health Care Service has been denied, modified or delayed by Health Net or one of its contracting providers, based in whole or in part on a decision that the health care service is not Medically Necessary; and

3. You have filed a grievance with Health Net and the disputed decision is upheld by Health Net or the grievance remains unresolved after 30 days. Within the next six months, you may apply to the Department for IMR or later, if the Department agrees to extend the application deadline. If your grievance requires expedited review you may bring it immediately to the Department's attention. The Department may waive the requirement that you follow Health Net's grievance process in extraordinary and compelling cases.

If your case is eligible for IMR, the dispute will be submitted to a medical Specialist who will make an independent determination of whether or not the care is Medically Necessary. You will receive a copy of the assessment made in your case from the IMR. If the IMR determines the service is Medically Necessary, Health Net will provide the Disputed Health Care Service. If your case is not eligible for IMR, the Department will advise you of your alternatives.

For non-urgent cases, the IMR organization designated by the Department must provide its determination within 30 days of receipt of the application for review and the supporting documents. For urgent cases involving imminent and serious threat to your health, including, but not limited to, serious Pain, the potential loss of life, limb or major bodily function or the immediate and serious deterioration of your health, the IMR organization must provide its determination within three business days.

For more information regarding the IMR process or to request an application form, please call the Member Services Department at 1-800-539-4072.

Independent Medical Review of Investigational or Experimental Therapies
Health Net does not cover Experimental or Investigational drugs, devices, procedures or therapies. However, if Health Net denies or delays coverage for your requested treatment on the basis that it is Experimental or Investigational and you meet the eligibility criteria set out below, you may request an independent medical review (IMR) of Health Net's decision from the Department of Managed Health Care. The Department does not require you to participate in Health Net's grievance system or appeals process before requesting IMR of denials based on the Investigational or Experimental nature of the therapy. In such cases you may immediately contact the Department to request an IMR of this denial.

Eligibility

1. You must have a life-threatening or seriously debilitating condition.
2. Your Physician must certify to Health Net that you have a life-threatening or seriously debilitating condition for which standard therapies have not been effective in improving your condition or are otherwise medically inappropriate and there is no more beneficial therapy covered by Health Net.
3. Your Physician must certify that the proposed Experimental or Investigational therapy is likely to be more beneficial than available standard therapies or as an alternative, you submit a request for a therapy that, based on documentation you present from the medical and scientific evidence, is likely to be more beneficial than available standard therapies.
4. You have been denied coverage by Health Net for the recommended or requested therapy.
5. If not for Health Net's determination that the recommended or requested treatment is Experimental or Investigational, it would be covered.

If Health Net denies coverage of the recommended or requested therapy and you meet the eligibility requirements, Health Net will notify you within five business days of its decision and your opportunity to request external review of Health Net's decision through IMR. Health Net will provide you with an application form to request an IMR of Health Net's decision. The IMR process is in addition to any other procedures or remedies that may be available to you. You pay no application or processing fees of any kind for IMR. You have the right to provide information in support of your request for IMR. If your Physician determines that the proposed therapy should begin promptly, you may request expedited review and the experts on the IMR panel will render a decision within seven days of your request. If the IMR panel recommends that Health Net cover the recommended or requested therapy, coverage for the services will be subject to the terms and conditions generally applicable to other benefits you are entitled to. A decision not to participate in the IMR process may cause you to forfeit any statutory right to pursue legal action against Health Net regarding the denial of the recommended or requested therapy. For more information, please call the Member Services Department at 1-800-539-4072.

Department of Managed Health Care

The California Department of Managed Health Care is responsible for regulating health care service plans. (Health Net is a health care service plan.)

If you have a grievance against Health Net, you should first telephone Health Net at 1-800-539-4072 and use our grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

If you need help with a grievance involving an Emergency, a grievance that has not been satisfactorily resolved by Health Net, or a grievance that has remained unresolved for more than 30 days, then you may call the Department for assistance.

You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are Experimental or Investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number (1-888-HMO-2219) and a TDD line (1-877-688-9891) for the hearing and speech impaired. The Department' s Internet Web site http://www.hmohelp.ca.gov has complaint forms, IMR application forms and instructions online.

Binding Arbitration

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 any right they may have 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 have no jurisdiction to award more than $200,000. In the event that 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: Litigation Administrator
PO Box 4504
Woodland Hills, CA 91365-4505

The arbitrator is required to follow applicable state or federal law. 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. The award will be final and binding on all parties except to the extent that State or Federal law provides 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 Litigation Administrator 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.

Involuntary Transfer to Another Primary Care Physician or Contracting Physician Group
Health Net has the right to transfer you to another Primary Care Physician or contracting Physician Group under certain circumstances. The following are examples of circumstances that may result in involuntary transfer:

- Refusal to Follow Treatment: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you continually refuse to follow recommended treatment or established procedures of Health Net, the Primary Care Physician, the contracting Physician Group.
- Health Net will offer you the opportunity to develop an acceptable relationship with another Primary Care Physician at the contracting Physician Group, or at another contracting Physician Group, if available. A transfer to another Physician Group will be at Health Net's discretion.
- Disruptive or Threatening Behavior: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you repeatedly disrupt the operations of the Physician Group or Health Net to the extent that the normal operations of either the Physician's office, the contracting Physician Group or Health Net are adversely impacted.
- Abusive Behavior: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you exhibit behavior that is abusive or threatening in nature toward the health care provider, his or her office staff, the contracting Physician Group or Health Net personnel.
- Inadequate Geographic Access to Care: You may be involuntarily transferred to an alternate Primary Care Physician or contracting Physician Group if it is determined that neither your residence nor place of work are within reasonable access to your current Primary Care Physician.

Other circumstances may exist where the treating Physician or Physicians have determined that there is an inability to continue to provide you care because the patient-Physician relationship has been compromised to the extent that mutual trust and respect have been impacted. In the U.S. the treating Physicians and contracting Physician Group must always work within the code of ethics established through the American Medical Association (AMA). (For information on the AMA code of ethics, please refer to the American Medical Association website at http://www.ama-assn.org). Under the code of

ethics, the Physician will provide you with notice prior to discontinuing as your treating Physician that will enable you to contact Health Net and make alternate care arrangements.

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

Medical Malpractice Disputes

Health Net and the health care providers that provide services to you through this Plan are each responsible for their own acts or omissions and are ordinarily not liable for the acts or omissions or costs of defending others.

When A Third Party Causes A Member Injuries

If you are ever injured through the actions of another person (a third party), Health Net will provide benefits for all covered services that you receive through this Plan. However, if you receive money because of your injuries, you must reimburse Health Net or the medical providers for the value of any services provided to you through this Plan.

Examples of how an injury could be caused by the actions of another person:

- You are in a car accident and the other driver is at fault; or
- You slip and fall in a store because a wet spot was left on the floor

Steps You Must Take
Health Net's legal right to reimbursement is called a lien.

If you are injured because of a third party, you must cooperate with Health Net's and the medical providers' efforts to obtain reimbursement, including:

- Telling Health Net and the medical providers the name and address of the third party, if you know it, the name and address of your lawyer, if you are using a lawyer and describing how the injuries were caused.
- Completing any paperwork that Health Net or the medical providers may reasonably require to assist in enforcing the lien;
- Promptly responding to inquiries from the lienholders about the status of the case and any settlement discussions;
- Notifying the lienholders immediately upon you or your lawyer receiving any money from the third parties or their insurance companies; and
- Holding any money that you or your lawyer receive from the parties or their insurance companies in trust and reimbursing Health Net and the medical providers for the amount of the lien as soon as you are paid by the third party.

How the Amount of Your Reimbursement is Determined
Your reimbursement to Health Net or the medical provider under this lien is based on the value of the services you receive and the costs of perfecting this lien. For purposes of determining the lien amount, the value of the services depends on how the provider was paid and will be determined as permitted by law. Unless the money that you receive came from a Workers' Compensation claim, the following applies:

- The amount of the reimbursement that you owe Health Net or the Physician Group will be reduced by the percentage that your recovery is reduced if a judge, jury or arbitrator determines that you were responsible for some portion of your injuries.
- The amount of the reimbursement that you owe Health Net or the Physician Group will also be reduced a pro rated share for any legal fees or costs that you paid from the money you received.
- The amount that you will be required to reimburse Health Net or the Physician Group for services you receive under this Plan will not exceed one-third of the money that you receive if you do engage a lawyer or one-half of the money you receive if you do not engage a lawyer.

Relationship of Parties

Contracting Physician Groups, Member Physicians, Hospitals and other health care providers are not agents or employees of Health Net.

Health Net and its employees are not the agents or employees of any Physician Group, Member Physician, Hospital or other health care provider.

All of the parties are independent contractors and contract with each other to provide you the covered services or supplies of this Plan.

The Group and the Members are not liable for any acts or omissions of Health Net, its agents or employees or of Physician Groups, any Physician or Hospital or any other person or organization with which Health Net has arranged or will arrange to provide the covered services and supplies of this Plan.

Provider/Patient Relationship
Member Physicians maintain a doctor-patient relationship with the Member and are solely responsible for providing professional medical services. Hospitals maintain a Hospital-patient relationship with the Member and are solely responsible for providing Hospital services.

Liability for Charges
While it is not likely, it is possible that Health Net may be unable to pay a Health Net provider. If this happens, the provider has contractually agreed not to seek payment from the Member.

However, this provision only applies to providers who have contracted with Health Net. You may be held liable for the cost of services or supplies received from a noncontracting provider if Health Net does not pay that provider.

This provision does not affect your obligation to pay any required Copayment or to pay for services and supplies that this Plan does not cover.

Prescription Drug Liability
Health Net will not be liable for any claim or demand as a result of damages connected with the manufacturing, compounding, dispensing or use of any Prescription Drug this Plan covers.

Continuity of Care Upon Termination of Provider Contract
If Health Net's contract with a Physician Group or other provider is terminated, Health Net will transfer any affected Members to another contracting Physician Group or provider and make every effort to ensure continuity of care. At least 60-days prior to termination of a contract with a Physician Group or acute care Hospital to which Members are assigned for services, Health Net will provide a written notice to affected Members. For all other Hospitals that terminate their contract with Health Net, a written notice will be provided to affected Members within 5 days after the Effective Date of the contract termination.

In addition, a Member may request continued care from a provider whose contract is terminated if at the time of termination the Member was receiving care from such a provider for:

- An Acute Condition;
- A Serious Chronic Condition not to exceed twelve months from the contract termination date;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- A newborn up to 36 months of age not to exceed twelve months from the contract termination date;
- A Terminal Illness (for the duration of the Terminal Illness); or
- A surgery or other procedure that has been authorized by Health Net as part of a documented course of treatment.

For definitions of Acute Condition, Serious Chronic Condition and Terminal Illness see "Definitions," Section 900.

Health Net may provide coverage for completion of services from a provider whose contract has been terminated, subject to applicable Copayments and any other exclusions and limitations of this Plan and if such provider is willing to accept the same contract terms applicable to the provider prior to the provider's contract termination. You must request continued care within 30 days of the provider's date of termination unless you can show that it was not reasonably possible to make the request within 30 days of the provider's date of termination and you make the request as soon as reasonably possible.

If you would like more information on how to request continued care, or request a copy of our continuity of care policy, please contact the Member Services Department at the telephone number on your Health Net ID Card.

Contracting Administrators
Health Net may designate or replace any contracting administrator that provides the covered services and supplies of this Plan. If Health Net designates or replaces any administrator and as a result procedures change, Health Net will inform you.

Any administrator designated by Health Net is an independent contractor and not an employee or agent of Health Net, unless otherwise specified in this Evidence of Coverage.

Decision-Making Authority
Health Net has discretionary authority to interpret the benefits of this Plan and to determine when services are covered by the Plan.

Coordination of Benefits

The Member's coverage is subject to the same limitations, exclusions and other terms of this Evidence of Coverage whether Health Net is the Primary Plan or the Secondary Plan.

Coordination of benefits (COB) is a process, regulated by law, that determines financial responsibility for payment of allowable expenses between two or more group health plans.

Allowable expenses are generally the cost or value of medical services that are covered by two or more group health plans, including two Health Net Plans.

The objective of COB is to ensure that all group health plans that provide coverage to an individual will pay no more than 100% of the allowable expense for services that are received. This payment will not exceed total expenses incurred or the reasonable cash value of those services and supplies when the group health plan provides benefits in the form of services rather than cash payments.

Health Net's COB activities will not interfere with your medical care.

Coordination of benefits is a bookkeeping activity that occurs between the two HMOs or insurers. However, you may occasionally be asked to provide information about your other coverage.

This coordination of benefits (COB) provision applies when a Member has health care coverage under more than one plan. "Plan" is defined below.

The order of benefit determination rules below determine which plan will pay as the primary plan. The primary plan that pays first pays without regard to the possibility that another plan may cover some expenses. A Secondary Plan pays after the Primary Plan and may reduce the benefits it pays so that payment from all group plans do not exceed 100% of the total allowable expense. "Allowable Expense" is defined below.

Definitions
The following definitions apply to the coverage provided under this Subsection only.

A. "Plan"—A "Plan" is any of the following that provides benefits or services for medical or dental care or treatment. However, if separate contracts are used to provide coordinated coverage for members of a group, the separate contracts are considered parts of the same Plan and there is no COB among those separate contracts.

   (1) "Plan" includes group insurance, closed panel (HMO, PPO or EPO) coverage or other forms of group or group-type coverage (whether insured or uninsured); Hospital indemnity benefits in excess of $200 per day; medical care components of group long-term care contracts, such as skilled nursing care.

   (Medicare is not included as a "Plan" with which Health Net engages in COB. We do, however, reduce benefits of this Plan by the amount paid by Medicare. For Medicare coordination of benefits, please refer to "Government Coverage" portion of this "General Provisions," Section 700.)

   (2) "Plan" does not include nongroup coverage of any type, amounts of Hospital indemnity insurance of $200 or less per day, school accident-type coverage, benefits for nonmedical components of group long-term care policies, Medicare supplement policies, a state plan under Medicaid or a governmental plan that, by law, provides benefits that are in excess of those of any private insurance plan or other non-governmental plan.

Each contract for coverage under (1) and (2) above is a separate Plan. If a Plan has two parts and COB rules apply only to one of the two, each of the parts is treated as a separate Plan.

B. Primary Plan or Secondary Plan—The order of benefit determination rules determine whether this Plan is a "Primary Plan" or "Secondary Plan" when compared to another Plan covering the person.

When this Plan is primary, its benefits are determined before those of any other Plan and without considering any other plan's benefits. When this Plan is secondary, its benefits are determined after those of another Plan and may be reduced because of the primary Plan's benefits.

C. Allowable Expense—This concept means a health care service or expense, including Deductibles and Copayments, that is covered at least in part by any of the plans covering the person. When a Plan provides benefits in the form of services, (for example an HMO) the reasonable cash value of each service will be considered an Allowable Expense and a benefit paid. An expense or service that is not covered by any of the Plans is not an Allowable Expense.

The following are examples of expenses or services that are not Allowable Expense:

(1) If a covered person is confined in a private room, the difference between the cost of a semi-private room in the Hospital and the private room, is not an Allowable Expense.

Exception:

If the patient's stay in a private Hospital room is Medically Necessary in terms of generally accepted medical practice or one of the Plans routinely provides coverage for Hospital private rooms, the expense or service is an Allowable Expense.

(2) If a person is covered by two or more Plans that compute their benefit payments on the basis of usual and customary fees, any amount in excess of the highest of the usual and customary fees for a specific benefit is not an Allowable Expense.

(3) If a person is covered by two or more Plans that provide benefits or services on the basis of negotiated fees, an amount in excess of the highest of the negotiated fees is not an Allowable Expense.

(4) If a person is covered by one Plan that calculates its benefits or services on the basis of usual and customary fees and another Plan that provides its benefits or services on the basis of negotiated fees, the Primary Plan's payment arrangements shall be the Allowable Expense for all Plans.

(5) The amount a benefit is reduced by the Primary Plan because of a covered person does not comply with the plan provisions is not an Allowable Expense.

Examples of these provisions are second surgical opinions, precertification of admissions and preferred provider arrangements.

D. Claim Determination Period—This is the Calendar Year or that part of the Calendar Year during which a person is covered by this Plan.

E. Closed Panel Plan—This is a Plan that provides health benefits to covered persons primarily in the form of services through a panel of providers that have contracted with or are employed by the Plan and that limits or excludes benefits for services provided by other providers, except in cases of emergency or referral by a panel member.

F. Custodial Parent—This is a parent who has been awarded custody of a child by a court decree. In the absence of a court decree, it is the parent with whom the child resided more than half of the Calendar Year without regard to any temporary visitation.

Order of Benefit Determination Rules

If the Member is covered by another group health Plan, responsibility for payment of benefits is determined by the following rules. These rules indicate the order of payment responsibility among Health Net and other applicable group health Plans by establishing which Plan is primary, secondary and so on.

A. Primary or Secondary Plan—The Primary Plan pays or provides its benefits as if the Secondary Plan or Plans did not exist.

B. No COB Provision—A Plan that does not contain a coordination of benefits provision is always primary.

There is one exception: coverage that is obtained by virtue of membership in a group that is designed to supplement a part of a basic package of benefits may provide that the supplementary coverage shall be excess to any other parts of the Plan provided by the contract holder. Examples of these types of situations are major medical coverages that are superimposed over base plan Hospital and surgical benefits and insurance-type coverages that are written in connection with a closed Panel Plan to provide out-of-network benefits.

C. Secondary Plan Performs COB—A Plan may consider the benefits paid or provided by another Plan in determining its benefits only when it is secondary to that other Plan.

D. Order of Payment Rules—The first of the following rules that describes which Plan pays its benefits before another Plan is the rule that will apply.

1. Subscriber (Non-Dependent) vs. Dependent—The Plan that covers the person other than as a dependent, for example as an employee, Subscriber or retiree, is primary and the Plan that covers the person as a dependent is secondary.
2. Child Covered By More Than One Plan—The order of payment when a child is covered by more than one Plan is:
   a. Birthday Rule—The Primary Plan is the Plan of the parent whose birthday is earlier in the year if:
      - The parents are married;
      - The parents are not separated (whether or not they ever have been married); or
      - A court decree awards joint custody without specifying that one party has the responsibility to provide health care coverage.

      If both parents have the same birthday, the plan that covered either of the parents longer is primary.
   b. Court Ordered Responsible Parent—If the terms of a court decree state that one of the parents is responsible for the child's health care expenses or health care coverage and the Plan of that parent has actual knowledge of those terms, that Plan is primary. This rule applies to claim determination periods or plan years commencing after the Plan is given notice of the court decree.

c. Parents Not Married, Divorced or Separated—If the parents are not married or are separated (whether or not they ever have been married) or are divorced, the order of benefits is:
   - The Plan of the Custodial Parent.
   - The Plan of the spouse of the Custodial Parent.
   - The Plan of the noncustodial parent.
   - The Plan of the spouse of the noncustodial parent.

3. Active vs. Inactive Employee—The Plan that covers a person as an employee who is neither laid off nor retired (or his or her dependent), is primary in relation to a Plan that covers the person as a laid off or retired employee (or his or her dependent). When the person has the same status under both Plans, the Plan provided by active employment is first to pay.

   If the other plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.

   Coverage provided an individual by one Plan as a retired worker and by another Plan as a dependent of an actively working spouse will be determined under the rule labeled D (1) above.

4. COBRA Continuation Coverage—If a person whose coverage is provided under a right of continuation provided by federal (COBRA) or state law (similar to COBRA) also is covered under another Plan, the Plan covering the person as an employee or retiree (or as that person's dependent) is primary and the continuation coverage is secondary. If the other Plan does not have this rule and if, as a result, the Plans do not agree on the order of benefits, this rule is ignored.
5. Longer or Shorter Length of Coverage—If the preceding rules do not determine the order or payment, the Plan that covers the Subscriber (non-dependent), retiree or dependent of either for the longer period is primary.
   a. Two Plans Treated As One—To determine the length of time a person has been covered under a Plan, two Plans shall be treated as one if the covered person was eligible under the second within twenty-four hours after the first ended.
   b. New Plan Does Not Include—The start of a new Plan does not include:
      (i) A change in the amount or scope of a Plan's benefits.
      (ii) A change in the entity that pays, provides or administers the Plan's benefits.
      (iii) A change from one type of Plan to another (such as from a single employer Plan to that of a multiple employer Plan).
   c. Measurement of Time Covered—The person's length of time covered under a Plan is measured from the person's first date of coverage under that Plan. If that date is not readily available for a group Plan, the date the person first became a Member of the Group shall be used as the date from which to determine the length of time the person's coverage under the present Plan has been in force.
6. Equal Sharing—If none of the preceding rules determines the Primary Plan, the Allowable Expenses shall be shared equally between the Plans.

Effect on the Benefits of This Plan

A. Secondary Plan Reduces Benefits—When this Plan is secondary, it may reduce its benefits so that the total benefits paid or provided by all plans during a Claim Determination Period are not more than 100% of total Allowable Expenses.

B. Coverage by Two Closed Panel Plans—If a covered person is enrolled in two or more closed Panel Plans and if, for any reason, including the person's having received services from a non-panel provider, benefits are not covered by one closed Panel Plan, COB shall not apply between that plan and other closed Panel Plans.

But, if services received from a non-panel provider are due to an emergency and would be covered by both Plans, then both Plans will provide coverage according to COB rules.

Right to Receive and Release Information

Certain facts about health care coverage and services are needed to apply these COB rules and to determine benefits payable under this Plan and other Plans.

Health Net may obtain the facts it needs from or give them to other organizations or persons for the purpose of applying these rules and determining benefits payable under this Plan and other Plans covering the person claiming benefits.

Health Net need not tell or obtain the consent of any person to do this. Each person claiming benefits under this Plan must give Health Net any facts it needs to apply those rules and determine benefits payable.

Health Net's Right to Pay Others

A "payment made" under another Plan may include an amount that should have been paid under this Plan. If this happens, Health Net may pay that amount to the organization that made the payment. That amount will then be treated as though it were a benefit paid under this Plan. Health Net will not have to pay that amount again.

The term "payment made" includes providing benefits in the form of services, in which case "payment made" means the reasonable cash value of the benefits provided in the form of services.

Recovery of Excessive Payments by Health Net

If the "amount of the payment made" by Health Net is more than it should have paid under this COB provision, Health Net may recover the excess from one or more of the persons it has paid or for whom it has paid or for any other person or organization that may be responsible for the benefits or services provided for the covered person.

"Amount of the payments made" includes the reasonable cash value of any benefits provided in the form of services.

Government Coverage

Medicare
If Medicare has made primary payment or is obligated to do so according to federal law and Health Net has provided services, Health Net will obtain reimbursement from Medicare, any organization or person receiving payments to which Health Net is entitled.

Medi-Cal
Medi-Cal is last to pay in all instances. Health Net will not attempt to obtain reimbursement from Medi-Cal.

Veterans' Administration
Health Net will not attempt to obtain reimbursement from the Department of Veterans' Affairs (VA) for service-connected or nonservice-connected medical care.

Workers' Compensation

This Plan does not replace Workers' Compensation Insurance. Your Group will have separate insurance coverage that will satisfy Workers' Compensation laws.

If you require covered services or supplies and the injury or illness is work-related and benefits are available as a requirement of any Workers' Compensation or Occupational Disease Law, your Physician Group will provide services and Health Net will then obtain reimbursement from the Workers' Compensation carrier liable for the cost of medical treatment related to your illness or injury.

MISCELLANEOUS PROVISIONS

Cash Benefits
Health Net, in its role as a health maintenance organization, generally provides all covered services and supplies through a network of contracting Physician Groups. Your Physician Group performs or authorizes all care and you will not have to file claims.

There is an exception when you receive covered Emergency Care or Urgently Needed Care from a provider who does not have a contract with Health Net.

When cash benefits are due, Health Net will reimburse you for the amount you paid for services or supplies, less any applicable Copayment. If you signed an assignment of benefits and the provider presents it to us, we will send the payment to the provider. You must provide proof of any amounts that you have paid.

If a parent who has custody of a child submits a claim for cash benefits on behalf of the child who is subject to a Medical Child Support Order, Health Net will send the payment to the Custodial Parent.

Benefits Not Transferable
No person other than a properly enrolled Member is entitled to receive the benefits of this Plan. Your right to benefits is not transferable to any other person or entity.

If you use benefits fraudulently, your coverage will be canceled. Health Net has the right to take appropriate legal action.

Notice of Claim
In most instances, you will not need to file a claim to receive benefits this Plan provides. However, if you need to file a claim (for example, for Emergency or Urgently Needed Care from a non-Health Net provider), you must do so within one year from the date you receive the services or supplies. Any claim filed more than one year from the date the expense was incurred will not be paid unless it is shown that it was not reasonably possible to file within that time limit, and that you have filed as soon as was reasonably possible.

Call the Member Services Department at the telephone number shown on your Health Net ID Card to obtain claim forms.

If you need to file a claim for emergency services or for services authorized by your Physician Group or PCP with Health Net, please send a completed claim form to:

Health Net Commercial Claims
P.O. Box 14703
Lexington, KY 40512

If you need to file a claim for Emergency Mental Disorders and Substance Abuse, or for other covered Mental Disorders and Substance Abuse Services provided upon referral by Managed Health Network (MHN), you must file the claim with MHN within one year after receiving those services. Any claim filed more than one year from the date the expense was incurred will not be paid unless it was shown that is was not reasonably possible to file the claim within one year, and that is was filed as soon as reasonably possible. You must use the CMS (HCFA) - 1500 form in filing the claim, and you should send the claim to MHN at the address listed in the claim form or to MHN at:

Managed Health Network
P.O. Box 14621
Lexington, KY 40512-4621

MHN will give you claim forms on request. For more information regarding claims for covered Mental Disorders and Substance Abuse Services, you may call MHN at 1-800-444-4281 or you may write MHN at the address given immediately above.

Health Care Plan Fraud
Health care plan fraud is defined as a deception or misrepresentation by a provider, Member, employer or any person acting on their behalf. It is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care plan by filing a claim that contains a false or deceptive statement is guilty of insurance fraud.

If you are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if you know of or suspect any illegal activity, call Health Net's toll-free Fraud Hotline at 1-800-977-3565. The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

Disruption of Care
Circumstances beyond Health Net's control may disrupt care; for example, 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 contracting Physician Group personnel or a similar event.

If circumstances beyond Health Net's control result in your not being able to obtain the Medically Necessary covered services or supplies of this Plan, Health Net will make a good faith effort to provide or arrange for those services or supplies within the remaining availability of its facilities or personnel. In the case of an emergency, go to the nearest doctor or Hospital. See "Emergency and Urgently Needed Care" section under "Introduction to Health Net," Section 100.

Sending and Receiving Notices
Any notice that Health Net is required to make will be mailed to the Group at the current address shown in Health Net's files. If the Subscriber or the Group is required to provide notice, the notice should be mailed to the corporate office at the address listed on the back cover of this Evidence of Coverage.

CONFIDENTIALITY OF MEDICAL RECORDS
A STATEMENT DESCRIBING HEALTH NET'S POLICIES AND PROCEDURES FOR PRESERVING THE CONFIDENTIALITY OF MEDICAL RECORDS IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST.

Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you about the ways in which Health Net of California and Managed Health Network (referred to as "we" or "the Plan") may collect, use and disclose your protected health information and your rights concerning your protected health information. "Protected health information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or behavioral health or condition, the provision of health care to you or the payment for that care.

We are required by federal and state laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

How We May Use And Disclose Your Protected Health Information

We may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment.

- Payment. We use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment or for premium billing.
- Health Care Operations. We use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or customer service.
- Treatment. We may use and disclose your protected health information to assist your health care providers (doctors, dentists, Hospitals and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.
- Plan Sponsor. If you are enrolled through a group health plan, we may provide non-identifiable summaries of claims and expenses for enrollees in a group health plan to the plan sponsor, which is usually the employer. If the plan sponsor provides plan administration services, we may also provide access to identifiable health information to support its performance of such services which may include but are not limited to claims audits or customer services functions. Health Net will only share health information upon a certification from the plan sponsor representing there are restrictions in place to ensure that only plan sponsor employees with a legitimate need to know will have access to health information in order to provide plan administration functions.

We may also disclose protected health information to a person, such as a family member, relative, or close personal friend, who’s involved with your care or payment. We may disclose the relevant protected health information to these persons if you do not object or we can reasonably infer from the circumstances that you do not object to the disclosure; however, when you are not present or are incapacitated, we can make the disclosure if, in the exercise of professional judgment, we believe the disclosure is in your best interest.

Other Permitted Or Required Disclosures

- As Required by Law. We must disclose protected health information about you when required to do so by law.
- Public Health Activities. We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
- Victims of Abuse, Neglect or Domestic Violence. We may disclose protected health information to government agencies about abuse, neglect or domestic violence.
- Health Oversight Activities. We may disclose protected health information to government oversight agencies (e.g.,California Department of Health Services) for activities authorized by law.
- Judicial and Administrative Proceedings. We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.
- Law Enforcement. We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- Coroners, Funeral Directors, Organ Donation. We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.
- Research. Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.
- To Avert a Serious Threat to Health or Safety. We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- Special Government Functions. We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- Workers' Compensation. We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

Other Uses Or Disclosures With An Authorization

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

Your Rights Regarding Your Protected Health Information

You have certain rights regarding protected health information that the Plan maintains about you.

- Right To Access Your Protected Health Information. You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.

- Right To Amend Your Protected Health Information. If you feel that protected health information maintained by the Plan is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by the Plan, as is often the case for health information in our records or you ask to amend a record that is already accurate and complete.

  If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.
- Right to an Accounting of Disclosures by the Plan. You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

  Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.
- Right To Request Restrictions on the Use and Disclosure of Your Protected Health Information. You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. We may not agree to your request. If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information or both; and (3) to whom you want the restrictions to apply.
- Right To Receive Confidential Communications. You have the right to request that we use a certain method to communicate with you about the Plan or that we send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- Right to a Paper Copy of This Notice. You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.
- Contact Information for Exercising Your Rights. You may exercise any of the rights described above by contacting our privacy office. See the end of this Notice for the contact information.

Health Information Security

Health Net requires its employees to follow the Health Net security policies and procedures that limit access to health information about Members to those employees who need it to perform their job responsibilities. In addition, Health Net maintains physical, administrative and technical security measures to safeguard your protected health information.

Changes To This Notice
We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. We also post a copy of our current Notice on our website at www.healthnet.com/uc. Any time we make a material change to this Notice, we will promptly revise and issue the new Notice with the new Effective Date.

Complaints
If you believe that your privacy rights have been violated, you may file a complaint with us or with the Secretary of the Department of Health and Human Services. All complaints to the Plan must be made in writing and sent to the privacy office listed at the end of this Notice.

We support your right to protect the privacy of your protected health information. We will not retaliate against you or penalize you for filing a complaint.

Contact The Plan
If you have any complaints or questions about this Notice or you want to submit a written request to the Plan as required in any of the previous sections of this Notice, you may send it in writing to:

Address: Health Net Privacy Office
Attention: Director, Information Privacy
P.O. Box 9103
Van Nuys, CA 91409

You may also contact us at:

Telephone: 1-800-539-4072
Fax: 1-818-676-8981
Email: Privacy@healthnet.com

DEFINITIONS

This section defines words that will help you understand your Plan. These words appear throughout this Evidence of Coverage with the initial letter of the word in capital letters.

Acute Conditions is a medical condition that involves a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and that has a limited duration. Completion of covered services shall be provided for the duration of the Acute Condition.

Behavioral Health Administrator is a specialized health care service plan which contracts with Health Net to underwrite and administer delivery of Mental Disorders and Substance Abuse services through a network of Participating Mental Health Practitioners and Participating Mental Health Facilities. Health Net has contracted with Managed Health Network (MHN) to be the Behavioral Health Administrator.

Calendar Year is the twelve-month period that begins at 12:01 a.m. Pacific Time on January 1 of each year.

Copayment is a fee charged to you for covered services when you receive them. The Copayment is due and payable to the provider of care at the time the service is received. The Copayment for each covered service is shown in "Schedule of Benefits and Copayments," Section 200.

Custodial Care is care that is rendered to a patient to assist in support of the essentials of daily living such as help in walking, getting in and out of bed, bathing, dressing, feeding, preparation of special diets and supervision of medications which are ordinarily self-administered and which patient:

- Is disabled mentally or physically and such disability is expected to continue and be prolonged;
- Requires a protected, monitored or controlled environment whether in an institution or in the home; and
- Is not under active and specific medical, surgical or psychiatric treatment that will reduce the disability to the extent necessary to enable the patient to function outside the protected, monitored or controlled environment.

Defined Disease is any deviation from or interruption of the normal structure or function of any part, organ, or system (or combination thereof) of the body that is manifested by a characteristic set of symptoms and signs and whose etiology, pathology and prognosis are known.

Domestic Partner is a person eligible for coverage provided that the partnership with the Subscriber meets all domestic partnership requirements under California law or other recognized state or local agency. The Domestic Partner and Subscriber must:

1. Have a common residence. It is not necessary that the legal right to possess the common residence be in both names.
2. Not be married or a member of another domestic partnership with someone else that has not been terminated, dissolved or judged a nullity.
3. Not be related by blood in a way that would prevent them from being married to each other in this state.
4. Be at least 18 years of age.
5. Be capable of consenting to the domestic partnership.

6. Be either of the following:
   - Members of the same sex; or
   - Members of the opposite sex and one or both be eligible for Social Security benefits and one or both be over the age of 62.
7. Both file a Declaration of Domestic Partnership with the Secretary of State or an equivalent document with another recognized state or local agency, or both are persons of the same sex who have validly formed a legal union other than marriage in a jurisdiction outside of California which is substantially equivalent to a Domestic Partnership as defined under California law

(The requirements listed above are statutory eligibility requirements. Your Group's Domestic Partner eligibility requirements may be less restrictive.)

In the alternative, a person of the opposite sex under age 62 who is the Domestic Partner of the Subscriber is eligible for coverage provided that the partnership meets requirements 1 through 5 above.

Durable Medical Equipment

- Serves a medical purpose (its reason for existing is to fulfill a medical need and it is not useful to anyone in the absence of illness or injury).
- Withstands repeated use.
- Fulfills basic medical needs, as opposed to satisfying personal preferences regarding style and range of capabilities.

Effective Date is the date that you become covered or entitled to receive the benefits this Plan provides.

Emergency Care is any otherwise covered service for an acute illness, a new injury or an unforeseen deterioration or complication of an existing illness, injury or condition already known to the person or, if a minor, to the minor's parent or guardian that a reasonable person with an average knowledge of health and medicine would seek if he or she was having serious symptoms and believed that without immediate treatment, any of the following would occur:

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

Emergency Care also includes treatment of severe Pain or active labor. Active labor means labor at the time that either of the following would occur:

- There is inadequate time to effect safe transfer to another Hospital prior to delivery or
- A transfer poses a threat to the health and safety of the Member or unborn child.

Emergency Care will also include additional screening, examination and evaluation by a Physician (or other health care provider acting within the scope of his or her license) to determine if a psychiatric emergency medical condition exists and the care and treatment necessary to relieve or eliminate such condition, within the capability of the facility.

Health Net will make any final decisions about Emergency Care. See "Independent Medical Review of Grievances Involving a Disputed Health Care Service" under "General Provisions" for the procedure to request Independent Medical Review of a Plan denial of coverage for Emergency Care.

Evidence of Coverage (EOC) is the booklet that Health Net has issued to the enrolled Subscriber, describing the coverage to which you are entitled.

Experimental is any procedure, treatment, therapy, drug, biological product, equipment, device or supply which Health Net has not determined to have been demonstrated as safe, effective or medically appropriate and which the United States Food and Drug Administration (FDA) or Department of Health and Human Services (HHS) has determined to be Experimental or Investigational or is the subject of a clinical trial.

Family Members are dependents of the Subscriber, who meet the eligibility requirements for coverage under this Plan and have been enrolled by the Subscriber.

Follow-Up Care is the care provided after Emergency Care or Urgently Needed Care when the Member's condition, illness or injury has been stabilized and no longer requires Emergency Care or Urgently Needed Care.

Group is the business organization (usually an employer or trust) to which Health Net has issued the Standardized Contract to provide the benefits of this Plan.

Standardized Contract is the contract Health Net has issued to the Group, in order to provide the benefits of this Plan.

Health Net of California, Inc. (herein referred to as Health Net) is a federally qualified health maintenance organization (HMO) and a California licensed health care service plan.

Health Net Service Area is the geographic area in California where Health Net has been authorized by the California Department of Managed Health Care to contract with providers, market products, enroll Members, and provide benefits through approved health plans.

Home Health Care Agency is an organization licensed by the state of California and certified as a Medicare participating provider or accredited by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).

Home Health Care Services are services, including skilled nursing services, provided by a licensed Home Health Care Agency to a Member in his or her place of residence that is prescribed by the Member's attending physician as part of a written plan. Home Health Care Services are covered if the Member is homebound, under the care of a contracting physician, and requires Medically Necessary skilled nursing services, physical, speech, occupational therapy, or respiratory therapy or medical social services. Only Intermittent Skilled Nursing Services, (not to exceed 4 hours a day), are covered benefits under this plan. Private Duty Nursing or shift care is not covered under this plan. See also "Intermittent Skilled Nursing Services" and "Private Duty Nursing."

Home Infusion Therapy is infusion therapy that involves the administration of medications, nutrients, or other solutions through intravenous, subcutaneously by pump, enterally or epidural route (into the bloodstream, under the skin, into the digestive system, or into the membranes surrounding the spinal cord) to a patient who can be safely treated at home. Home Infusion Therapy always originates with a prescription from a qualified physician who oversees patient care and is designed to achieve physician-defined therapeutic end points.

Hospice is a facility or program that provides a caring environment for meeting the physical and emotional needs of the terminally ill. The Hospice and its employees must be licensed according to applicable state and local laws and certified by Medicare.

Hospital is a legally operated facility licensed by the state as an acute care Hospital and approved either by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) or by Medicare.

Intermittent Skilled Nursing Services are services requiring the skilled services of a registered nurse or LVN, which do not exceed 4 hours in every 24 hours.

Investigational approaches to treatment are those that have progressed to limited use on humans but are not widely accepted as proven and effective procedures within the organized medical community. Health Net will decide whether a service or supply is Investigational.

Medical Child Support Order is a court judgment or order that, according to state or federal law, requires employer health plans that are affected by that law to provide coverage to your child or children who are the subject of such an order. Health Net will honor such orders.

Medically Necessary (or Medical Necessity) means health care services that a Physician, exercising prudent clinical judgment, would provide to a patient for the purpose of preventing, evaluating, diagnosing or treating an illness, injury, disease or its symptoms, and that are:

- In accordance with generally accepted standards of medical practice;
- Clinically appropriate, in terms of type, frequency, extent, site and duration, and considered effective for the patient's illness, injury or disease; and
- Not primarily for the convenience of the patient, Physician, or other health care provider, and not more costly than an alternative service or sequence of services at least as likely to produce equivalent therapeutic or diagnostic results as to the diagnosis or treatment of that patient's illness, injury or disease.

For these purposes, "generally accepted standards of medical practice" means standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community, Physician Specialty Society recommendations, the views of Physicians practicing in relevant clinical areas and any other relevant factors.

Medicare is the Health Insurance Benefits for the Aged and Disabled Act, cited in Public Law 89-97, as amended.

Member is the Subscriber or an enrolled Family Member.

Member Physician is a Physician who practices medicine as an associate of a contracting Physician Group.

Mental Disorders are nervous or mental conditions that meet all of the following criteria:

- It is a clinically significant behavioral or psychological syndrome or pattern;
- It is associated with a painful symptom, such as distress;
- It impairs a patient's ability to function in one or more major life activities; or
- It is a condition listed as an Axis I Disorder (excluding V Codes) in the most recent edition of the DSM by the American Psychiatric Association.

Nurse Practitioner (NP) is a registered nurse certified as a Nurse Practitioner by the California Board of Registered Nursing. The NP, through consultation and collaboration with Physicians and other health providers, may provide and make decisions about, health care.

Open Enrollment Period is a period of time each Calendar Year, during which individuals who are eligible for coverage in this Plan may enroll for the first time or Subscribers, who were enrolled previously, may add their eligible dependents. Enrolled Members can also change Physician Groups at this time.

The Group decides the exact dates for the Open Enrollment Period.

Changes requested during the Open Enrollment Period become effective on the first day of the calendar month following the date the request is submitted or on any date approved by Health Net.

Out-of-Pocket Maximum is the maximum amount of Copayments you must pay for Covered Services for each Calendar Year. It is your responsibility to inform Health Net when you have satisfied the Out-of-Pocket Maximum, so it is important to keep all receipts for Copayments that were actually paid. Deductibles and Copayments, which are paid toward certain covered services, are not applicable to your Out-of-Pocket Maximum and these exceptions are specified in "Out-of-Pocket Maximum," Section 300.

Outpatient Surgical Center is a facility other than a medical or dental office, whose main function is performing surgical procedures on an outpatient basis. It must be licensed as an outpatient clinic according to state and local laws and must meet all requirements of an outpatient clinic providing surgical services.

Pain means a sensation of hurting or strong discomfort in some part of the body caused by an injury, illness, disease, functional disorder or condition.

Participating Mental Health Facility is a Hospital, residential treatment center, structured outpatient program, day treatment, partial hospitalization program, or other mental health care facility that has signed a service contract with the Behavioral Health Administrator, to provide Mental Disorder and Substance Abuse benefits.

This facility must be licensed by the state of California to provide acute or intensive psychiatric care, detoxification services or Substance Abuse rehabilitation services.

Participating Mental Health Professional is a Physician or other professional who is licensed by the state of California to provide mental health care. The Participating Mental Health Professional must have a service contract with the Behavioral Health Administrator to provide Mental Disorder and Substance Abuse rehabilitation services.

Physician is a doctor of medicine (M.D.) or a doctor of osteopathy (D.O.).

Physician Assistant is a health care professional certified by the state as a Physician Assistant and authorized to provide medical care when supervised by a Physician.

Physician Group is a group of Physicians, who are organized as a legal entity, that has an agreement in effect with Health Net to provide medical care to Health Net Members. They are sometimes referred to as a "contracting Physician Group" or "Participating Physician Group (PPG)." Another common term is "a medical group." An individual practice association may also be a Physician Group.

Plan is the health benefits purchased by the Group and described in the Standardized Contract and this Evidence of Coverage.

Primary Care Physician is a Member Physician who coordinates and controls the delivery of covered services and supplies to the Member. Primary Care Physicians include general and family practitioners, internists, pediatricians and obstetricians/gynecologists.

Prior Authorization is Health Net's approval process for certain Level I, Level II or Level III Drugs that require pre-approval. Member Physicians must obtain Health Net's Prior Authorization before certain Level I, Level II or Level III Drugs will be covered.

Private Duty Nursing means continuous nursing services provided by a licensed nurse (RN, LVN or LPN) for a patient who requires more care than is normally available during a home health care visit or is normally and routinely provided by the nursing staff of a hospital or skilled nursing facility. Private Duty Nursing includes nursing services (including intermittent services separated in time, such as 2 hours in the morning and 2 hours in the evening) that exceeds a total of four hours in any 24-hour period. Private Duty Nursing may be provided in an inpatient or outpatient setting, or in a non-institutional setting, such as at home or at school. Private Duty Nursing may also be referred to as "shift care."

Residential Treatment Center is a twenty-four hour, structured and supervised group living environment for children, adolescents or adults where psychiatric, medical and psychosocial evaluation can take place, and distinct and individualized psychotherapeutic interventions can be offered to improve their level of functioning in the community. Health Net requires that all contracted Residential Treatment Centers must be appropriately licensed by their state in order to provide residential treatment services.

Serious Chronic Condition is a medical condition due to a disease, illness, or other medical problem or medical disorder that is serious in nature and that persists without full cure or worsens over an extended period of time or requires ongoing treatment to maintain remission or prevent deterioration

Serious Emotional Disturbances of a Child is when a child under the age of 18 has one or more Mental Disorders identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or a developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following:

- As a result of the Mental Disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home or (ii) the Mental Disorder and impairments have been present for more than six months or are likely to continue for more than one year;
- The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a Mental Disorder; or
- The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Severe Mental Illness include schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorders, pervasive developmental disorder (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with the most recent edition of the Diagnostic and Statistical Manual for Mental Disorders), autism, anorexia nervosa and bulimia nervosa.

Skilled Nursing Facility is an institution that is licensed by the appropriate state and local authorities to provide skilled nursing services. In addition, Medicare must approve the facility as a participating Skilled Nursing Facility.

Specialist is a Member Physician who delivers specialized services and supplies to the Member. Any Physician other than an obstetrician/gynecologist acting as a Primary Care Physician, general or family practitioner, internist or pediatrician is considered a Specialist. With the exception of well-woman visits to an obstetrician/gynecologist, all Specialist visits must be referred by your Primary Care Physician to be covered.

Subscriber is the principal eligible, enrolled Member. The Subscriber must meet the eligibility requirements established by the Group and agreed to by Health Net as well as those described in this Evidence of Coverage. An eligible employee (who becomes a Subscriber upon enrollment) may enroll members of his or her family who meet the eligibility requirements of the Group and Health Net.

Substance Abuse is alcoholism, drug addiction or other substance abuse problems.

Substance Abuse Care Facility is a Hospital, residential treatment center, structured outpatient program, day treatment or partial hospitalization program or other behavioral health care facility that is licensed to provide Substance Abuse detoxification services or rehabilitation services.

Terminal Illness is an incurable or irreversible condition that has a high probability of causing death within one year or less. Completion of covered services shall be provided for the duration of a Terminal Illness.

UC Standardized Contract is the contract Health Net has issued to the Group, in order to provide the benefits of this Plan.

Urgently Needed Care is any otherwise covered medical service that a reasonable person with an average knowledge of health and medicine would seek for treatment of an injury, unexpected illness or complication of an existing condition, including pregnancy, to prevent the serious deterioration of his or her health, but which does not qualify as Emergency Care, as defined in this section. This may include services for which a person should reasonably have known an emergency did not exist.

PLAN ADMINISTRATION

By authority of The Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this Plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the Group Hospital and Professional Service Agreement. What is written in this document and/or the Group Insurance Contracts does not constitute a guarantee of plan coverage or benefits--particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

This section describes how the Plan is administered and what your rights are.

Sponsorship and Administration of the Plan

The University of California is the Plan sponsor for the Plan described in this booklet. If you have a question, you may direct it to:

University of California
Human Resources and Benefits
Health & Welfare Administration
300 Lakeside Drive, 12th Floor
Oakland, CA 94612
(800) 888-8267

Retirees may also direct questions to the University's Customer Service Center at the above phone number.

Claims under the Plan are processed by Health Net at the following address and phone number:

HEALTH NET
P.O. Box 9103
Van Nuys, CA 91409-9103
1-800-539-4072

Group Contract Number

The Group Contract Number for this Plan is: 92-2557406

Type of Plan

This Plan is a health and welfare plan that provides group medical care benefits. This Plan is one of the benefits offered under the University of California's employee health and welfare benefits program.

Plan Year

The plan year is January 1 through December 31.

Continuation of the Plan

The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. Plan benefits are not accrued or vested benefit entitlements. The right to terminate or amend applies to all Employees, Retirees and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums and what portion of the premiums the University will pay. The portion of the premiums that University pays is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation.

Financial Arrangements

The benefits under the Plan are provided by Health Net under a UC Standardized Contract . The monthly cost of the premiums are currently shared between you and the University of California.

Agent for Serving of Legal Process

Legal process may be served on Health Net at the address listed above.

Your Rights under the Plan

As a participant in a University of California medical plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office and other specified sites, all Plan documents, including the UC Standardized Contract, at a time and location mutually convenient to the participant and the Plan Administrator.

Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Claims under the Plan

To file a claim or to appeal a denied claim, refer to pages 55 and 67 of this document.

Nondiscrimination Statement

In conformance with applicable law and University policy, the University of California is an affirmative action/equal opportunity employer.

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director of Diversity and Employee Programs, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Director of Academic Affirmative Action, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

INDEX (MED COB DOCUMENT ONLY)

Contact us:

Health Net
Post Office Box 9103
Van Nuys, California 91409-9103

Customer Contact Center

1-800-539-4072 or www.healthnet.com/uc

1-800-331-1777 (Spanish)

1-877-891-9053 (Mandarin)

1-877-891-9050 (Cantonese)

1-877-339-8596 (Korean)

1-877-891-9051 (Tagalog)

1-877-339-8621 (Vietnamese)

Telecommunications Device for
the Hearing and Speech Impaired

1-800-995-0852

MEDICARE COB

Health Net
Medicare Programs

EVIDENCE OF COVERAGE

Medicare Prescription Drug Plan

For University of California Medicare members in Fresno, Madera, Nevada or Ventura Counties

Plan PN8
EOCID 193612:

EVIDENCE OF COVERAGE:

Your Medicare Part D prescription drug coverage as a Member of Health Net

This Evidence of Coverage gives the details about your Medicare Part D prescription drug coverage. It is an important legal document. Please keep it in a safe place.

Health Net of California, Inc. (Health Net) Member Services:

For help or information, please call Member Services, 8:00 am to 8:00 p.m., 7 days a week. A Member Services representative will be available to answer your call directly during the annual enrollment period and 60 days after from 8 am until 8 pm. However, after March 2, 2008, your call will be handled by our automated phone system on Saturdays, Sundays and holidays. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than the next business day). Calls to these numbers are free:

Phone: 1-800-539-4072

TTY/TDD: 1-800-929-9955 (This number is for people who have difficulties with hearing or speech. You need special telephone equipment to use this number.)

WEB SITE: WWW.HEALTHNET.COM/UC

BENEFITS AT A GLANCE

This is your Evidence of Coverage booklet for your Medicare Part D Prescription Drug plan. For your medical benefits, please refer to your Medicare Coordination of Benefits (COB) Evidence of Coverage booklet.

Additional Requirements or restrictions on when you can get covered drugs

We cover the drugs listed in the Formulary. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. The requirements for coverage or limits on certain drugs are listed as follows:

- Prior Authorization: We require you to get Prior Authorization for certain drugs. This means that you or your doctor will need to get approval from us before you fill your prescription. If they don't get approval, we may not cover the drug.
- Quantity Limits: For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. For example, we will provide up to 6 tablets per prescription for ZITHROMAX. This limit will replace your standard 30 or 90 day supply.
- Step Therapy: In somecases, we require you to first try one drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.
- Generic Substitution: When there is a generic version of a brand name drug available, our Network Pharmacies will automatically give you the generic version, unless your doctor has told us that you must take the Brand Name Drug. If you choose to fill your prescription with a Brand Name Drug when a generic equivalent is available, you may be responsible for a higher copayment and/or the difference in cost between the Brand and Generic Drug.
- Age Limits: Some drugs may require Prior Authorization if your age does not meet manufacturer, Food and Drug Administration, or clinical recommendations.
- Gender Limit: Some drugs are only covered for males or females based on manufacturer, Food and Drug Administration, or clinical recommendations.
- Therapy Limit: Some drugs are only covered for a specific length of time based on manufacturer, Food and Drug administration, or clinical recommendations.

If your physician determines that you are not able to meet a Prior Authorization, Quantity Limit, Step Therapy restriction, generic substitution, or other utilization management requirement for medical necessity reasons, you or your physician may request an exception. See Section 6 to learn more about how to request an exception.

Replacement for lost or stolen medications are not covered.

Benefits

What follows is a brief description of the cost-sharing amounts you are responsible for as a Member of our plan. For more information, please refer to Section 4 - Prescription Drug Coverage of this document.

Note: If you get extra help from Medicare to help pay for your prescription drug costs you will get a document called, "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs". The document will list the cost-sharing amounts you are responsible for once you receive extra help from Medicare. For more information about getting extra help from Medicare, please see Section 2 of this document.

Deductible
This Plan does not have a Deductible.

Initial Coverage Period
During the initial coverage level, we will pay part of the costs for your Covered Drugs and you (or others on your behalf) will pay the other part. The amount you pay when you fill a covered prescription is called the copayment/coinsurance. Your copayment/coinsurance will vary depending on the drug and where the prescription is filled.

Drug Tier	Retail Co-payment/Co-insurance (30-day supply)	Retail Co-payment/Co-insurance (90-day supply)	Mail-Order or obtained through the UC Walk-Up Service Co-payment/Co-Insurance (90-day supply)
Tier 1 – Preferred Generic Drug	$10	$30	$20
Tier 2 – Preferred Brand Drug	$20	$60	$40
Tier 3 – Non-Preferred Generic and Brand Drugs	$35	$105	$70
Sexual Dysfunction Drugs	50%	N/A	N/A
Specialty Tier I and Specialty Tier S Drugs	25%	25%	N/A

Notes:

- Generic drugs will be dispensed when a Generic Drug equivalent is available. If you request a Brand Name Drug when a generic equivalent is commercially available, you must pay the difference between the generic equivalent and the Brand Name Drug plus the applicable copayment. However, if the prescription drug order states "dispense as written," "do not substitute" or words of similar meaning in the physician's handwriting, you will only be responsible for the applicable copayment.
- After your yearly out-of-pocket drug costs reach $2,000, excluding any generic substitution costs, copayments and coinsurances will not be required for the remainder of the calendar year until you qualify for Catastrophic Coverage.
- Prescription drugs for the treatment of diabetes (including insulin) are covered as stated in the Formulary, specific brands of blood glucose monitors and testing strips, Ketone test strips, lancet puncture devices and lancets when used in monitoring blood glucose levels.
- Drugs (including injectable medications) when Medically Necessary for treating sexual dysfunction are limited to two doses per week or eight tablets per month. Sexual Dysfunction drugs are not available through the mail order program.
- Covered Medicare Part D Drugs are available at Out-of-Network Pharmacies in special circumstances including illness while traveling outside of the Plan's service area where there is no Network Pharmacy. In these circumstances, your copayments will be the same as retail pharmacy copayments described above.
- Some retail pharmacies may provide up to a 90-day supply of maintenance medication for a copayment per 30-day supply. Please check with your retail pharmacy to see if this service is available to you.
- Your provider must get Prior Authorization from Health Net for certain prescription drugs. Contact Health Net for details.

Plan Specific Out-of-Pocket Maximum for Outpatient Prescription drugs

Once you have spent $2,000, excluding any generic substitution costs (the difference in cost between a brand name and generic drug), your copayment/coinsurance will be waived for the remainder of the year. All expenses that apply to the $2000 out-of-pocket maximum will automatically be calculated by Health Net. Generic substitution costs for Part D drugs will apply towards the $4,050 Medicare Catastrophic Coverage limit, stated below.

Catastrophic Coverage

Once you, and/or others on your behalf, spend $4,050 out-of-pocket for the year for covered Part D drugs, including any additional charges you paid for requesting a brand over a generic, you will qualify for Catastrophic Coverage. During Catastrophic Coverage you will pay the greater of:

- $2.25 for generics or drugs that are treated like generics and $5.60 for all other drugs; or
- 5% coinsurance.

We will pay the rest. Note that your co-insurance payment for each prescription drug order will not exceed $10 for preferred Generic Drugs, $20 for preferred brand drugs and $35 for nonpreferred generic and brand drugs.

Transition Policy

New members in our plan may be taking drugs that are not on our Formulary, or that are subject to certain restrictions, such as Prior Authorization or Step Therapy. Members should talk to their doctors to decide if they should switch to an appropriate drug that we cover or request a Formulary Exception (which is a type of Coverage Determination) in order to get coverage for the drug. See Section 6 (Appeals and Grievance: What to do if you have complaints) to learn more about how to request an Exception. While these new members might talk to their doctors to determine the right course of action, we may cover the non-Formulary drug in certain cases during the first 90 days of new membership.

For each of the drugs that is not on our Formulary or that have coverage restrictions or limits, we will cover a temporary 60 day supply (unless the prescription is written for fewer days) when the new Member goes to a Network Pharmacy and the drug is otherwise a "Part D drug". After the first 60-day supply, we generally will not pay for these drugs as part of our transition policy again. We will provide you with a written notice after we cover your temporary supply. This notice will explain the steps you can take to request an exception and how to work with your doctor to decide if you should switch to an appropriate drug that we cover

If the new Member is a resident of a long-term care facility, we will cover a temporary 102-day transition supply (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days for a new Member of our plan who is a resident of a long-term care facility. If a new Member who is a resident of a long-term care facility needs a drug that is not on our Formulary or subject to other restrictions, such as Step Therapy or dosage limits, but the new Member is past the first 90 days of new membership in our plan, we will cover a 34-day emergency supply of that drug (unless the prescription is for fewer days) while the new Member pursues a Formulary Exception.

If a Member is a resident of a long-term care facility but is moving to a non-long-term care facility (e.g., home), we will cover a temporary 30-day supply. If a Member is not a resident of a long-term care facility (e.g., living at home) but is moving to a long-term care setting, we will cover a temporary 34-day supply.

Please note that our transition policy applies only to those drugs that are "Part D Drugs" and that are purchased at a Network Pharmacy. If a Member is a resident of a long-term care facility, but obtains drugs from an out-of-network long-term care pharmacy, we will cover these drugs if certain conditions apply. See "Filling prescriptions outside the network" in Section 1 for more information. The transition policy could not be used to purchase a non-Part D drug or a drug out-of-network, unless the individual qualifies for out-of-network access.

What is the geographic Service Area for our Plan?

This Plan's geographic Service Area includes all counties in the State of California.

If you move out of California, you must contact your Group to update your information. Employer-sponsored coverage may not be available to you in all states. Please check with your employer group for their service area coverage.

How to contact our Plan's Member Service

If you have any questions or concerns, please call or write to Member Service. We will be happy to help you. Our business hours are 8:00 a.m. to 8:00 p.m., 7 days a week.

CALL 1-800-539-4072. This number is also on the cover of this Evidence of Coverage for easy reference. Calls to this number are free.

TTY/TDD 1-800-929-9955. This number requires special telephone equipment. It is on the cover of this Evidence of Coverage for easy reference. Calls to this number are free.

WRITE Health Net Medicare Programs
PO Box 1728
Augusta, GA 30903-1728

WEB SITE www.healthnet.com/uc

UNIVERSITY OF CALIFORNIA

ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS

January 1, 2008

The following information applies to the University of California plan and supersedes any corresponding information that may be contained elsewhere in the document to which this insert is attached. The University establishes its own medical plan eligibility, enrollment and termination criteria based on the University of California Group Insurance Regulations ("Regulations") and any corresponding Administrative Supplements. Portions of these Regulations are summarized below.

ELIGIBILITY

The following individuals are eligible to enroll in this Plan. If the Plan is a Health Maintenance Organization (HMO) or Exclusive Provider Organization (EPO) Plan, they are only eligible to enroll in the plan if they meet the Plan's geographic service area criteria. Anyone enrolled in a non-University Medicare Advantage Managed Care contract or enrolled in a non-University Medicare Part D Prescription Drug Plan will be deenrolled from this health plan.

Subscriber

Employee: You are eligible if you are appointed to work at least 50% time for twelve months or more or are appointed at 100% time for three months or more or have accumulated 1,000***** hours while on pay status in a twelve-month period. To remain eligible, you must maintain an average regular paid time****** of at least 17.5 hours per week and continue in an eligible appointment. If your appointment is at least 50% time, your appointment form may refer to the time period as follows: "Ending date for funding purposes only; intent of appointment is indefinite (for more than one year)."

* Lecturers - see your benefits office for eligibility.

** Average Regular Paid Time - For any month, the average number of regular paid hours per week (excluding overtime, stipend or bonus time) worked in the preceding twelve (12) month period. Average regular paid time does not include full or partial months of zero paid hours when an employee works less than 43.75% of the regular paid hours available in the month due to furlough, leave without pay or initial employment.

Retiree: A former University Employee receiving monthly benefits from a University-sponsored defined benefit plan.

You may continue University medical plan coverage as a Retiree when you start collecting retirement or disability benefits from a University-sponsored defined benefit plan. You must also meet the following requirements:

(a) you meet the University's service credit requirements for Retiree medical eligibility;

(b) the effective date of your Retiree status is within 120 calendar days of the date employment ends (or the date of the (c)Employee/Retiree's death for a Survivor); and
(c) you elect to continue medical coverage at the time of retirement.

A **Survivor**—a deceased Employee's or Retiree's Family Member receiving monthly benefits from a University-sponsored defined benefit plan—may be eligible to continue coverage as set forth in the University's Group Insurance Regulations. For more information, see the UC *Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members*.

If you are eligible for Medicare, you must follow UC's Medicare Rules. See "Effect of Medicare on Retiree Enrollment" below.

Eligible Dependents (Family Members)

When you enroll any Family Member, your signature on the enrollment form or the confirmation number on your electronic enrollment attests that your Family Member meets the eligibility requirements outlined below. The University and/or the Plan reserves the right to periodically request documentation to verify eligibility of Family Members including any who are required to be your tax dependent(s). Documentation could include a marriage certificate, birth certificate(s), adoption records, Federal Income Tax Return, or other official documentation.

Spouse: Your legal spouse.

Child: All eligible children must be under the limiting age (18 for legal wards, 23 for all others), unmarried, and may not be emancipated minors. The following categories are eligible:

(a) your natural or legally adopted children;
(b) your stepchildren (natural or legally adopted children of your spouse) if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;
(c) grandchildren of you or your spouse if living with you, dependent on you or your spouse for at least 50% of their support and are your or your spouse's dependents for income tax purposes;
(e) children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental disability may continue to be covered past age 23 provided:

- the incapacity began before age 23, the child was enrolled in a group medical plan before age 23 and coverage is continuous;

- the child is claimed as your dependent for income tax purposes or is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment which may offset the Social Security or Supplemental Security Income; and
- the child lives with you if he or she is not your or your spouse's natural or adopted child.

Application must be made to the Plan at least 31 days before the child's 23rd birthday and is subject to approval by the Plan. The Plan may periodically request proof of continued disability. Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If you are a newly hired Employee with an incapacitated child, you may also apply for coverage for that child. The child must have had continuous group medical coverage since age 23, and you must apply for University coverage during your Period of Initial Eligibility.

Other Eligible Dependents (Family Members): You may enroll a same-sex domestic partner (and the same-sex domestic partner's children/grandchildren/stepchildren) as set forth in the University of California Group Insurance Regulations.

The University will recognize an opposite-sex domestic partner as a family member that is eligible for coverage in UC-sponsored benefits if the employee/retiree or domestic partner is age 62 or older and eligible to receive Social Security benefits and both the employee/retiree and domestic partner are at least 18 years of age.

An adult dependent relative is no longer eligible for coverage. Only an adult dependent relative who was enrolled as an eligible dependent as of December 31, 2003 may continue coverage in UC-sponsored plans.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, a Retiree, a Survivor or a Family Member, but not under any combination of these. If an Employee and the Employee's spouse or domestic partner are both eligible Subscribers, each may enroll separately or one may cover the other as a Family Member. If they enroll separately, neither may enroll the other as a Family Member. Eligible children may be enrolled under either parent's or eligible domestic partner's coverage but

not under both. Additionally, a child who is also eligible as an Employee may not have dual coverage through two University-sponsored medical plans.

More Information

For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's Customer Service Center. You may also access eligibility factsheets on the web site: http://atyourservice.ucop.edu.

Enrollment

For information about enrolling yourself or an eligible Family Member, see the person at your location who handles benefits. If you are a Retiree, contact the University's Customer Service Center. Enrollment transactions may be completed by paper form or electronically, according to current University practice. To complete the enrollment transaction, paper forms must be received by the local Accounting or Benefits office or by the University's Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by midnight of the last day of the enrollment period.

During a Period of Initial Eligibility (PIE)

A PIE ends 31 days after it begins.

If you are an Employee, you may enroll yourself and any eligible Family Members during your PIE. Your PIE starts the day you become an eligible Employee.

You may enroll any newly eligible Family Member during his or her PIE. The Family Member's PIE starts the day your Family Member becomes eligible, as described below. During this PIE you may also enroll yourself and/or any other eligible Family Member if not enrolled during your own or their own PIE. You must enroll yourself in order to enroll any eligible Family Member. Family members are only eligible for the same plan in which you are enrolled.

(a) For a spouse, on the date of marriage.

(b) For a natural child, on the child's date of birth.

(c) For an adopted child, the earlier of:

  (i) the date you or your Spouse has the legal right to control the child's health care, or

  (ii) the date the child is placed in your physical custody. If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.

(d) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you decline enrollment for yourself or your eligible Family Members because of other group medical plan coverage and you lose that coverage involuntarily (or if the employer stops contributing toward the other coverage for you or your Family Members), you may be able to enroll yourself and those eligible Family Members during a PIE that starts on the day the other coverage is no longer in effect.

If you are in an HMO, POS or EPO Plan and you move or are transferred out of that Plan's service area, or will be away from the Plan's service area for more than two months, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan. Your PIE starts with the effective date of the move or the date you leave the Plan's service area.

At Other Times For Employees And Retirees

You and your eligible Family Members may also enroll during a group open enrollment period established by the University.

If you are an Employee and opt out of medical coverage or fail to enroll yourself during a PIE or open enrollment period, you may enroll yourself at any other time upon completion of a 90 consecutive calendar day waiting period.

If you are an Employee or Retiree and fail to enroll your eligible Family Members during a PIE or open enrollment period, you may enroll your eligible Family Members at any other time upon completion of a 90 consecutive calendar day waiting period.

The 90-day waiting period starts on the date the enrollment form is received by the local Accounting or Benefits office and ends 90 consecutive calendar days later.

If you have one or more children enrolled in the Plan, you may add a newly eligible Child at any time. See "Effective Date".

If you are an Employee or a Retiree and there is a lifetime maximum for all benefits under this plan, and you or a Family Member reaches that maximum, you and your eligible Family Members may be eligible to enroll in another UC-sponsored medical plan. Contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

If you are a Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan (or its Medicare version) you were enrolled in immediately before retiring. You must elect to continue enrollment for yourself and enrolled Family Members before the effective date of retirement (or the date disability or survivor benefits begin).

If you are a Survivor, you may not enroll your legal spouse or domestic partner.

UNIVERSITY OF CALIFORNIA

ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS

January 1, 2008

Effective Date

The following effective dates apply provided the appropriate enrollment transaction (paper form or electronic) has been completed within the applicable enrollment period.

If you enroll during a PIE, coverage for you and your Family Members is effective the date the PIE starts.

If you are a Retiree continuing enrollment in conjunction with retirement, coverage for you and your Family Members is effective on the first of the month following the first full calendar month of retirement income.

The effective date of coverage for enrollment during an open enrollment period is the date announced by the University.

For enrollees who complete a 90-day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment transaction is completed.

An Employee or Retiree already enrolled in adult plus child(ren) or family coverage may add additional children, if eligible, at any time after their PIE. Retroactive coverage is limited to the later of:

(a) the date the Child becomes eligible, or

(b) a maximum of 60 days prior to the date your Child's enrollment transaction is completed.

Change in Coverage

In order to change from single to adult plus child(ren) coverage, or two adult coverage, or family coverage, or to add another Child to existing family coverage, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Effect of Medicare on Retiree Enrollment

If you are a Retiree and you and/or an enrolled Family Member is or becomes eligible for premium-free Medicare Part A (Hospital Insurance) as primary coverage, then that individual must also enroll in and remain in Medicare Part B (Medical Insurance). Once Medicare coverage is established, coverage in both Part A and Part B must be continuous. This includes anyone who is entitled to Medicare benefits through their own or their spouse's employment. Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this plan.

Retirees or their Family Member(s) who become eligible for premium-free Medicare Part A on or after
January 1, 2004 and do not enroll in Part B will permanently lose their UC-sponsored medical coverage.

Retirees and their Family Members who were eligible for premium-free Medicare Part A prior to January 1, 2004, but declined to enroll in Part B of Medicare, are assessed a monthly offset fee by the University to cover increased costs. The offset fee may increase annually, but will stop when the Retiree or Family Member becomes covered under Part B.

Retirees or Family Members who are not eligible for premium-free Part A will not be required to enroll in Part B, they will not be assessed an offset fee, nor will they lose their UC-sponsored medical coverage. Documentation attesting to their ineligibility for Medicare Part A will be required. (Retirees/Family Members who are not entitled to Social Security and premium-free Medicare Part A will not be required to enroll in Part B.)

An exception to the above rules applies to Retirees or Family Members in the following categories who will be eligible for the non-Medicare premium applicable to this plan and will also be eligible for the benefits of this plan without regard to Medicare:

(a) Individuals who were eligible for premium-free Part A, but not enrolled in Medicare Part B prior to July 1, 1991.

(b) Individuals who are not eligible for premium-free Part A.

You should contact Social Security three months before your or your Family Member's 65th birthday to inquire about your eligibility and how to enroll in the Hospital (Part A) and Medical (Part B) portions of Medicare. If you qualify for disability income benefits from Social Security, contact a Social Security office for information about when you will be eligible for Medicare enrollment.

Upon Medicare eligibility, you or your Family Member must complete a University of California Medicare Declaration form, as well as submit a copy of your Medicare card. This notifies the University that you are covered by Part A and Part B of Medicare. The University's Medicare Declaration form is available through the University's Customer Service Center or from the web site: http://atyourservice.ucop.edu. Completed forms should be returned to University of California, Human Resources and Benefits, Health & Welfare Administration-Retiree Insurance Program, Post Office Box 24570, Oakland, CA 94623-9911.

Any individual enrolled in a University-sponsored Medicare Advantage Managed Care Contract must assign his/her Medicare benefit to that plan or lose UC-sponsored medical coverage. Anyone enrolled in a non-University Medicare Advantage Managed Care contract or enrolled in a non-University Medicare Part D Prescription Drug Plan will be deenrolled from this health plan.

Medicare Secondary Payer Law (MSP)

The Medicare Secondary Payer (MSP) Law affects the order in which claims are paid by Medicare and an employer group health plan. UC Retirees re-hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to MSP. For Employees or their spouses who are age 65 or older and eligible for a group health plan due to employment, MSP indicates that Medicare becomes the secondary payer and the employer plan becomes the primary payer. You should carefully consider the impact on your health benefits and premiums should you decide to return to work after you retire.

Medicare Private Contracting Provision and Providers Who do Not Accept Medicare

Federal Legislation allows physicians or practitioners to opt out of Medicare. Medicare beneficiaries wishing to continue to obtain services **(that would otherwise be covered by Medicare)** from these physicians or practitioners will need to enter into written "private contracts" with these physicians or practitioners. These private agreements will require the beneficiary to be responsible for all payments to such medical providers. Since services provided under such "private contracts" are not covered by Medicare or this Plan, the Medicare limiting charge will not apply.

Some physicians or practitioners have **never** participated in Medicare. Their services (that would be covered by Medicare if they participated) will not be covered by Medicare or this Plan, and the Medicare limiting charge will not apply.

If you are classified as a Retiree by the University (or otherwise have Medicare as a primary coverage), are enrolled in Medicare Part B, and choose to enter into such a "private contract" arrangement as described above with one or more physicians or practitioners, or if you choose to obtain services from a provider who does not participate in Medicare, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. In either case, no benefits will be paid by this Plan for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered. Therefore, it is important that you confirm that your provider takes Medicare prior to obtaining services for which you wish the Plan to pay.

However, even if you do sign a private contract or obtain services from a provider who does not participate in Medicare, you may still see other providers who have not opted out of Medicare and receive the benefits of this Plan for those services.

TERMINATION OF COVERAGE

The termination of coverage provisions that are established by the University of California in accordance with its Regulations are described below. Additional Plan provisions apply and are described elsewhere in the document.

Deenrollment Due to Loss of Eligible Status

If you are an Employee and lose eligibility, your coverage and that of any enrolled Family Member stops at the end of the last month in which premiums are taken from earnings based on an eligible appointment.

If you are a Retiree or Survivor and your annuity terminates, your coverage and that of any enrolled Family Member stops at the end of the last month in which you are eligible for an annuity.

If your Family Member loses eligibility, you must complete the appropriate transaction to delete him or her within 60 days of the date the Family Member is no longer eligible. Coverage stops at the end of the month in which he or she no longer meets all the eligibility requirements. For information on deenrollment procedures, contact the person who handles benefits at your location (or the University's Customer Service Center if you are a Retiree).

Deenrollment Due to Fraud

Coverage for you or your Family Members may be terminated for fraud or deception in the use of the services of the Plan, or for knowingly permitting such fraud or deception by another. Such termination shall be effective upon the mailing of written notice to the Subscriber (and to the University if notice is given by the Plan). A Family Member who commits fraud or deception will be permanently deenrolled while any other Family Member and the Subscriber will be deenrolled for 12 months. If a Subscriber commits fraud or deception, the Subscriber and any Family Members will be deenrolled for 12 months.

Leave of Absence, Layoff or Retirement

Contact your local Benefits Office for information about continuing your coverage in the event of an authorized leave of absence, layoff or retirement.

Optional Continuation of Coverage

If your coverage or that of a Family Member ends, you and/or your Family Member may be entitled to elect continued coverage under the terms of the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, and if that continued coverage ends, specified individuals may be eligible for further continuation under California law. The terms of these continuation provisions are contained in the University of California notice "Continuation of Group Insurance Coverage", available from the University's "At Your Service" website (http://atyourservice.ucop.edu). The notice is also available from the person in your department who handles benefits and from the University's Customer Service Center. You may also direct questions about these provisions to your local Benefits Office or to the University's Customer Service Center if you are a Retiree.

PLAN ADMINISTRATION

By authority of the Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the Group Hospital and Professional Service Agreement. What is written in this document does not constitute a guarantee of plan coverage or benefits--particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

This section describes how the Plan is administered and what your rights are.

Sponsorship and Administration of the Plan

The University of California is the Plan sponsor and administrator for the Plan described in this booklet. If you have a question, you may direct it to:

University of California
Human Resources and Benefits
Health & Welfare Administration
300 Lakeside Drive, 12th Floor
Oakland, CA 94612
(800) 888-8267

Retirees may also direct questions to the University's Customer Service Center at the above phone number.

Claims under the Plan are processed by Health Net at the following address and phone number:

Health Net Medicare HMO COB
P.O. Box 14703
Lexington, KY 40512
1-800-539-4072

UNIVERSITY OF CALIFORNIA

ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS

January 1, 2008

Group Contract Number

The Group Contract Number for this Plan is: 5047RD, 5047RH, 5047RN, 5047RS, 5047RW, 5047SA, 5047SE, 5047SK, 5047SP, 5047ST, 5047SX, 5047TD, 5047TJ, 5047TN, 5047TT, 5047TY, 5047UD, 5047UH, 5047UP, 5047UU, 5047UZ, 5047VD, 5047VJ

Type of Plan

This Plan is a health and welfare plan that provides group medical care benefits. This Plan is one of the benefits offered under the University of California's employee health and welfare benefits program.

Plan Year

The plan year is January 1 through December 31.

Continuation of the Plan

The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. Plan benefits are not accrued or vested benefit entitlements. The right to terminate or amend applies to all Employees, Retirees and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums and what portion of the premiums the University will pay. The portion of the premiums that University pays is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation.

Financial Arrangements

The benefits under the Plan are provided by Health Net under a Group Service Agreement.

The plan costs are currently shared between you and the University of California.

Agent for Serving of Legal Process

Legal process may be served on Health Net at the address listed above.

Your Rights under the Plan

As a participant in a University of California medical plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to:

- Examine, without charge, at the Plan Administrator's office and other specified sites, all Plan documents, including the Group Service Agreement, at a time and location mutually convenient to the participant and the Plan Administrator.
- Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Claims under the Plan

To file a claim or to appeal a denied claim, refer to page 23 of this document.

Nondiscrimination Statement

In conformance with applicable law and University policy, the University of California is an affirmative action/equal opportunity employer.

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director of Diversity and Employee Programs, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Director of Academic Affirmative Action, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

Table of Contents

INTRODUCTION - WELCOME TO HEALTH NET

Welcome to Health Net !

This is a Medicare Prescription Drug Plan

Now that you are enrolled in our Plan, a Medicare Prescription Drug Plan, you are getting your Medicare prescription drug coverage through Health Net Life Insurance Company. Throughout the remainder of this Evidence of Coverage, we refer to Health Net Life Insurance Company as "Health Net".

Throughout the remainder of this Evidence of Coverage, we refer to the Medicare Prescription Drug Plan as "Plan".

This Evidence of Coverage explains how to get your Medicare prescription drug coverage through our Plan.

This Evidence of Coverage, together with your enrollment form, riders, and amendments that we may send to you explain your rights, benefits, and responsibilities as a Member of our Plan.

This Evidence of Coverage provides information that will explain to you:

- What is covered in our Plan and what is not covered.
- How to get your prescriptions filled, including some rules you must follow.
- What you will have to pay for your prescriptions.
- What to do if you are unhappy about something related to getting your prescriptions filled.
- How to leave our Plan, including your choices for continuing Medicare prescription drug coverage.
- If you need this Evidence of Coverage in a different format (such as in Spanish or large print), please call us so we can send you a copy.

Please tell us how we're doing

We want to hear from you about how well we are doing as your Medicare Prescription Drug Plan. You can call or write to us at any time – your comments are always welcome, whether they are positive or negative. From time to time, we conduct surveys that ask our members to tell about their experiences with this Plan. If you are contacted, we hope you will participate in a Member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

How to contact the Medicare program and the 1-800-MEDICARE (TTY/TDD 1-877-486-2048) helpline

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, sometimes referred to as ESRD (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the Federal agency in charge of the Medicare program. "CMS" stands for Centers for Medicare & Medicaid Services. CMS contracts with and regulates Medicare Prescription Drug Plans (including our Plan).

Here are ways to get help and information about Medicare from CMS:

Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048. Calls to these numbers are free.

Use a computer to look at www.medicare.gov, the official government Web site for Medicare information. This Web site gives you a lot of up-to-date information about Medicare and nursing homes. It includes Medicare publications you can print directly from your computer. It has tools to help you compare Medicare Health Plans and Prescription Drug Plans in your area. You can also search the "Helpful Contacts" section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this Web site using their computer.

Health Insurance Counseling and Advocacy Program (HICAP) – an organization in your state that provides free Medicare help and information

Health Insurance Counseling and Advocacy Program (HICAP) is an organization paid by the Federal government to give free health insurance information and help to people with Medicare. HICAP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. HICAP has information about Medicare Prescription Drug Plans, Medicare Health Plans and Medigap (Medicare supplemental insurance) policies.

You can contact HICAP at:

Council on Aging
1971 E. 4th Street, Ste 200
Santa Ana, CA 92705-3917

Toll free: 1-800-434-0222
Local call: 1-714-560-0424

You can also find the Web site for HICAP at www.medicare.gov.

Lumetra – a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare

In California, there is a Quality Improvement Organization called Lumetra. Lumetra is a group of doctors and other health care experts paid by the Federal government to check on and help improve the care given to Medicare patients. In addition to other quality improvement and beneficiary protection activities, the doctors and other health experts in Lumetra review written quality of care complaints made by Medicare patients. See Section 6 for more information about complaints.

You can contact Lumetra at:

Lumetra Headquarters
One Sansome Street, Suite 600
San Francisco, 94104-4448
Toll-free: 1-800-841-1602
Local call: 1-415-677-2000

Other organizations

Medicaid agency – a state government agency that handles health care programs for people with low incomes

Medicaid is a joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact:

California Department of Health Services
P.O. Box 997413
Sacramento, CA 95899-7413
Local call: 1-916-636-1980

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits; disability; family benefits; survivors' benefits; and benefits for the aged, blind, and disabled. If you have questions about any of these benefits you can call the Social Security Administration at 1-800-772-1213. TTY/TDD users should call 1-800-325-0778. Calls to these numbers are free. You can also visit www.ssa.gov.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). TTY/TDD users should call 312-751-4701. You can also visit www.rrb.gov.

Employer (or "Group") Coverage

Please contact your Group if you have any questions about your premium, benefits or the open enrollment season.

Genetically Handicapped Persons Program - a State Pharmaceutical Assistance Program (SPAP)

The Genetically Handicapped Persons Program is a state-funded program that provides financial assistance for prescription drugs to low-income and medically needy senior citizens and individuals with disabilities. The Genetically Handicapped Persons Program may help pay for co-payments/co-insurance for those who qualify. Please contact the Genetically Handicapped persons Program to determine what benefits may be available to you.

You can contact the Genetically Handicapped persons Program at:

State of California Department of Health Services
Genetically Handicapped Persons Program
P.O. Box 942732
Sacramento, CA 94234-7320
Toll-free: 1-800-639-0597

SECTION 1 - PLAN BASICS

What is this Plan?

A Medicare Part D Precription Drug Plan offered by Health Net. Now that you are enrolled in our Plan, you are getting your Medicare Part D prescription drug coverage through Health Net. This Evidence of Coverage explains your benefits and services, what you have to pay, and the rules you must follow to get your prescription drugs covered.

Overview of Medicare Part D prescription drug coverage

Medicare prescription drug coverage is insurance that helps pay for your prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B. We will generally cover the drugs listed in our Formulary as long as the drug is medically necessary, the prescription is filled at a Plan Network Pharmacy, and other coverage rules are followed. We do not pay for drugs that are covered by Medicare Part B. As a member, all you have to do is continue to pay any applicable Deductibles, co-payments, and co-insurances. If you have limited income and resources, you may get extra help from Medicare to pay your premium, Deductible, co-payments and co-insurances so that you get your prescription drugs for little or no cost. Please see Section 2 or call Member Service to learn more.

Note: For Plan members with Diabetes, Medicare Part B supplies that will not be under the drug benefit include lancets, test scripts, glucometers, etc. Diabetic supplies that are covered under Medicare Part D include those items related to the injection of insulin, e.g., insulin syringe, gauze, and alcohol swabs. Inhalers associated with the inhaled form of insulin are also covered under Medicare Part D.

Help us keep your membership record up-to-date

We have a file of information about you as a plan member. Pharmacists use this membership record to know what drugs are covered for you. The membership record has information from your enrollment form, including your address and telephone number. It shows your specific Plan coverage and other information. Section 8 - Your Rights and Responsibilities as a Member of this Plan, tells you how we protect the privacy of your personal health information.

Please help us keep your membership record up-to-date by letting Member Service know right away if there are any changes in your name, address, or phone number, or if you go into a nursing home. Also, tell Member Service about any changes in prescription drug coverage you have from other sources, such as from Medicaid or your spouse's current or former employer. In addition, you should tell Member Service about any changes in coverage due to claims filed under liability insurance, such as workers' compensation claims or claims against another driver in an automobile accident.

Plan membership card

Now that you are a Member of our Plan, you have a Plan membership card.
During the time you are a plan Member and using plan services, you must use your Plan membership card at Network Pharmacies. Please carry your Plan membership card with you at all times. You will need to show this card in order to get your prescription drugs paid for. If your membership card is ever damaged, lost, or stolen, call Member Service right away and we will send you a new card.

Please note that this membership card is separate from your membership card for your Medicare Coordination of Benefits HMO plan.

Using plan pharmacies to get your prescription drugs covered by us

What are Network Pharmacies?

With few exceptions, you must use Network Pharmacies to get your prescription drugs covered.

- What is a "Network Pharmacy"? A Network Pharmacy is a pharmacy at which you can get your prescription drug benefits. We call them "Network Pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our Network Pharmacies. Once you go to one, you are not required to continue going to the same pharmacy to fill your prescription; you can go to any of our Network Pharmacies. However, if you switch to a different Network Pharmacy, you must either have a new prescription written by a physician or have the previous pharmacy transfer the existing prescription to the new pharmacy if any refills remain.

- What are "Covered Drugs"? "Covered drugs" is the general term we use to mean all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in the Formulary.

How do I fill a prescription at a Network Pharmacy?

To fill your prescription, you must show your Plan membership card at one of our Network Pharmacies. If you do not have your membership card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your co-payment). If this happens, you can ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described at the end of this section.

The Pharmacy Directory gives you a list of Plan Network Pharmacies.

As a Member of our Plan we will send you a Pharmacy Directory, which gives you a list of our Network Pharmacies. You can use it to find the Network Pharmacy closest to you. If you don't have the Pharmacy Directory, you can get a copy from Member Service. They can also give you the most up-to-date information about changes in this Plan's pharmacy network. In addition, you can find this information on our Web site.

What if a pharmacy is no longer a "Network Pharmacy"?

Sometimes a pharmacy might leave the plan's network. If this happens, you will have to get your prescriptions filled at another Plan Network Pharmacy. Please refer to your Pharmacy Directory or call Member Service to find another Network Pharmacy in your area.

How do I fill a prescription through Plan's network mail order pharmacy service?

You can use our network mail order pharmacy service to fill prescriptions for what we call "maintenance drugs." These are drugs that you take on a regular basis, for a chronic or long-term medical condition.

When you order prescription drugs through our network mail order pharmacy service, you must order at least a 60-day supply, and no more than a 90-day supply, of the drug.

Generally, it takes us 14 days to process your order and ship it to you. However, sometimes your mail order may be delayed. To get a prescription if the mail order is delayed, please contact ExpressScript at 1-800-316-3106, TTY/TDD 1-800-972-4348.

You are not required to use our mail order services to get an extended supply of maintenance medications. You can also get an extended supply through some retail Network Pharmacies. Some retail pharmacies may agree to accept the mail order co-payment for an extended supply of medications, which may result in no out-of-pocket payment difference to you. Other retail pharmacies may provide an extended supply, but charge a higher co-payment than our mail order service. Please call our Member Service to find out which retail pharmacies offer an extended supply.

UC Walk-Up Service through UC Medical Center Pharmacies

Health Net and the UC Medical Center Pharmacies have partnered to offer UC members with the ability to fill up to a 90-day prescription for maintenance medications at any of the UC designated Medical Center Pharmacies. Just like Health Net's current Mail Order Program, members can now obtain up to a 90-day supply for only two copays, at one of the UC-designated Medical Center pharmacies.

Filling prescriptions outside the network

We have Network Pharmacies outside of the Service Area where you can get your drugs covered as a Member of our plan. If you get your drugs at one of these Network Pharmacies, the pharmacy can process the claim electronically and will only charge you the co-payment/co-insurance you owe for the drug. Generally, we only cover drugs filled at an Out-of-Network Pharmacy in limited circumstances when a Network Pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an Out-of-Network Pharmacy. Before you fill your prescription in these situations, call Member Service to see if there is a Network Pharmacy in your area where you can fill your prescription. If you do go to an Out-of-Network Pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just your co-payment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. You should submit a claim to us if you fill a prescription at an Out-of-Network Pharmacy, as any amount you pay will help you qualify for Catastrophic Coverage (see Section 4). To learn how to submit a paper claim, please refer to the paper claims process described next.

We will cover your prescription at an Out-of-Network Pharmacy (regardless of whether you are within or outside our Service Area) if at least one of the following applies:

- If you are unable to obtain a covered drug in a timely manner because there is no Network Pharmacy within a reasonable driving distance that provides 24 hour service.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail, mail-order pharmacy or UC's Walk-Up Service (including high cost and unique drugs).
- If you are getting a vaccine that is medically necessary but not covered by Medicare Part B and some Covered Drugs that are administered in your doctor's office.

How do I submit a paper claim?

When you go to a Network Pharmacy, your claim is automatically submitted to us by the pharmacy. However, if you go to an Out-of-Network Pharmacy for one of the reasons listed above, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. To submit a claim:

- Complete a claim form. If you need a claim form, call Member Service. You may also print a claim form from our website at www.healthnet.com
- Attach your prescription receipt(s) to the claim form. You must attach the actual prescription receipt, which includes required information about the dispensing pharmacy and the prescription drug you purchased. If you do not have the actual prescription receipt, a duplicate may be obtained from the dispensing pharmacy. Cash register receipts cannot be used when submitting a claim.
- Mail the completed claim form and actual prescription receipt(s) to:

  Health Net
  Attention: Claims
  10540 White Rock Road Suite 280
  Rancho Cordova, CA 95670

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

If you submit a paper claim to us, the claim is treated as a request for a Coverage Determination. If you are asking us to reimburse you for a prescription drug that is not on our Formulary or is subject to coverage requirements or limits, your doctor may need to submit additional documentation supporting your request. See Section 6 to learn more about requesting Coverage Determinations.

Specialty pharmacies

Home infusion pharmacies

Health Net will cover home infusion therapy if:

- Your prescription drug is on our Plan's Formulary or a Formulary Exception has been granted for your prescription drug,
- Your prescription drug is not otherwise covered under Medicare Part B,
- Our plan has approved your prescription for home infusion therapy, and
- Your prescription is written by an authorized prescriber.

Please refer to your Pharmacy Directory to find a home infusion pharmacy provider in your area. For more information, please contact Member Service.

Long-term care pharmacies

In some cases, residents of a long-term care facility may access their prescription drugs through the facility's long-term care pharmacy or another network long-term care pharmacy. Please refer to your Pharmacy Directory to find out if your long-term care pharmacy is part of our network. If it is not, or for more information, please contact Member Service.

Indian Health Service/Tribal/Urban Indian Health Program (I/T/U) Pharmacies

Only Native Americans and Alaska Natives have access to Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies through Health Net's pharmacy network. Those other than Native Americans and Alaskan Natives may be able to access these pharmacies under limited circumstances (e.g. emergencies).

Please refer to your Pharmacy Directory to find an I/T/U pharmacy in your area. For more information, please contact Member Service.

Some vaccines and drugs may be administered in your doctor's office

We may cover vaccines that are preventive in nature (but not the cost associated with administering the vaccine) and are not already covered by Medicare Part B. In addition we cover some drugs that may be administered in your doctor's office. (Please see Section 4, "How does your enrollment in Plan affect coverage for drugs covered under Medicare Part A or Part B?" for more information.)

SECTION 2 - EXTRA HELP WITH DRUG PLAN COSTS FOR PEOPLE WITH LIMITED INCOME AND RESOURCES

What extra help is available?

Medicare provides "extra help" to pay prescription drug costs for people who meet specific income and resources limits. Resources include your savings and stocks, but not your home or car. If you qualify, you will get help paying for your Medicare drug plan's monthly premium, yearly Deductible (if applicable), and prescription copayment and coinsurance amounts.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help one of two ways. The amount of extra help you get will depend on your income and resources.

1. You automatically qualify for extra help and don't need to apply. If you have full coverage from a state Medicaid program, get help from Medicaid paying your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare mails letters monthly to people who automatically qualify for extra help.

2. You apply and qualify. You may qualify if your yearly income is less than $15,315 (single) or $20,535 (married and living with your spouse)*, and your resources are less than $11,710 (single) or $23,410 (married and living with your spouse). Resources include your savings and stocks but not your home or car. If you think you may qualify, call Social Security at 1-800-772-1213, visit www.socialsecurity.gov on the web, or apply at your State Medical Assistance (Medicaid) office. TTY users should call 1-800-325-0778. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next.

   *The above income amounts are for 2007 and will change in 2008. If you pay at least half of the living expenses of dependent family members, income limits are higher.

How do my costs change when I qualify for extra help?

The extra help you get from Medicare will help you pay for your Medicare drug plan's monthly premium, yearly Deductible (if applicable), and prescription copayment and coinsurance amounts. The amount of extra help you get is based on your income and resources.

If you qualify for extra help, we will send you by mail an "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs" that explains your costs as a Member of our Plan.

What if you believe you have qualified for extra help and you believe that you are paying an incorrect co-payment amount?

If you believe you have qualified for extra help and you believe that you are paying an incorrect co-payment amount when you get your prescription at a pharmacy, our Plan has established a process that will allow you to provide evidence of your proper co-payment level.

Contact the customer service number on your membership card and advise the representative that you believe you qualify for extra help and are paying an incorrect co-payment. You may be required to provide one of the following:

- A copy of your Medicaid card which includes your name and an eligibility date during the discrepant period;
- A copy of a state document that confirms active Medicaid status during the discrepant period;
- A print out from the State electronic enrollment file showing Medicaid status during the discrepant period;
- A screen print from the State's Medicaid systems showing Medicaid status during the discrepant period;
- A letter from the State Medicaid agency showing Medicaid status during the discrepant period;
- Other documentation provided by the State showing Medicaid status during the discrepant period.
- Supporting documentation must be submitted within 60 days of when you paid the co-payment.

Please be assured that if you overpay your co-payment, we will generally reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future co-payments. Of course, if the pharmacy hasn't collected a co-payment from you and is carrying your co-payment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions.

How do you get more information?

For more information on who can get extra help with prescription drug costs and how to apply, call the Social Security Administration at 1-800-772-1213, or visit www.socialsecurity.gov on the Web. TTY/TDD users should call 1-800-325-0778.

In addition, you can look at the 2007 Medicare & You Handbook, visit www.medicare.gov on the Web, or call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

If you have any questions about our Plan, please refer to our Member Service numbers listed on the cover and in the Benefits at a Glance section. Or, visit our Web site.

SECTION 3 - ENROLLMENT IN THIS PLAN

The University of California establishes its own medical plan criteria for employees and retirees based on the University of California Group Insurance Regulations ("Regulation") and any corresponding Administrative Supplements. Please refer to portions of those regulations in the Medicare Coordination of Benefits (COB) Evidence of Coverage booklet, which are also applicable here.

Who Is Eligible For Coverage

The covered prescription drugs of this plan are available to the following people as long as they live in the United States, either work or live in our Service Area and meet any additional eligibility requirements of the Group:

- The principal Member who:
  - Is entitled to Medicare;
  - Is presently, and will continue to be covered under Part A and/or Part B of Medicare; and
  - Is not enrolled in Medicare Part D through another Health Care Service Plan.
- Spouse, who must be listed on the enrollment form completed by the principal Member and meets the same qualifications as the principal member. (The term "spouse" also includes the member's domestic partner as defined.)

Paying the plan premium for your coverage as a Member of our Plan

Please contact your Group for information about your plan premium

Do you have to continue to pay your Part A or Part B premiums?

To be a Member of our Plan, you must either be entitled to Medicare Part A or enrolled in Medicare Part B and live in our Service Area. If you currently pay a premium for Medicare Part A and/or Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and to remain a Member of this plan.

Some members who belong to a Medicare Savings Program (QMB only, SLMB only, QI) may be eligible to get extra help in paying for the cost of their Medicare Part A and/or Part B premiums. If interested in the program, please see Section 2 or call Member Service for more information.

What is the Late Enrollment Penalty?

If you don't join a Medicare drug plan when you are first eligible, and you go without creditable prescription drug coverage (as good as Medicare's) for 63 continuous days or more, you may have to pay a late enrollment penalty to join a plan later. This penalty amount changes every year, and you will have to pay it as long as you have Medicare prescription drug coverage. However, if you qualified for extra help in 2006 and/or 2007, you may not have to pay a penalty.

If you must pay a late enrollment penalty, your penalty is calculated when you first join a Medicare drug plan. To estimate your penalty, take 1% of the national base beneficiary premium for the year you join (in 2007, the national base beneficiary premium is $27.35). Multiply it by the number of full months you were eligible to join a Medicare drug plan but didn't, and then round that amount to the nearest ten cents. This is your estimated penalty amount, which is added each month to your Medicare drug plan's premium for as long as you are in that plan.

If you disagree with your late enrollment penalty, you may be eligible to have it reconsidered (reviewed). Call Member Service to find out more about the reconsideration process and how to ask for such a review.

You won't have to pay a late enrollment penalty if:

- You had creditable prescription drug coverage (as good as Medicare's)
- The period of time that you didn't have creditable prescription drug coverage was less than 63 continuous days
- You prove that you were not informed that your prescription drug coverage was not creditable
- You lived in an area affected by Hurricane Katrina AND you signed up for a Medicare prescription drug plan by December 31, 2006, AND you stay in a Medicare prescription drug plan
- You received or are receiving extra help AND you join a Medicare prescription drug plan by December 31, 2007, AND you stay in a Medicare prescription drug plan

Your late enrollment penalty may be reduced or eliminated if:

- You receive extra help in 2008 or after

SECTION 4 - PRESCRIPTION DRUG COVERAGE

This section describes your prescription drug coverage as a Member of our Plan. We will explain what a formulary is and how to use it, our drug management programs, how much you will pay when you fill a prescription for a covered drug, and what an Explanation of Benefits is and how to get additional copies.

What drugs are covered by this Plan?

What is a formulary?

We have a formulary that lists all drugs that we cover. We will generally cover the drugs listed in our Formulary as long as the drug is medically necessary, the prescription is filled at a Network Pharmacy or through our network mail order pharmacy service, and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described in Section 4.

The drugs on the Formulary are selected by our Plan with the help of a team of health care providers. We select the prescription therapies believed to be a necessary part of a quality treatment program. Both brand-name drugs and Generic Drugs are included on the Formulary. A Generic Drug has the same active-ingredient formula as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs.

Not all drugs are included on the Formulary. In some cases, the law prohibits coverage of certain types of drugs. (See “Drug Exclusions”, later in this section, for more information about the types of drugs that cannot be covered under a Medicare Prescription Drug Plan.) In other cases, we have decided not to include a particular drug.

In certain situations, prescriptions filled at an Out-of-Network Pharmacy may also be covered. See Section 1 – Plan Basics, for more information about filling prescription at Out-of-Network Pharmacies.

How do you find out what drugs are on the Formulary?

You may call Member Service to find out if your drug is on the Formulary or to request a copy of our Formulary. You can also get updated information about the drugs covered by us by visiting our Web site.

What are drug tiers?

Drugs on our Formulary are organized into different drug tiers, or groups of different drug types. Your co-insurance/co-payment depends on which drug tier your drug is in. The “Benefits at a Glance” section at the beginning of the document shows the co-insurance/co-payment amount you pay for each tier when you are in your initial coverage period.

You can ask us to make an Exception (which is a type of Coverage Determination) to your drug’s tier placement in certain circumstances. See Section 6 to learn more about how to request a "tiering Exception."

Can the Formulary change?

We may add or remove drugs from the Formulary during the year. Changes in the Formulary may affect which drugs are covered and how much you will pay when filling your prescription. If we remove drugs from the Formulary, or add Prior Authorizations, Quantity Limits and/or Step Therapy restrictions on a drug or move a drug to a higher cost-sharing tier, and you are taking the drug affected by the change, we will notify you of the change at least 60 days before the date that the change becomes effective. If we don't notify you of the change in advance, we will give you a 60 day supply of the drug when you request a refill of the drug. However, if a drug is removed from our Formulary because the drug has been recalled from the market, we will not give 60-days notice before removing the drug from the Formulary or give you a 60 day supply of the drug when you request a refill. Instead, we will remove the drug from our Formulary immediately and notify members about the change as soon as possible.

Immediately after receiving the 60-day notice or 60-day supply, you should work with your physician to either switch to a drug we cover or request an Exception (which is a type of Coverage Determination). If your physician determines that you need the drug that is being removed from our Formulary and none of the drugs we cover is medically appropriate for you, you or your physician may request an Exception. Similarly, if your physician determines that you are not able to meet a Prior Authorization, Quantity Limit, Step Therapy restriction, or other utilization management requirement for medical necessity reasons, you or your physician may request an Exception. See Section 6 to learn more about how to request an Exception.

What if your drug is not on the Formulary?

If your prescription is not listed on the Formulary, you should first contact Member Service to be sure it is not covered.

If Member Service confirms that we do not cover your drug, you have three options:

- You can ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of Covered Drugs that are used to treat similar medical conditions, please contact Member Service.
- You can ask us to make an Exception (which is a type of Coverage Determination) to cover your drug. See Section 6 to learn more about how to request an Exception.
- You can pay out-of-pocket for the drug and request that the plan reimburse you by requesting an Exception (which is a type of Coverage Determination). This does not obligate the plan to reimburse you if the Exception request is not approved. If the Exception is not approved, you may appeal the plan's denial. See Section 6 for more information on how to request an Exception or Appeal.

If you recently joined this plan, you may be able to get a temporary supply of a drug you were taking when you joined our plan if it is not on our Formulary. Please see the Benefits at a Glance section in the beginning of this document to learn more about our Transition Policy.

In some cases, we will contact you if you are taking a drug that is not on our Formulary. We can give you the names of Covered Drugs that also are used to treat your condition so you can ask your doctor if any of these drugs are an option for your treatment.

Drug exclusions and limitations

The following exclusions and limitations apply to any category or type of drugs described throughout this Evidence of Coverage.

- Medications on the Formulary that are specifically excluded by Medicare will not count towards your yearly out-of-pocket costs. In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for these drugs. These include some prescription medications in the following categories:
  - Agents used for the symptomatic relief of cough and cold;
  - Prescription vitamin and mineral products;
  - Sexual dysfunction drugs;
  - Barbiturates; and
  - Benzodiazepines

  Please refer to the Formulary to find out which drugs we are offering additional coverage or call Customer Service if you have any questions.
- Dispensing may be limited to less than a one-month (30 days) supply due to manufacturer packaging and/or appropriate length of treatment.
- Quantity and daily dosing limits may apply to specific drugs. Please refer to the Formulary.
- Sexual dysfunction drugs are covered up to the quantities as indicated on the Formulary.
- Smoking cessation drugs are covered up to a 12-week course of therapy per calendar year if you are currently enrolled in a comprehensive smoking cessation program. Prior authorization from Health Net is required.
- By law, certain types of drugs or categories of drugs are not covered by Medicare Prescription Drug Plans, including:
  - Drugs used to treat infertility;
  - Anorexiants, appetite suppressants, diet aids, weight loss medications, and drugs medications used to treat obesity or weight gain;
  - Smoking cessation medications that do not require a prescription;
  - Experimental or investigational medications;
  - Agents when used for cosmetic purposes or hair growth;
  - Non-prescription medications; and
  - Outpatient drugs for which the manufacturer seeks to require associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale.

In addition, a Medicare Prescription Drug Plan cannot cover a drug that would be covered under Medicare Part A or Part B. See "How does your enrollment in this Plan affect coverage for drugs covered under Medicare Part A or Part B?" below.

Also, while a Medicare Prescription Drug Plan can cover off-label uses of a prescription drug, we cover the off-label use only in cases where the use is supported by certain reference book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted. If the use is not supported by one of the following reference books (known as compendia), then the drug would be considered a non-Part D drug and could not be covered by our plan:

- American Hospital Formulary Service Drug Information;
- United States Pharmacopoeia Drug Information; and
- DRUGDEX Information System.

We offer additional coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for Catastrophic Coverage). In addition, if you are receiving extra help from Medicare to pay for your prescriptions, the extra help will not pay for these drugs. Please refer to your Formulary to find out which drugs we are offering additional coverage for or call Member Service if you have any questions.

Drug Management Programs

Utilization management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed these requirements and limits for our Plan to help us to provide quality coverage to our members. The Benefits at a Glance section of this document lists the utilization management tools that we use in this plan.

You can find out if the drug you take is subject to these additional requirements or limits by looking in the Formulary. If your drug is subject to one of these additional restrictions or limits and your physician determines that you are not able to meet the additional restriction or limit for medical necessity reasons, you or your physician can request an Exception (which is a type of Coverage Determination). See Section 6 for more information about how to request an Exception.

Drug utilization review

We conduct drug utilization reviews for all of our members to make sure that they are receiving safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribes their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

- Possible medication errors
- Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition
- Drugs that are inappropriate because of your age or gender
- Possible harmful interactions between drugs you are taking
- Drug allergies
- Drug dosage errors

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Medication therapy management programs

We offer medication therapy management programs at no additional cost for members who have multiple medical conditions, who are taking many prescription drugs, and who have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help us provide better coverage for our members. For example, these programs help us make sure that our members are using appropriate drugs to treat their medical conditions and help us identify possible medication errors.

We offer a medication therapy management program for members that meet specific criteria. We may contact members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you do not need to pay anything extra to participate.

If you are selected to join a medication therapy management program we will send you information about the specific program, including information about how to access the program.

How does your enrollment in this Plan affect coverage for the drugs covered under Medicare Part A or Part B?

Your enrollment in this Plan does not affect Medicare coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B even though you are enrolled in this Plan. In addition, if your drug would be covered by Medicare Part A or Part B, it cannot be covered by us even if you choose not to participate in Part A or Part B. Some drugs may be covered under Medicare Part B in some cases and through this plan (Medicare Part D) in other cases but never both at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or us for the drug in question.

See your Medicare & You Handbook for more information about drugs that are covered by Medicare Part A and Part B.

How much do you pay for drugs covered by this Plan?

If you qualify for extra help with your drug costs, your costs for your drugs may be different than those described below. See Section 2 "Extra Help with Drug Plan Costs for People with Limited Income and Resources" and the "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs" for more information.

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., Deductible (if applicable), Initial Coverage Period, and catastrophic level), the type of drug it is, and whether you are filling your prescription at an in-network or Out-of-Network Pharmacy. Your drug costs for each coverage level are described in the Benefits at a Glance section at the beginning of this document. Below describes each phase of the benefit.

Deductible

This is the amount that must be paid each year before we begin paying for part of your drug costs. Refer to the Benefits at a Glance section at the beginning of this document to see if this Plan has a Deductible.

Initial Coverage Period

During the Initial Coverage Period, we will pay part of the costs for your Covered Drugs and you will pay the other part. The amount you pay when you fill a covered prescription is called the co-insurance/co-payment. Your co-insurance/co-payment will vary depending on the drug, drug tier, and where the prescription is filled.

Catastrophic Coverage

All Medicare Prescription Drug Plans include Catastrophic Coverage for people with high drug costs. In order to qualify for Catastrophic Coverage, you must spend $4,050 out-of-pocket for the year. When the total amount you have paid toward your Deductible (if applicable), co-payments, and co-insurance reaches $4,050, you will qualify for Catastrophic Coverage.

Note: As mentioned earlier we offer additional coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards your Deductible (if applicable), or total out of pocket costs (that is, the amount you pay does not help you move through the benefit or qualify for Catastrophic Coverage).

Vaccines (including administration)

Our Plan's prescription drug benefit covers a number of vaccines (including vaccine administration). The amount you will be responsible for will depend on how the vaccine is dispensed and who administers it. Also, please note that in some situations, the vaccine and its administration will be billed separately. When this happens, you may pay separate cost-sharing amounts for the vaccine and for the vaccine administration.

Note that in some cases, you will be receiving the vaccine from someone who is not part of our pharmacy network and that you may have to pay for the entire cost of the vaccine and its administration in advance. You will need to mail us the receipts, and then you will be reimbursed. Actual vaccine costs will vary by vaccine type and by whether your vaccine is administered by a pharmacist or by another provider.

How is your out-of-pocket cost calculated?

What type of prescription drug payments count toward your out-of-pocket costs?

The following types of payments for prescription drugs can count toward your out-of-pocket costs and help you qualify for Catastrophic Coverage so long as the drug you are paying for is a Part D drug, on the Formulary (or if you get a favorable decision on a Coverage Determination, Exception request or Appeal), obtained at a Network Pharmacy (or you have an approved claim from an Out-of-Network Pharmacy); and otherwise meets our coverage requirements:

- Your annual Deductible (if applicable); and
- Your co-insurance or co-payments made on drugs that are normally covered in a Medicare Prescription Drug Plan.
- After your yearly out-of-pocket drug costs reach $2,000, excluding any generic substitution costs, copayments and coinsurances will not be required for the remainder of the calendar year until you qualify for Catastrophic Coverage.

When you have spent a total of $4,050 for these items, you will reach the Catastrophic Coverage level. The amount you pay for your monthly premium does not count toward reaching the Catastrophic Coverage level.

Purchases that will not count toward your out-of-pocket costs:

- Prescription drugs purchased outside the United States and its territories;
- Prescription drugs not covered by the Plan;
- Prescription drugs obtained at an out-of-network pharmacy when that purchase does not meet our requirements for out-of-network coverage.
- Prescription drugs covered by Part A or Part B.
- Certain prescription drugs covered by us but not normally covered in a Medicare Prescription Drug Plan.

Who can pay for your prescription drugs, and how do these payments apply to your out-of-pocket costs?

Except for your premium payments, any payments you make for Part D Drugs covered by us count toward your out-of-pocket costs and will help you qualify for Catastrophic Coverage. In addition, when the following individuals or organizations pay your costs for such drugs, these payments will count toward your out-of-pocket costs (and will help you qualify for Catastrophic Coverage):

- Family members or other individuals;
- Qualified State Pharmacy Assistance Programs (SPAPs);
- Medicare programs that provide extra help with prescription drug coverage; and
- Most charities or charitable organizations. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

Payments made by the following do not count toward your out-of-pocket costs:

- Group Health Plans;
- Insurance Plans and government funded health programs (e.g. TRICARE, the VA, the Indian Health Service); and
- Third party arrangements with a legal obligation to pay for prescription costs (e.g., Workers Compensation).

If you have coverage from a third party such as those listed above that pays a part of or all of your out-of-pocket costs, you must disclose this information to us.

We will be responsible for keeping track of your out-of-pocket cost amount and will let you know when you have qualified for Catastrophic Coverage. If you are in a coverage gap or Deductible period (if applicable) and have purchased a covered Part D drug at a Network Pharmacy under a special price or discount card that is outside the Plan's benefit, you may submit documentation and have it count towards qualifying you for Catastrophic Coverage. In addition, every month you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits is a document you will get each month you use your prescription drug coverage. It will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your drugs. You will get your Explanation of Benefits in the mail each month that you use the benefits provided by us. You will not get an Explanation of Benefits if you don't use any benefits that month.

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of prescriptions you filled during the month, as well as the amount paid for each prescription;
- Information about how to request an Exception and Appeal our coverage decisions;
- A description of changes to the Formulary affecting the prescriptions you filled that will occur at least 60 days in the future;
- A summary of your coverage this year, including information about:
  - Annual Deductible (if applicable)-the amount you pay, and/or others pay before you start receiving prescription coverage.
  - Total Out-Of-Pocket Costs That Count Towards Catastrophic Coverage The total amount you and/or others have spent on prescription drugs that count towards you qualifying for Catastrophic Coverage. This total includes the amounts spent for your Deductible (if applicable), co-payments and co-insurance. (This amount does not include the Plan premium or payments made by your current or former employer/union, another insurance plan or policy, a government funded health program or other excluded parties.)

What should you do if you did not get an Explanation of Benefits or if you wish to request one?

An Explanation of Benefits is also available upon request. To get a copy, please contact Member Service.

How does your prescription drug coverage work if you go to a hospital or skilled nursing facility?

If you are admitted to a hospital for a Medicare-covered stay, Medicare Part A should cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, we should cover your prescription drugs as long as all coverage requirements are met (such as the drugs being on our Formulary, filled at a Network Pharmacy, etc.) and they are not covered by Medicare Part A or Part B. We will also cover your prescription drugs if they are approved under the Coverage Determination, Exceptions, or Appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay: After Medicare Part A stops paying for your prescription drug costs, we will cover your prescriptions as long as the drug meets all of our coverage requirements (including the requirement that the skilled nursing facility pharmacy be in our pharmacy network, unless you meet standards for out-of –network care, and that the drug would not otherwise be covered by Medicare Part B coverage). When you enter, live in, or leave a skilled nursing facility you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a new Medicare Prescription Drug Plan. Please see Section 7 of this document for more information about leaving this Plan and joining a new Medicare Prescription Drug Plan.

SECTION 5 - IF YOU HAVE OTHER PRESCRIPTION DRUG COVERAGE

We will send you a Coordination of Benefits Survey so that we can know what other drug coverage you have in addition to the coverage you get through this plan. CMS requires us to collect this information from you, so when you get the survey, please fill it out and send it to us. The information you provide helps us calculate how much you and others have paid for your drugs. In addition, if you lose or get additional prescription drug coverage, please call Member Service to update your membership records.

If you have Medicare and Medicaid

Medicare, not Medicaid, will pay for most of your prescription drugs. You will continue to get your health coverage under both Medicare and Medicaid as long as you still qualify for Medicaid benefits.

If you are a Member of a State Pharmacy Assistance Program (SPAP)

If you are currently enrolled in a SPAP, you may get help paying any applicable Deductibles, and co-payments/co-insurance. Please contact your SPAP to determine what benefits are available to you. Please see the Introduction section for more information.

If you have a Medigap policy with prescription drug coverage

If you currently have a Medicare Supplement (Medigap) policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell it you have enrolled in our Plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your policy and adjust your premium.

Each year (prior to November 15), your Medigap insurance company must send you a letter explaining your options and how the removal of drug coverage from your Medigap policy will affect your premiums. If you did not get these notices or cannot find them, you have the right to contact your Medigap issuer and request a copy.

SECTION 6 - APPEALS AND GRIEVANCES: WHAT TO DO IF YOU HAVE COMPLAINTS

What to do if you have complaints

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage. Please call our Member Service numbers listed on the cover.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint and what we are required to do when someone makes a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be Disenrolled from this Plan or penalized in any way if you make a complaint.

A complaint will be handled as a Grievance, Coverage Determination, or an Appeal, depending on the subject of the complaint.

What is a Grievance?

A Grievance is any complaint other than one that involves a Coverage Determination. You would file a Grievance if you have any type of problem with us or one of our Network Pharmacies that does not relate to coverage for a prescription drug. For example, you would file a Grievance if you have a problem with things such as waiting times when you fill a prescription, the way your network pharmacist or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of a Network Pharmacy. For more information about Grievances, including how to file a Grievance, see the section "How to file a Grievance" below.

What is a Coverage Determination?

Whenever you ask for a Part D prescription drug benefit, the first step is called requesting a Coverage Determination. If your doctor or pharmacist tells you that a certain prescription drug is not covered, you must contact us if you want to request a Coverage Determination. When we make a Coverage Determination, we are making a decision whether or not to provide or pay for a Part D drug and what your share of the cost is for the drug. You have the right to ask us for an "Exception," which is a type of Coverage Determination, if you believe you need a drug that is not on our list of Covered Drugs (Formulary) or believe you should get a drug at a lower co-payment. You can also ask for an Exception to a utilization management tool, such as a Quantity Limit, that applies to the drug you're requesting. If you request an Exception, your doctor must provide a statement to support your request. For more information about Coverage Determinations, including Exceptions, see the section "How to request a Coverage Determination" below.

What is an Appeal?

- An appeal is any of the procedures that deal with the review of an unfavorable Coverage Determination. You cannot request an Appeal if we have not issued a Coverage Determination. If we issue an unfavorable Coverage Determination, you may file an Appeal called a "redetermination" if you want us to reconsider and change our decision. If our redetermination decision is unfavorable, you have additional appeal rights. For more information about appeals,

see the section "How to request an Appeal" below.

How to File a Grievance

This part of Section 6 explains how to file a Grievance. A Grievance is different from a request for a Coverage Determination because it usually will not involve coverage or payment for Part D prescription drug benefits (concerns about our failure to cover or pay for a certain drug should be addressed through the Coverage Determination process discussed below).

What types of problems might lead to you filing a Grievance?

- You feel that you are being encouraged to leave (Disenroll from) our Plan.
- Problems with the Member Service you receive.
- Problems with how long you have to spend waiting on the phone or in the pharmacy.
- Disrespectful or rude behavior by pharmacists or other staff.
- Cleanliness or condition of pharmacy.
- If you disagree with our decision not to expedite your request for an expedited Coverage Determination or redetermination.
- You believe our notices and other written materials are difficult to understand.
- Failure to give you a decision within the required timeframe.
- Failure to forward your case to the independent review entity if we do not give you a decision within the required timeframe.
- Failure by the plan sponsor to provide required notices.
- Failure to provide required notices that comply with CMS standards.

In certain cases, you have the right to ask for a "fast Grievance," meaning your Grievance will be decided within 24 hours. We discuss these fast Grievances in more detail below.

If you have a Grievance, we encourage you to first call Member Services at the number listed on the cover. We will try to resolve any complaint that you might have over the phone. If you request a written response to your phone complaint, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the Grievance procedure. You may submit your complaint in writing or via facsimile to Health Net at:

Health Net
Appeals & Grievances Department
Post Office Box 10450
Van Nuys, CA 91410-0450

Fax: 1-800-977-1959

Upon receipt of your complaint, we will initiate the Grievance procedure and acknowledge receipt of your request within 5 business days of receipt.

You are also entitled to a quick review of your complaint if you disagree with our decision in the following circumstances:

- We deny your request for a fast review of a request for drug benefits
- We deny your request for a fast review of an Appeal of denied drug benefits

We call this the Expedited Grievance procedure. If you have questions about this procedure, please call Member Service at the phone number listed on the cover. Requests for Expedited Grievance may be submitted by telephone at 1-800-806-8811 (TTY/TTD 1-800-929-9955). You may also submit your request in writing or via facsimile to Health Net at:

Health Net
Appeals & Grievances Department
Post Office Box 10450
Van Nuys, CA 91410-0450

Fax: 1-800-977-1959

We will quickly review your request and notify you of our decision within 24 hours of receiving your complaint. Once the Expedited Grievance is received by Health Net, a Clinical Practitioner will review your complaint to determine the circumstances surrounding the denial of your request for expedited review. You will be notified of the outcome of the Expedited Grievance case verbally and in writing within 24 hours of initial receipt of your complaint.

Complaints about a decision regarding payment for, or provision of, covered benefits that you believe should be provided or paid for by Health Net must be appealed through Health Net's Medicare Part D Appeals procedure.

We must notify you of our decision about your Grievance as quickly as your complaint requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

For quality of care complaints, you may also complain to the Quality Improvement Organization (QIO)

Complaints concerning the quality of care received under Medicare may be acted upon by the Medicare prescription drug plan under the Grievance process, by an independent organization called the QIO, or by both. For any complaint filed with the QIO, Health Net must cooperate with the QIO in resolving the complaint.

How to file a quality of care complaint with the QIO

Quality of care complaints filed with the QIO must be made in writing. A Member who files a quality of care Grievance with a QIO is not required to file the Grievance within a specific time period. See the Introduction for information about the QIOs.

How to request a Coverage Determination

What is the purpose of this section?

The purpose of this section is to explain what you can do if you have problems getting the prescription drugs you believe we should provide and you want to request a Coverage Determination. We use the

word “provide” in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting.

What is a Coverage Determination?

The Coverage Determination made by Health Net is the starting point for dealing with requests you may have about covering or paying for a Part D prescription drug. If your doctor or pharmacist tells you that a certain prescription drug is not covered you should contact Health Net and ask us for a Coverage Determination. With this decision, we explain whether we will provide the prescription drug you are requesting or pay for a drug you have already received. If we deny your request (this is sometimes called an “adverse Coverage Determination”), you can “appeal” our decision by going on to Appeal Level 1 (see below). If we fail to make a timely Coverage Determination on your request, it will be automatically forwarded to the independent review entity for review (see Appeal Level 2 below).

The following are examples of Coverage Determinations:

- You ask us to pay for a drug you have already received. This is a request for a Coverage Determination about payment. You can call Member Service to get help in making this request.
- You ask for a Part D drug that is not on your Plan’s list of Covered Drugs (called a "Formulary"). This is a request for a "Formulary Exception." You can refer to our Member Service to ask for this type of decision. See "What is an Exception" below for more information about the Exceptions process.
- You ask for an Exception to our Plan’s utilization management tools - such as Prior Authorization, dosage limits, Quantity Limits, or Step Therapy requirements. Requesting an Exception to a utilization management tool is a type of Formulary Exception. You can call Member Service to ask for this type of decision. See "What is an Exception" below for more information about the Exceptions process.
- You ask us to reimburse you for a drug you bought at an Out-of-Network Pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a doctor’s office, will be covered by the plan. See Section 1 for a description of these circumstances. You can refer to our Member Service to make a request for payment or coverage for drugs provided by an Out-of-Network Pharmacy or in a doctor’s office.

When we make a Coverage Determination, we are giving our interpretation of how the Part D prescription drug benefits that are covered for members of our Plan apply to your specific situation. This document and any amendments you may receive describe the Part D prescription drug benefits covered by our Plan, including any limitations that may apply to these benefits. This Evidence of Coverage also lists exclusions (benefits that are “not covered” by our Plan) in Section 4.

What is an Exception?

An Exception is a type of Coverage Determination. You can ask us to make an Exception to our coverage rules in a number of situations.

- You can ask us to cover your drug even if it is not on our Formulary.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a Quantity Limit, you can ask us to waive the limit and cover more.

- If your drug is contained in our non-preferred tier or our injectable tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our Formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs in the Specialty Tier S.

Generally, we will only approve your request for an Exception if the alternative drugs included on the Plan's Formulary or the drug in the highest tier subject to the tiering Exceptions process would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

Your physician must submit a statement supporting your Exceptions request. In order to help us make a decision more quickly, you should include supporting medical information from your doctor when you submit your Exception request.

If we approve your Exception request, our approval is valid for the remainder of the plan year, so long as your doctor continues to prescribe the drug for you and it continues to be safe and effective for treating your condition. If we deny your Exception request, you can appeal our decision.

Note: If we approve your Exception request for a non-Formulary drug, you cannot request an Exception to the co-payment we require you to pay for the drug.

Who may ask for a Coverage Determination?

You can ask us for a Coverage Determination yourself, or your prescribing doctor or someone you name may do it for you. The person you name would be your appointed representative. You can name a relative, friend, advocate, doctor, or anyone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to act as your appointed representative. This statement must be sent to us at Health Net, 10540 White Rock Road, Suite 280, Rancho Cordova, CA 95670. You can call Member Service to learn how to name your appointed representative.

You also have the right to have an attorney ask for a Coverage Determination on your behalf. You can 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.

Asking for a "Standard" or "Fast" Coverage Determination

Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard timeframe?

A decision about whether we will cover a Part D prescription drug can be a "standard" Coverage Determination that is made within the standard timeframe (typically within 72 hours; see below), or it can be a "fast" Coverage Determination that is made more quickly (typically within 24 hours; see below). A fast decision is sometimes called an "expedited Coverage Determination."

You can ask for a fast decision only if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for Part D Drugs that you have not received yet. You cannot get a fast decision if you are requesting payment for a Part D drug that you already received.)

Asking for a standard decision

To ask for a standard decision, you, your doctor, or your appointed representative should refer to our Member Service numbers listed on the cover and in the Benefits at a Glance section for assistance. Or, you can deliver a written request to Health Net, 10540 White Rock Road, Suite 280, Rancho Cordova, CA 95670, or fax it to 1-916-463-9754. To reach us after our regular business hours, please fax your request to 1-916-463-9754. Requests received after business hours are handled on the next business day.

Asking for a fast decision

You, your doctor, or your appointed representative can ask us to give a fast decision (rather than a standard decision) by calling our Member Service numbers listed on the cover and in the Benefits at a Glance section. Or, you can deliver a written request to Health Net, 10540 White Rock Road, Suite 280, Rancho Cordova, CA 95670, or fax it to 1-916-463-9754. To reach us after our regular business hours, please fax your request to 1-916-463-9754. Requests received after business hours are handled on the next business day. Be sure to ask for a "fast," "expedited," or "24-hour" review.

- If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.
- If you ask for a fast Coverage Determination without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast Coverage Determination, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "Grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast Coverage Determination, we will give you our decision within the 72-hour standard timeframe.

What happens when you request a Coverage Determination?

What happens, including how soon we must decide, depends on the type of decision.

1. For a standard Coverage Determination about a Part D drug, which includes a request about payment for a Part D drug that you already received.

   Generally, we must give you our decision no later than 72 hours after we have received your request, but we will make it sooner if your health condition requires. However, if your request involves a request for an Exception (including a Formulary Exception, tiering Exception, or an Exception from utilization management rules – such as dosage or Quantity Limits or Step Therapy requirements), we must make our decision no later than 72 hours after we have received your doctor's "supporting statement," which explains why the drug you are asking for is medically necessary. If you are requesting an Exception, you should submit your prescribing doctor's supporting statement with the request, if possible.

We will give you a decision in writing about the prescription drug you have requested. You will get this notification when we make our decision under the timeframe explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section "Appeal Level 1" explains how to file this appeal.

If we have not given you an answer within 72 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

2. For a fast Coverage Determination about a Part D drug that you have not received.

If you get a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review -- sooner if your health requires. If your request involves a request for an Exception, we must make our decision no later than 24 hours after we get your doctor's "supporting statement," which explains why the non-Formulary or non-preferred drug you are asking for is medically necessary.

We will give you a decision in writing about the prescription drug you have requested. You will get this notification when we make our decision, under the timeframe explained above. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section "Appeal Level 1" explains how to file this appeal.

If we decide you are eligible for a fast review, and we have not responded to you within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

If we do not grant your or your doctor's request for a fast review, we will give you our decision within the standard 72- hour timeframe discussed above. If we tell you about our decision not to provide a fast review by phone, we will send you a letter explaining our decision within three calendar days after we call you. The letter will also tell you how to file a "Grievance" if you disagree with our decision to deny your request for a fast review, and will explain that we will automatically give you a fast decision if you get a doctor's support for a fast review.

What happens if we decide completely in your favor?

If we make a Coverage Determination that is completely in your favor, what happens next depends on the situation.

1. For a standard decision about a Part D drug, which includes a request about payment for a Part D drug that you already received.

   We must authorize or provide the benefit you have requested as quickly as your health requires, but no later than 72 hours after we received the request. If your request involves a request for an Exception, we must authorize or provide the benefit no later than 72 hours after we get your doctor's "supporting statement." If you are requesting reimbursement for a drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we get the request.

2. For a fast decision about a Part D drug that you have not received.

   We must authorize or provide you with the benefit you have requested no later than 24 hours of receiving your request. If your request involves a request for an Exception, we must authorize or provide the benefit no later than 24 hours after we get your doctor's "supporting statement."

What happens if we deny your request?

If we deny your request, we will send you a written decision explaining the reason why your request was denied. We may decide completely or only partly against you. For example, if we deny your request for payment for a Part D drug that you have already received, we may say that we will pay nothing or only part of the amount you requested. If a Coverage Determination does not give you all that you requested, you have the right to appeal the decision. (See Appeal Level 1).

How to request an Appeal

The purpose of this section is to explain what you can do if you disagree with our Coverage Determination decision.

What kinds of decisions can be appealed?

If you are unhappy with our Coverage Determination decision, you can ask for an Appeal called a "redetermination." You can generally appeal our decision not to cover a Part D drug, vaccine, or other Part D benefit. You may also appeal our decision not to reimburse you for a Part D drug that you paid for, if you think we should have reimbursed you more than you received, or if you are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription. Finally, if we deny your Exceptions request, you can appeal.

How does the Appeals process work?

There are five levels to the Appeals process. Here are a few things to keep in mind as you read the description of these steps in the Appeals process:

- Moving from one level to the next. At each level, your request for Part D prescription drug benefits or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the requested drug or on other factors.
- Who makes the decision at each level? You make your request for coverage or payment of a Part D prescription drug directly to us. We review this request and make a Coverage Determination. If our Coverage Determination is to deny any part of your request, you can go on to the first level of appeal by asking us to review our Coverage Determination. If you are still dissatisfied with the outcome, you can ask for further review. If you ask for further review, your appeal is sent outside of Health Net, where people who are not connected to us review your case and make the decision. After the first level of appeal, all subsequent levels of appeal will be decided by someone who is connected to the Medicare program or the federal court system. This will help ensure a fair, impartial decision.

Each appeal level is discussed in greater detail below.

Appeal Level 1: If we deny any part of your request in our Coverage Determination, you may ask us to reconsider our decision. This is called an “appeal” or “request for redetermination.”

Please call Member Service if you need help with filing your appeal. You may ask us to reconsider our Coverage Determination, even if only part of our decision is not what you requested. When we get your request to reconsider the Coverage Determination, we give the request to people at our organization who were not involved in making the Coverage Determination. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether you are requesting reimbursement for a Part D drug you already received and paid for, or authorization of a Part D benefit (that is, a Part D drug that you have not yet received). If your appeal concerns a decision we made about authorizing a Part D benefit that you have not received yet, then you and/or your doctor will first need to decide whether you need a fast appeal. The procedures for deciding on a standard or a fast appeal are the same as those described for a standard or fast Coverage Determination. Please see the discussion under “Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard timeframe?" and “Asking for a fast decision.” While the process for deciding on a standard or fast appeal is the same as in

the case of a Coverage Determination, the place where the Appeal is sent is different. See "What if you want a 'fast' appeal" later in this section for more information.

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to get and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

- In writing: Health Net Appeals & Grievances Department
  Post Office Box 10450
  Van Nuys, CA 91410-0450
- By fax, at 1-800-977-1959.
- By telephone -- if it is a fast appeal -- at 1-800-806-8811.
- In person, at 21281 Burbank Blvd., Woodland Hills, CA, 91367.

You also have the right to ask us for a copy of information regarding your appeal. You can call at 1-800-806-8811, or write us at

Health Net Appeals & Grievances Department
Post Office Box 10450
Van Nuys, CA 91410-0450

Who may file your appeal of the Coverage Determination?

The rules about who may file an Appeal are almost the same as the rules about who may ask for a Coverage Determination. For a standard request, you or your appointed representative may file the request. A fast appeal may be filed by you, your appointed representative, or your prescribing doctor.

How soon must you file your appeal?

You need to file your appeal within 60 calendar days from the date included on the notice of our Coverage Determination. We can give you more time if you have a good reason for missing the deadline.

To file a standard appeal, you can send the Appeal to us in writing at,

Health Net Appeals & Grievances Department
Post Office Box 10450
Van Nuys, CA 91410-0450.

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast Coverage Determination. You, your doctor, or your appointed representative can ask us to give a fast appeal (rather than a standard appeal) by calling our Member Service numbers listed on the cover and in the Benefits at a Glance section. Or, you can deliver a written request to,

Health Net Appeals & Grievances Department
Post Office Box 10450
Van Nuys, CA 91410-0450
or fax it to 1-800-977-1959.

To reach us after our regular business hours, please fax your request to 1-800-977-1959. Requests received after business hours are handled on the next business day. Be sure to ask for a "fast," "expedited," or "72-hour" review. Remember, that if your prescribing doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically treat you as eligible for a fast appeal. While the process for deciding on a standard or fast appeal is the same as in the case of a Coverage Determination, the place where the Appeal is sent is different.

How soon must we decide on your appeal?

How quickly we decide on your appeal depends on the type of appeal:

1. For a standard decision about a Part D drug, which includes a request for reimbursement for a Part D drug you already paid for and received.

   After we get your appeal, we have up to 7 calendar days to give you a decision, but will make it sooner if your health condition requires us to. If we do not give you our decision within 7 calendar days, your request will automatically go to the second level of appeal, where an independent review organization will review your case.

2. For a fast decision about a Part D drug that you have not received.

   After we get your appeal, we have up to 72 hours to give you a decision, but will make it sooner if your health requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

What happens next if we decide completely in your favor?

1. For a decision about reimbursement for a Part D drug you already paid for and received.

   We must send payment to you no later than 30 calendar days after we get your request to reconsider our Coverage Determination.

2. For a standard decision about a Part D drug you have not received.

   We must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 7 calendar days after we get your appeal.

3. For a fast decision about a Part D drug you have not received.

   We must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 72 hours after we received your appeal.

What happens next if we deny your appeal?

If we deny any part of your appeal, you or your appointed representative have the right to ask an independent review organization to review your case. This independent review organization contracts with the Federal government and is not part of our Plan.

Appeal Level 2: If we deny any part of your first appeal, you may ask for a review by a government-contracted independent review organization

What independent review organization does this review?

At the second level of appeal, your appeal is reviewed by an outside, independent review organization that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency

that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this independent review organization.

How soon must you file your appeal?

You or your appointed representative must make a request for review by the independent review organization in writing within 60 calendar days after the date you were notified of the decision on your first appeal. You must send your written request to the independent review organization whose name and address is included in the redetermination notice you receive from us. The independent review organization's name and address is also listed on the Request for Reconsideration form you will receive with the redetermination notice if we deny your appeal. You can use the Request for Reconsideration form to ask the independent review organization to review your case.

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast Coverage Determination, except your prescribing doctor cannot file the request for you-- only you or your appointed representative may file the request. If you want to ask for a fast appeal, please follow the instructions under "Asking for a fast decision." Remember, that if your prescribing doctor provides a written or oral statement supporting your request for a fast appeal, the independent review organization will automatically treat you as eligible for a fast appeal.

How soon must the independent review organization decide?

After the independent review organization gets your appeal, how long the independent review organization can take to make a decision depends on the type of appeal:

1. For a standard request about a Part D drug, which includes a request about reimbursement for a Part D drug that you already paid for and received, the independent review organization has up to 7 calendar days from the date it gets your request to give you a decision.
2. For a fast decision about a Part D drug that you have not received, the independent review organization has up to 72 hours from the time it gets the request to give you a decision.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. For a decision about reimbursement for a Part D drug you already paid for and received.

   We must pay within 30 calendar days from the date we get notice reversing our Coverage Determination. We will also send the independent review organization a notice that we have given effect to their decision.
2. For a standard decision about a Part D drug you have not received.

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our Coverage Determination. We will also send the independent review organization a notice that we have given effect to their decision.
3. For a fast decision about a Part D drug you have not received.

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our Coverage Determination. We will also send the independent review organization a notice that we have given effect to their decision.

What happens next if the independent review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You or your appointed representative may continue your appeal by asking for a review by an Administrative Law Judge (see Appeal Level 3), so long as the dollar value of the contested Part D benefit meets the minimum requirement provided in the independent review organization's decision.

Appeal Level 3: If the independent review organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

As stated above, if the independent review organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge. You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date of the decision made at Appeal Level 2. You may request that the Administrative Law Judge extend this deadline for good cause. You must send your written request to the Administrative Law Judge Field Office indicated in the Notice of Reconsideration letter sent by the independent review organization. The address and contact information for the Administrative Law Judge Field Office is located in this notice. Administrative Law Judge Field Office's can also be found at http://www.hhs.gov/omha/offices.html.

During the Administrative Law Judge review, you may present evidence, review the record (by either receiving a copy of the file or getting the file in person when feasible), and be represented by counsel. The Administrative Law Judge will not review your appeal if the dollar value of the contested Part D benefit does not meet the minimum requirement provided in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

How is the dollar value (the "amount remaining in controversy") calculated?

If we have refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes any costs you could incur based on what you would be charged for the drug and the number of refills prescribed for the requested drug during the plan year. Projected value includes your co-payments and costs paid by other entities.

You may also combine multiple Part D claims to meet the dollar value if:

1. The claims involve the delivery of Part D prescription drugs to you;
2. All of the claims have received a determination by the independent review organization as described in Appeal Level 2;
3. Each of the combined requests for review are filed in writing within 60 calendar days after the date that each decision was made at Appeal Level 2; and
4. Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor:

The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it. What happens next depends on the type of appeal:

1. For a decision about payment for a Part D drug you already received.

   We must send payment to you no later than 30 calendar days from the date we get notice reversing our Coverage Determination.

2. For a standard decision about a Part D drug you have not received.

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our Coverage Determination.

3. For a fast decision about a Part D drug you have not received.

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our Coverage Determination.

If the Judge rules against you:

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

Appeal Level 4: Your case may be reviewed by the Medicare Appeals Council

The Medicare Appeals Council will first decide whether to review your case. There is no minimum dollar value for the Medicare Appeals Council to hear your case. If you got a denial at Appeal Level 3, you or your appointed representative can request review by filing a written request with the Council.

The Medicare Appeals Council does not review every case. If they decide not to review your case, then you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor:

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. For a decision about payment for a Part D drug you already received.

   We must send payment to you no later than 30 calendar days from the date we get notice reversing our Coverage Determination.

2. For a standard decision about a Part D drug you have not received.

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our Coverage Determination.

3. For a fast decision about a Part D drug you have not received.

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our Coverage Determination.

If the Council decides against you:

If the amount involved meets the minimum requirement provided in the Medicare Appeals Council's decision, you have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). The letter you get from the Medicare Appeals Council will tell you how to request this review. If the value is less than the minimum requirement, the Council's decision is final and you may not take the Appeal any further.

Appeal Level 5: Your case may go to a Federal Court

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case.

If the contested amount meets the minimum requirement provided in the Medicare Appeals Council's decision, you may ask a Federal Court Judge to review the case.

How soon will the Judge make a decision?

The Federal judiciary is in control of the timing of any decision.

If the Judge decides in your favor:

Once we get notice of a judicial decision in your favor, what happens next depends on the type of appeal:

1. For a decision about payment for a Part D drug you already received.

   We must send payment to you within 30 calendar days from the date we get notice reversing our Coverage Determination.

2. For a standard decision about a Part D drug you have not received.

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our Coverage Determination.

3. For a fast decision about a Part D drug you have not received.

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our Coverage Determination.

If the Judge decides against you:

The Judge's decision is final and you may not take the Appeal any further.

Binding Arbitration

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 EOC 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. 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 any right they may have 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 arbitration's 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 have no jurisdiction to award more than $200,000. In the event that 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: Litigation Administrator
PO Box 4504
Woodland Hills, CA 91365-4505

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this EOC, 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. The award will be final and binding on all parties except to the extent that 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 Litigation Administrator 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.

Please note that binding arbitration does not apply to disputes that are subject to the Medicare Appeals process as described earlier in this section.

SECTION 7 - LEAVING THIS PLAN AND YOUR CHOICES FOR CONTINUING PRESCRIPTION DRUG COVERAGE AFTER YOU LEAVE

What is "Disenrollment"?

"Disenrollment" from our Plan means ending your membership with us. Disenrollment can be voluntary (your own choice) or, in limited circumstances, involuntary (not your own choice):

You might leave our Plan because you have decided that you want to leave. You can decide to leave for any reason during specified times (See "When Can You Disenroll/Switch Prescription Drug Plans?" below).

There are also a few situations where you would be required to leave. For example, you would have to leave our Plan if you move out of our geographic Service Area or if we no longer offer prescription drug coverage in your geographic area. We are not allowed to ask you to leave our Plan because of your health.

Whether leaving our Plan is your choice or not, this section explains your Medicare prescription drug coverage choices after you leave and the rules that apply.

Until your prescription drug coverage with our Plan ends, use our Network Pharmacies to fill your Part D prescription drugs

You can choose to Disenroll from your current Plan from November 15 through December 31 of every year. In certain cases, such as if you move or enter a nursing home, you can Disenroll from your Plan at other times. After you request to Disenroll, your Plan will let you know, in writing, the date your coverage ends. If you don't get a letter, call Member Service and ask for the date.

While you are waiting for your membership to end, you are still a Member and must continue to get your prescription drugs as usual through our Plan's Network Pharmacies. In most cases, your Part D prescriptions are covered only if they are filled at a Network Pharmacy, are listed on our Formulary, and you follow other coverage rules.

If you have any questions about your prescription drug coverage with our Plan, please refer to our Member Service numbers listed on the cover and in the Benefits at a Glance section.

What are your options for getting Part D prescription drug coverage if you leave our Plan?

If you leave our Plan, to get prescription drug coverage you may join another Medicare Prescription Drug Plan. You also have the choice of joining a Medicare Advantage Plan or a Medicare Cost Plan with prescription drug coverage if this type of plan is available in your area, they are accepting new members, and you meet the eligibility requirements of the plan.

Medicare Part D Prescription Drug Plan. You may choose to join another Prescription Drug Plan that adds prescription drug benefits to your regular Medicare coverage. To enroll in another Prescription Drug Plan in your area, you must be entitled to Medicare benefits under Part A and/or currently enrolled in Part B, and reside in the service area of the Prescription Drug Plan. Refer to the next section, "When can you Disenroll / switch Medicare Prescription Drug plans" for information on when you can make this change.

Medicare Advantage Prescription Drug Plan (MA-PD) or Medicare Cost Plan with Part D Prescription Drug Coverage. If you choose to join a Medicare Advantage Plan that offers Part D prescription drug coverage, then you must get your Medicare prescription drug coverage through that Medicare Advantage Plan. If you choose to join a Medicare Cost Plan that offers prescription drug coverage, you can get your drug coverage either from the Cost Plan or by joining a separate Medicare Prescription Drug Plan. For more information on joining a Medicare Advantage Plan or a Medicare Cost Plan in your area, please contact 1-800-MEDICARE (TTY/TDD users call 1-877-486-2048) or visit www.medicare.gov. Refer to the next section, "When can you Disenroll / switch Medicare Prescription Drug plans" for information on when you can make this change. You should contact the new plan that you are interested in for information on how and when you are able to join it.

Note: If you Disenroll from our Plan and do not enroll in another Medicare Part D Prescription Drug Plan, or do not have other prescription drug coverage that is at least as good as Medicare prescription drug coverage, you may have to pay a penalty if you enroll in a Medicare prescription drug plan at a later date. Refer to Section 3 for more information on the penalty.

When can you Disenroll / switch Medicare Part D Prescription Drug Plans?

In general, you may only Disenroll or switch prescription drug plans every year during the Annual Coordinated Enrollment Period (see below) or under certain special circumstances. You can switch your Prescription Drug Plan during the following periods:

Annual Coordinated Enrollment Period

During the Annual Coordinated Enrollment Period, any Medicare beneficiary may Disenroll from any Prescription Drug Plan and join another Prescription Drug Plan, or join a Medicare Advantage Plan with prescription drug coverage, or choose not to have any Medicare prescription drug coverage.

For coverage beginning in 2008, the Annual Coordinated Enrollment Period begins on November 15th and ends on December 31st.

Please remember, if during this election period you Disenroll from our Plan and do not enroll in another Prescription Drug Plan or Medicare Advantage Plan with Part D prescription drug coverage during this election period, you may have to pay a penalty for Medicare prescription drug coverage in the future.

If you join another Prescription Drug Plan during the Annual Coordinated Enrollment Period, your enrollment in our Plan will end on December 31st and your enrollment in the new plan will be effective on January 1st of the following year.

Special Enrollment Period

Generally, you may not Disenroll from our Plan and enroll in a new Prescription Drug Plan during other times of the year unless you qualify for a Special Enrollment Period. In order to qualify for a Special Enrollment Period, one of the following must apply to you:

- Our Plan no longer offers prescription drug coverage in the area where you live.
- You move outside our Plan's Service Area. The Plan's Service Area includes the state(s) listed under "What is the geographic Service Area of our Plan?" on page (v) at the beginning of this Evidence of Coverage.
- You have an involuntary loss of Creditable Prescription Drug Coverage.

- You were not adequately informed about your loss of Creditable Prescription Drug Coverage, or you were not adequately informed that you never had Creditable Prescription Drug Coverage.
- Your enrollment in our Plan was unintentional, inadvertent, or a mistake, because of the error, misrepresentation or inaction of a Federal employee, or a person acting upon the Federal government's behalf.
- You get benefits from both Medicare and Medicaid programs or you were eligible for benefits from both Medicare and Medicaid and you lose your Medicaid benefits.
- Our Plan's contract with the Centers for Medicare & Medicaid Services is terminated.
- You were a Member of a Medicare Advantage Plan with Part D prescription drug coverage and decided to join a Prescription Drug Plan during the Medicare Advantage Plan's Open Election Period.
- You are able to demonstrate that our Plan has substantially violated a material provision in its contract. This includes, but is not limited to:
- If our Plan failed to provide you with prescription drug coverage in a timely manner.
- You are able to demonstrate that our Plan misrepresented itself in its marketing.
- You are enrolling in or Disenrolling from a Medicare Prescription Drug Plan sponsored by your current or former employer or by your spouse's current or former employer.
- In certain cases in which our Plan is sanctioned by the Centers for Medicare & Medicaid Services.
- You enroll in or disenroll from your state's Program of All-Inclusive Care for the Elderly.
- You move into, live in, or move out of certain medical facilities, including a skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, psychiatric hospital or unit, rehabilitation hospital or unit, long-term care hospital, or certain other hospitals.
- You get extra help and the Centers for Medicare & Medicaid Services enrolled you in your current plan.

If you feel you qualify for a Special Enrollment Period, please contact your Group to assist you in the enrollment process.

How do you Disenroll?

If you are joining another Prescription Drug Plan, you must contact that plan to request enrollment information. Once you are enrolled in your new plan, your membership in our Plan will automatically end with no action required on your part. Your new plan will tell you, in writing, the date when your prescription drug coverage in that plan begins. Your prescription drug coverage with our Plan will end on that same day (this will be your "Disenrollment date"). Remember, you are still a Member of our Plan until your Disenrollment date, and must continue to get your prescription drug coverage, as usual, through our Plan until the date your membership ends.

If you wish to leave our Plan, and you are not enrolling in another Prescription Drug Plan, you will need to submit a Disenrollment request to your Group. Your request should include your name, Medicare number, date of birth, and Health Net identification number. Please remember to sign and date the request and to include a phone number where we can reach you in case we need additional information. You can contact your Group to get a copy of the Disenrollment form and the address or fax number

where you can send the Disenrollment request. You may also Disenroll by calling 1-800-MEDICARE (1-800-633-4227), TTY/TDD users should call 1-877-486-2048. You may only Disenroll during the Annual Coordinated Election Period unless you qualify for a Special Enrollment Period.

When can our Plan Disenroll you?

Our Plan can Disenroll you for the following reasons:

- You are no longer eligible for Medicare Part D prescription drug coverage.
- If our Plan is no longer contracting with Medicare or leaves your Service Area.
- When you move out of our Plan's Service Area. The Plan's Service Area includes the state(s) listed under "What is the geographic Service Area of our Plan?" on page (v) at the beginning of this Evidence of Coverage.
- You materially misrepresent third-party reimbursement.
- You engage in disruptive behavior, provided fraudulent information when you enrolled or abuse your enrollment card.
- The Group Service Agreement (between the Group and us) is terminated, including termination due to nonpayment of premiums by the Group.

If You Are No Longer Eligible For Medicare Part D Prescription Drug Coverage

If you lose your eligibility for Medicare prescription drug coverage, our Plan can no longer offer you Medicare prescription drug coverage. In order to be eligible for prescription drug coverage under Medicare, you must have Part A and/or Part B, and reside in our Plan's Service Area.

When Health Net Is No Longer Contracting With Medicare or Your Plan Leaves Your Service Area

If we leave the Medicare program or no longer offer prescription drug coverage in the Service Area where you live, we will notify you in writing. (Note, the Plan's Service Area includes the state(s) listed under "What is the geographic Service Area of our Plan?" on page (v) at the beginning of this Evidence of Coverage.) If this happens, your membership in our Plan will end, and you will have to enroll in another Medicare Prescription Drug Plan to continue your prescription drug coverage. All of the benefits and rules described in this Evidence of Coverage will continue until your membership ends. This means that you must continue to get your prescription drugs in the usual way through our Plan's Network Pharmacies until your membership ends.

Your choices include joining another Medicare Prescription Drug Plan or a Medicare Advantage Plan with prescription drug coverage if these plans are available in your area and are accepting new members. Once we have notified you in writing that we are leaving the Medicare program or the area where you live, you may enroll in another plan (See "When Can You Disenroll/Switch Prescription Drug Plans?" above for specific information on special enrollment periods)

Health Net has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract may be renewed each year. However, Health Net or CMS can decide to end the contract at any time. You will generally be notified 90 days in advance if this situation occurs. However, your advance notice may be as little as 30 days or even fewer days if CMS must end our contract in the middle of the year.

When You Move Out Of Our Plan's Service Area

This Plan's Service Area includes the state(s) listed under "What is the geographic Service Area of our Plan?" on page (v) at the beginning of this Evidence of Coverage. If you move out of the Service Area, you must contact your Group to update your information and you will need to leave ("Disenroll" from) our Plan. An earlier part of this section tells about the choices you have if you leave our Plan and explains how to leave.

You Materially Misrepresent Third-Party Reimbursement

If you intentionally withhold or falsify information about third-party reimbursement coverage, CMS requires Health Net to Disenroll you. In addition, if you are Disenrolled from our Plan for misrepresentation of third party reimbursement, Health Net has the right to decline you future enrollment in our Prescription Drug Plan.

You Engage in Disruptive Behavior, Provide Fraudulent Information When You Enrolled, or Abuse Your Enrollment Card

You may be asked to leave our Plan in the following circumstances:

- If you behave in a way that seriously affects our ability to arrange or provide services for you or for others who are members of our Plan. We cannot make you leave (i.e., Disenroll from) our Plan for this reason unless we get permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
- If you give us information on your enrollment form that you know is false or deliberately misleading, and it affects whether or not you can enroll in our Plan.
- If you let someone else use your Plan membership card to get prescription drugs for themselves or for others. Before we ask you to leave (i.e., Disenroll from) our Plan for this reason, we must refer your case to the Inspector General, and this may result in criminal prosecution.

We cannot ask you to leave our Plan because of your health

No member of any Medicare Part D Prescription Drug Plan can be asked to leave the plan for any health-related reasons or the number of prescriptions a member takes. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227; TTY/TDD 1-877-486-2048), the national Medicare help line.

You have the right to make a complaint if we ask you to leave our Plan

If we ask you to leave our Plan, we will tell you our reasons in writing and explain how you can file a complaint against us if you want. Refer to Section 6 for more information.

SECTION 8 - YOUR RIGHTS AND RESPONSIBILITIES AS A MEMBER OF THIS PLAN

Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this first part of Section 8, we explain your Medicare rights and protections as a Member of this Plan. We will tell you what you can do if you think you are being treated unfairly or your rights are not being respected. If you want Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. We must obey laws against discrimination that protect you from unfair treatment. These laws say that we cannot discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability you may have.

If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. You can also reach the Office for Civil Rights at 1800-368-1019 or TTY/TDD 1-800-537-7697, or call the Office for Civil Rights in your area, which are listed at the end of this EOC.

If you need help with communication, such as help from a language interpreter, please call our Member Service numbers listed on the cover.

Your right to the privacy of your medical records and personal health information

There are Federal and State laws that protect the privacy of your medical records and personal health information. We keep your personal health information private as protected under these laws. Any personal health information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged 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 review your request and determine whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about the privacy of your personal information and medical records, please call our Member Service numbers listed on the cover.

NOTE: As a Member of Health Net, personal information, including prescription drug event data, will be released to Medicare, who may release it to researchers pursuant to all applicable privacy laws, for research purposes.

Your right to get your prescriptions filled within a reasonable period of time

As explained in this Evidence of Coverage, you should get all of your prescriptions filled from a Network Pharmacy, that is, from pharmacies that contract with our Plan. You have the right to go to any Network Pharmacies in order to get your prescriptions filled at the benefit level. You have the right to timely access to your prescriptions. "Timely access" means that you can get your prescriptions filled within a reasonable amount of time. Section 1 explains how to use a Network Pharmacy to get your prescriptions filled.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to know about the different Medication Management Treatment Programs we offer and in which you may participate. You have the right to be told about any risks involved in your care. You have the right to refuse treatment. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

You have the right to get a detailed explanation from us if you believe that a Network Pharmacy has denied coverage for a drug that you believe you are entitled to get or care you believe you should continue to get. In these cases, you must request an initial decision. "Initial decisions" are discussed in Section 6.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "Grievances" are the two different types of complaints you can make. Which one you make depends on your situation. Appeals and Grievances are discussed in Section 6.

If you make a complaint, we must treat you fairly (i.e., not discriminate against you). You have the right to get a summary of information about the Appeals and Grievances that members have filed against us in the past. To get this information, call our Member Service numbers listed on the cover.

Your right to get information about your drug coverage and costs

This Evidence of Coverage tells you what you have to pay for prescription drugs as a Member of Plan. If you need more information, please call our Member Service numbers listed on the cover. You have the right to an explanation from us about any bills you may get for drugs not covered by our Plan. We must tell you in writing why we will not pay for a drug, and how you can file an Appeal to ask us to change this decision. See Section 6 for more information about filing an Appeal.

Your right to get information about Health Net and our Network Pharmacies

You have the right to get information from us about Health Net and this Plan. This includes information about our financial condition and about our Network Pharmacies. To get any of this information, call Member Service at the phone number listed on the cover.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call our Member Service numbers listed on the cover and in the Benefits at a Glance section. You can also get free help and information from your State Health Insurance Assistance Program, or SHIP (the Introduction tells how to contact the SHIP in your state). In addition, the Medicare program has written a booklet called Your Medicare Rights and Protections. To get a free copy, call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, you can visit www.medicare.gov to order this booklet or print it directly from your computer.

What can you do if you think you have been treated unfairly or your rights are not being respected?

For concerns or problems related to your Medicare rights and protections described in this section, you can call our Member Service numbers listed on the cover. You can also get help from your State Health Insurance Assistance Program, or SHIP (the Introduction tells how to contact the SHIP in your state).

What are your responsibilities as a Member of our Plan?

Along with the rights you have as a Member of our Plan, you also have some responsibilities. Your responsibilities include the following:

- Become familiar with your coverage and the rules you must follow to get care as a member. You can use this Evidence of Coverage and other information we give you to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Member Service at the phone number listed on the cover if you have any questions.
- Give your health care provider(s) the information they need to care for you, and follow the treatment plans and instructions given to you. Be sure to ask your health care provider(s) if you have any questions.
- Pay any applicable premium and Deductible, copayment and coinsurance amounts you may owe for the Covered Drugs you get. You must also meet your other financial responsibilities that are described in Section 3.
- Let us know if you have any questions, concerns, problems, or suggestions. If you do, please call our Member Service numbers listed on the cover.

SECTION 9 - LEGAL NOTICES

Notice about governing law

Many different laws apply to this Evidence of Coverage. Some parts may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The 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 (CMS). Specifically, laws on the Medicare prescription drug program can be found at sections 1860D-1 through 1860D-42 of the Social Security Act (42 U.S.C. §§ 1395w-101 through 1395w-152) and in Part 423 of Title 42 of the Code of Federal Regulations. In addition, other Federal laws may apply, and, under certain situations, the laws of your state may also apply.

Notice about non-discrimination

When we make decisions about the provision of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Prescription Drug Plans, like us, 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, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

Prescription drug fraud

If you believe something has occurred fraudulently, wastefully and/or abusively, in relation to your prescription drug coverage, please contact Health Net at 1-800-747-0877. All calls will be kept confidential, and you may remain anonymous if you choose.

Circumstances Beyond Health Net's Control

Except as otherwise required by law or regulation, to the extent that a natural disaster, war, riot, civil insurrection, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, disability of significant medical group personnel, or other similar events, not within the control of Health Net, results in the facilities, or personnel, of Health Net not being available to provide or arrange for services or benefits under this Evidence of Coverage, Health Net's obligation to provide such services or benefits shall be limited to the requirement that Health Net make a good faith effort to provide or arrange for the provision of such services or benefits within the resulting limitations on the availability of its facilities or personnel.

When A Third Party Causes A Member Injuries

If you are ever injured through the actions of another person (a third party), Health Net will provide benefits for all covered medications that you receive through this plan. However, except as otherwise required by law or regulation, if you receive money because of your injuries, you must reimburse Health Net or the pharmacy for the value of any medications provided to you through this plan.

Examples of how an injury could be caused by the actions of another person:

- You are in a car accident and the other driver is at fault.
- You slip and fall in a store because a wet spot was left on the floor.

Steps You Must Take

Health Net's legal right to reimbursement is called a lien.

If you are injured because of a third party, you must cooperate with Health Net's and the pharmacy's efforts to obtain reimbursement, including:

- Telling Health Net and the pharmacy the name and address of the third party, if you know it, the name and address of your lawyer, if you are using a lawyer, and describing how the injuries were caused.
- Completing any paperwork that Health Net or the pharmacy may require to assist in enforcing the lien.
- Promptly responding to inquiries from the lienholders about the status of the case and any settlement discussions.
- Notifying the lienholders immediately upon you or your lawyer receiving any money from the third parties or their insurance companies.
- Holding any money that you or your lawyer receive from the third party or their insurance companies in trust, and reimbursing Health Net and the pharmacy for the amount of the lien as soon as you are paid by the third party.

How The Amount Of your Reimbursement Is Determined

Your reimbursement to Health Net or the pharmacy under this lien is based on the value of the medications you receive and the costs of perfecting this lien. For purposes of determining the lien amount, the value of the medications depends on how the pharmacy was paid and will be determined as permitted by law. Unless the money that you receive came from a Workers' Compensation claim, the following applies:

- The amount of the reimbursement that you owe Health Net or the pharmacy will be reduced by the percentage that your recovery is reduced if a judge, jury or arbitrator determines that you were responsible for some portion of your injuries.
- The amount of the reimbursement that you owe Health Net or the physician group will also be reduced by a pro rata share for any legal fees or costs that you paid from the money you received.
- The amount that you will be required to reimburse Health Net or the pharmacy for medications you receive under this plan will not exceed one-third of the money that you receive if you do engage a lawyer, or one-half of the money you receive if you do not engage a lawyer.
- Coordination of benefits protects you from higher plan premiums. The end result is more affordable health care.

Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

This Notice tells you about the ways in which Health Net (referred to in this Notice as "we" or "the Plan") may collect, use and disclose your protected health information and your rights concerning your protected health information. "Protected health information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We are required by federal and state laws to provide you with this notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this notice while it is in effect. Some of the uses and disclosures described in this notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

How We May Use And Disclose Your Protected Health Information

We may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment.

Payment. We use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment or for premium billing.

Health Care Operations. We use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or customer service.

Treatment. We may use and disclose your protected health information to assist your health care providers (doctors, dentists, hospitals and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.

Plan Sponsor. If you are enrolled through a group health plan, we may provide non-identifiable summaries of claims and expenses for enrollees in a group health plan to the plan sponsor, which is usually the employer. If the plan sponsor provides plan administration services, we may also provide access to identifiable health information to support its performance of such services which may include but are not limited to claims audits or customer services functions. Health Net will only share health information upon a certification from the plan sponsor representing there are restrictions in place to ensure that only plan sponsor employees with a legitimate need to know will have access to health information in order to provide plan administration functions.

We may also disclose protected health information to a person, such as a family member, relative, or close personal friend, who’s involved with your care or payment. We may disclose the relevant protected health information to these persons if you do not object or we can reasonably infer from the circumstances that you do not object to the disclosure; however, when you are not present or are incapacitated, we can make the disclosure if, in the exercise of professional judgment, we believe the disclosure is in your best interest.

Other Permitted Or Required Disclosures

As Required by Law. We must disclose protected health information about you when required to do so by law.

Public Health Activities. We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.

Victims of Abuse, Neglect or Domestic Violence. We may disclose protected health information to government agencies about abuse, neglect or domestic violence.

Health Oversight Activities. We may disclose protected health information to government oversight agencies (e.g., California Department of Health Services) for activities authorized by law.

Judicial and Administrative Proceedings. We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.

Law Enforcement. We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.

Coroners, Funeral Directors, Organ Donation. We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.

Research. Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.

To Avert a Serious Threat to Health or Safety. We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

Special Government Functions. We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.

Workers' Compensation. We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

Other Uses Or Disclosures With An Authorization

Other uses or disclosures of your protected health information will be made only with your written authorization, unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

Your Rights Regarding Your Protected Health Information

You have certain rights regarding protected health information that the Plan maintains about you.

Right To Access Your Protected Health Information. You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.

Right To Amend Your Protected Health Information. If you feel that protected health information maintained by the Plan is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by the Plan, as is often the case for health information in our records or you ask to amend a record that is already accurate and complete.

If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.

Right to an Accounting of Disclosures by the Plan. You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.

Right To Request Restrictions on the Use and Disclosure of Your Protected Health Information. You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. We may not agree to your request. If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information or both; and (3) to whom you want the restrictions to apply.

Right To Receive Confidential Communications. You have the right to request that we use a certain method to communicate with you about the Plan or that we send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

Right to a Paper Copy of This Notice. You have a right at any time to request a paper copy of this notice, even if you had previously agreed to receive an electronic copy.

Contact Information for Exercising Your Rights. You may exercise any of the rights described above by contacting our privacy office. See the end of this notice for the contact information.

Health Information Security

Health Net requires its employees to follow the Health Net security policies and procedures that limit access to health information about Members to those employees who need it to perform their job responsibilities. In addition, Health Net maintains physical, administrative and technical security measures to safeguard your protected health information.

Changes To This Notice

We reserve the right to change the terms of this notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the future. We will provide you with a copy of the new notice whenever we make a material change to the privacy practices described in this notice. We also post a copy of our current notice on our website at www.healthnet.com. Any time we make a material change to this notice, we will promptly revise and issue the new notice with the new effective date.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with us and/or with the Secretary of the Department of Health and Human Services. All complaints to the Plan must be made in writing and sent to the privacy office listed at the end of this notice.

We support your right to protect the privacy of your protected health information. We will not retaliate against you or penalize you for filing a complaint.

Contact The Plan

If you have any complaints or questions about this notice or you want to submit a written request to the Plan as required in any of the previous sections of this notice, you may send it in writing to:

Health Net Privacy Office
Attention: Director, Information Privacy
Post Office Box 9103
Van Nuys, CA 91409

You may also contact us at:

Telephone: 1-800-539-4072
Fax: 1-818-676-8981
Email: Privacy@healthnet.com

SECTION 10 - DEFINITIONS OF SOME WORDS USED IN THIS EVIDENCE OF COVERAGE

For the terms listed below, this section either gives a definition or directs you to a place in this Evidence of Coverage that explains the term

Appeal – An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for health care services or payment for services you already received. You may also make a complaint if you disagree with a decision to stop services that you are receiving. For example, you may ask for an Appeal if Medicare doesn't pay for an item or service you think you should be able to get. There is a specific process that your Part D Plan Sponsor must use when you ask for an Appeal. Section 6 explains what appeals are, including the process involved in making an Appeal.

Brand Name Drugs- A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, Generic Drugs are manufactured and sold by other drug manufacturers and are sometimes not available until after the patent on the brand-name drug has expired.

Catastrophic Coverage- The phase in the benefit where the Member will pay a low co-payment or co-insurance for their drugs after they or other qualified parties on their behalf have spent $4,050 in drug costs during their covered year. Please see Section 4 of this document.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 1 tells how you can contact CMS.

Coverage Determination –A decision from your Medicare drug plan about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a Coverage Determination. You need to call or write to your plan to ask for a formal decision about the coverage if you disagree.

Covered Drugs – The general term we use to mean all of the prescription drugs covered by our Plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is as good as the standard Medicare prescription drug coverage, that expects to pay out, on average, as much as or more than Medicare's standard prescription drug coverage.

Deductible – The amount of money you must first pay for your drugs before the plan will begin paying for your Covered Drugs.

Disenroll or Disenrollment – The process of ending your membership in our Plan. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 7 discusses Disenrollment.

Domestic Partner – A domestic partner is a person eligible for coverage provided that the partnership with the Subscriber meets all domestic partnership requirements under California law or other recognized state or local agency. The Domestic Partner and Subscriber must:

1. Have a common residence. It is not necessary that the legal right to possess the common residence be in both names.
2. Not be married or a member of another domestic partnership with someone else that has not been terminated, dissolved or judged a nullity.
3. Not be related by blood in a way that would prevent them from being married to each other in this state.
4. Be at least 18 years of age.
5. Be capable of consenting to the domestic partnership.
6. Be either of the following:
7. Members of the same sex; or
8. Members of the opposite sex and one or both be eligible for Social Security benefits and one or both be over the age of 62.
9. Both file a Declaration of Domestic Partnership with the Secretary of State or an equivalent document with another recognized state or local agency, or both are persons of the same sex who have validly formed a legal union other than marriage in a jurisdiction outside of California which is substantially equivalent to a Domestic Partnership as defined under California law.

(The requirements listed above are California statutory eligibility requirements. Your Group's Domestic Partner eligibility requirements may be less restrictive.)

Evidence of Coverage and Disclosure Information – This document, along with your enrollment form and any other attachments, which explains your coverage, defines our obligations, and explains your rights and responsibilities as a Member of our Plan.

Exception – A type of Coverage Determination that, if approved, allows you to get a drug that is not on your plan sponsor's Formulary (a Formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a Formulary exception).

Formulary – A list of Covered Drugs provided by the plan. Our Formulary includes drugs that are listed on the Health Net Medicare Drug List and the Health Net Group Formulary Supplement.

Generic Drug – A prescription drug that has the same active-ingredient formula as a brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as brand-name drugs.

Grievance – A type of complaint you make about us or one of our plan providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 6 for more information about Grievances.

Group – The business organization (usually an employer or trust) to which Health Net has issued the Group Service Agreement to provide the benefits of this Plan.

Initial Coverage Period – This is the period after you have met your Deductible (if you have one) and before you reach Catastrophic Coverage.

Late Enrollment Penalty – An amount added to your monthly premium for a Medicare drug plan, if you don't join when you're first able. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions.

Medicare – 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 (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage Plan with Prescription Drug Coverage –A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. In most cases, Medicare Advantage Plans also offer Medicare prescription drug coverage. A Medicare Advantage Plan can be an HMO, PPO, or a Private Fee-for-Service Plan.

Medicare Health Plan – A Medicare Advantage Plan (such as an HMO, PPO, or Private Fee-for-Service Plan) or other plan such as a Medicare Cost Plan. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plans that are offered in their area, except those who have End-Stage Renal Disease (unless certain exceptions apply).

Medigap Policy -- A Medicare supplement insurance policy sold by private insurance companies to fill "gaps" in the Original Medicare Plan. Except in Massachusetts, Minnesota, and Wisconsin, there are 12 standardized plans labeled Plan A through Plan L. Medigap policies only work with the Original Medicare Plan.

Member (member of our Plan) – 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 Service – A department responsible for answering your questions about your membership, benefits, grievances, and appeals. See the Benefits at a Glance section for information about how to contact Member Service

Network Pharmacy – A Network Pharmacy is a pharmacy where members of our Plan can get their prescription drug benefits. We call them "Network Pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our Network Pharmacies.

Out-of-Network Pharmacy – A pharmacy that does not have a contract with our Plan to coordinate or provide Covered Drugs to members of our Plan. As explained in this Evidence of Coverage, most services you get from non-Network Pharmacies are not covered by our Plan unless certain conditions apply. See Section 1.

Part D Drugs – Drugs that Congress permitted our plan to offer as part of a standard Medicare prescription drug benefit. We may or may not offer all Part D Drugs, see your Formulary for a specific list of Covered Drugs. Certain categories of drugs, such as benzodiazepines and barbiturates, were specifically excluded by Congress from the standard prescription drug package (see Section 4 for a listing of these drugs). These drugs are not considered Part D Drugs.

Prior Authorization – Approval in advance to get certain drugs that may or may not be on our Formulary. Some services are covered only if your doctor or other plan provider gets "Prior Authorization" from us. Covered services that need Prior Authorization are marked in the Formulary.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Service Area – A geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan.

Specialty Tier I (Injectable Drugs) – Lower cost injectable drugs. These medications are available to you at a coinsurance level.

Specialty Tier S (Specialty Drugs) – High cost oral and injectable specialty drugs. These medications are available to you at a coinsurance level and are not eligible for exceptions for payment at a lower tier.

Step Therapy – A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug for that condition.

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration 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.

SECTION 11 - PLAN ADMINISTRATION

By authority of The Regents, University of California Human Resources and Benefits, located in Oakland, California, administers this Plan in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts/service agreements, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. The terms of those documents apply if information in this document is not the same. The University of California Group Insurance Regulations will take precedence if there is a difference between its provisions and those of this document and/or the Group Hospital and Professional Service Agreement. What is written in this document and/or the Group Insurance Contracts does not constitute a guarantee of plan coverage or benefits--particular rules and eligibility requirements must be met before benefits can be received. Health and welfare benefits are subject to legislative appropriation and are not accrued or vested benefit entitlements.

Sponsorship and Administration of the Plan
The University of California is the Plan sponsor for the Plan described in this booklet. If you have a question, you may direct it to:

University of California
Human Resources and Benefits
Health & Welfare Administration
300 Lakeside Drive, 12th Floor
Oakland, CA 94612
(800) 888-8267

Retirees may also direct questions to the University's Customer Service Center at the above phone number.

Claims under the Plan are processed by Health Net at the following address and phone number:

HEALTH NET
P.O. Box 9103
Van Nuys, CA 91409-9103
1-800-539-4072

Group Contract Number
The Group Contract Number for this Plan is: 92-2557406

Type of Plan
This Plan is a health and welfare plan that provides group medical care benefits. This Plan is one of the benefits offered under the University of California's employee health and welfare benefits program.

Plan Year
The plan year is January 1 through December 31.

Continuation of the Plan
The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time. Plan benefits are not accrued or vested benefit entitlements. The right to terminate or amend applies to all Employees, Retirees and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums and what portion of the premiums the University will pay. The portion of the premiums that University pays is determined by UC and may change or stop altogether, and may be affected by the state of California's annual budget appropriation.

Financial Arrangements
The benefits under the Plan are provided by Health Net under a UC Standardized Contract . The monthly cost of the premiums are currently shared between you and the University of California.

Agent for Serving of Legal Process
Legal process may be served on Health Net at the address listed above.

Your Rights under the Plan
As a participant in a University of California medical plan, you are entitled to certain rights and protections. All Plan participants shall be entitled to:

Examine, without charge, at the Plan Administrator's office and other specified sites, all Plan documents, including the UC Standardized Contract , at a time and location mutually convenient to the participant and the Plan Administrator.

Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

Claims under the Plan
To file a claim or to appeal a denied claim, refer to pages 55 and 67 of this document.

Nondiscrimination Statement
In conformance with applicable law and University policy, the University of California is an affirmative action/equal opportunity employer.

Please send inquiries regarding the University's affirmative action and equal opportunity policies for staff to Director of Diversity and Employee Programs, University of California Office of the President, 300 Lakeside Drive, Oakland, CA 94612 and for faculty to Director of Academic Affirmative Action, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

SECTION 12 - INDEX (PDP DOCUMENT ONLY)

For more information, please contact us at:

Health Net Medicare Programs
PO Box 870502
Surfside Beach, SC 29587-8713

Customer Service Department
1-800-539-4072

Telecommunications Device for the Deaf
1-800-929-9955

WWW.HEALTHNET.COM/UC

Our office hours are from 8:00 a.m. to 8:00 p.m., 7 days a week.