Health Net
Medicare Programs

A COMPLETE

explanation of your plan

For University of California Medicare Retirees
Effective 1/1/2009

Evidence of Coverage
Health Net Seniority Plus
Plan 2G7
EOCID: 239263

Schedule changes in 2009

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

Part D Prescription Drugs

- Under **"Part D Prescription Drugs,"** amended the third bullet of the **"Note"** section, by replacing:

  "Drugs (including injectable medications) when Medically Necessary for treating erectile dysfunction are limited to two doses per week or eight tablets per month. Erectile Dysfunction drugs are not available through the mail order program."

  To:

  "Drugs (including injectable medications) when Medically Necessary for treating erectile dysfunction are limited to one dose per week or four tablets per month. Erectile Dysfunction drugs are not available through the mail order program."

Hearing Services

- Under "Hearing Services" under the "What you must pay when you get these covered services" column, amended the following text for clarification purpose:

  2 Standard Hearing Aids (analog or digital, one pair) are covered every 36 months that adequately meet the Member's medical needs and are determined to be Medically Necessary.

  A standard hearing aid (analog or digital) is one that restores adequate hearing to the member and is determined medically necessary.

  No benefits will be provided for hearing aid charges which exceeds specifications prescribed for the correction of hearing loss.

Table of Contents

1. University of California - Eligibility, Enrollment, Termination and Plan Administration Provisions

January 1, 2009

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; 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 except for a child who is incapable of self-support due to a physical or mentally disabling injury, illness or condition), 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;

(e) children for whom you are legally required to provide group health insurance pursuant to an administrative or court order. (Child must also meet UC eligibility requirements.)

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 chiefly dependent upon you for support and maintenance;
- 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

The Plan will notify the Employee that the child's coverage will end when the child reaches a University-sponsored medical plan's upper age limit at least 90 days prior to the date the child reaches that age. Application for extended coverage must be made to the Plan within 60 days of the date the Notice is mailed. If Plan does not complete determination of the child's continuing eligibility by the date the child reaches the Plan's upper age limit, the child will remain covered pending Plan's determination. The Plan may periodically request proof of continued disability, but not more than once a year after the initial certification. 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. If age 23 or more, 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. The Plan may ask for proof that the child is still incapable of self-support due to a physical or mentally disabling injury, illness or condition, but not more than once a year after the initial certification.

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 are in a Health Maintenance Organization (HMO), Exclusive Provider Organization (EPO), or Point of Service (POS) 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".

You may enroll without waiting for the University's next open enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1. You have met all of the following requirements:
   a. You were covered under another health plan as an individual or dependent, including coverage under a COBRA or CalCOBRA continuation, the Healthy Families Program, or no share-of-cost Medi-Cal coverage.
   b. You certified in writing at the time you became eligible for coverage under this Plan that you were declining coverage under this Plan or disenrolling because you were covered under another health plan as stated above and you were given written notice that if you choose to enroll later, you may be required to wait until the University's next open enrollment period to do so.

c. Your coverage under the other health plan wherein you were covered as an individual or dependent ended because you lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, your coverage under a COBRA or CalCOBRA continuation was exhausted, you lost coverage under the Healthy Families Program as a result of exceeding the program's income or age limits, or you lost no-share-of-cost Medi-Cal coverage.

d. You properly file an application with the University within 31 days from the date on which you lose coverage.

2. A court has ordered coverage be provided for a spouse, domestic partner or dependent child under your UC-sponsored medical plan and an application is filed within 31 days from the date the court order is issued. (Family member(s) must also meet UC eligibility requirements.)

3. You have a change in family status through marriage or domestic partnership, or the birth, adoption, or placement for adoption of a child:

   a. If you are enrolling following marriage or domestic partnership, you and your new spouse or domestic partner must enroll within 31 days of the date of marriage or domestic partnership. Your new spouse or domestic partner's eligible children may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Coverage will be effective as of the date of marriage or domestic partnership.

   b. If you are enrolling following the birth, adoption, or placement for adoption of a child, your spouse (if you are already married) or domestic partner, who is eligible but not enrolled, may also enroll at that time. Other children may not enroll at that time unless they qualify under another of these circumstances listed above. Application must be made within 31 days of the birth or date of adoption or placement for adoption; coverage will be effective as of the date of birth, adoption, or placement for adoption.

4. You meet or exceed a lifetime limit on all benefits under another health plan. Application must be made within 31 days of the date a claim or a portion of a claim is denied due to your meeting or exceeding the lifetime limit on all benefits under the other plan. Coverage will be effective on the first day of the month following the date you file the enrollment application.

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 94623-1570.

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 will be deenrolled from this health plan. Anyone 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 for which premiums are taken from earnings based on an eligible appointment. If you are hospitalized or undergoing treatment of a medical condition covered by this Plan, benefits will cease to be provided and you may have to pay for the cost of those benefits yourself. You may be entitled to continued benefits under terms, which are specified elsewhere under EXTENSION OF BENEFITS and HIPPA COVERAGE AND CONVERSION. (If you apply for HIPPA COVERAGE AND CONVERSION, the benefits may not be the same as you had under this Plan.)

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 later of (1) the date shown on the written notice to you; or (2) the date of the mailing of written notice to you (and to the University if notice is given by the Plan). A Family Member who commits fraud or deception will be permanently deenrolled. If you commit fraud or deception, you 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 UC “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.

Grace Period

There shall be a Grace Period, which provides additional time to University to complete full payment of monthly premiums to Plan following the premium Due Date. The Due Date is the date the full premium is due and payable to Plan for a coverage month. The Grace Period shall be in force 31 days following the Due Date. The Agreement shall remain in force during the Grace Period. No penalties or late fees shall be charged by Plan to University during the Grace Period. If the University fails to pay Plan the premiums due during the Grace Period, Plan will not end coverage for covered Employee Members or Family Members until the end of the Grace Period. The Employee Members will not be required by Plan to pay the premiums for the University nor will Members be required to pay more than their copay for any services received during the Grace Period.

If premiums due are not paid by the end of the Grace Period, the Agreement will be canceled as described above. If you are hospitalized or undergoing treatment of a medical condition covered by this Plan, benefits will cease to be provided and you may have to pay for the cost of those benefits yourself. You may be entitled to continued benefits under terms, which are specified elsewhere under Extension of Benefits and HIPPA Coverage and Conversion. (If you apply for HIPPA Coverage and Conversion, the benefits may not be the same as you had under this Plan.)

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
P.O. Box 10198
Van Nuys, CA 91410-09108
1-800-539-4072

Group Contract Number

The Group Contract Number for this Plan is: 5047MW, 5047RA, K, Q, U, Y, 5047SC, G, M, R, V, Z, 5047TF, L, Q, V, 5047UA, F, K, R, W, 5047VA, F, 5522AM, S.

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 63 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.

2. Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Health Net Seniority Plus

This mailing gives you the details about your Medicare health coverage, and explains how to get the health care you need. This is an important legal document. Please keep it in a safe place.

Health Net Member Services:
For help or information, please call Member Services or go to our Plan website at www.healthnet.com/uc.

1-800-539-4072 (Calls to these numbers are free)
TTY/TDD users call: 1-800-929-9955

Hours of Operation:
8:00 a.m. to 8:00 p.m., seven days a week

This Plan is offered by Health Net of California, Inc., referred throughout the EOC as "we", "us" or "our." Health Net Seniority Plus is referred to as "Plan" or "our Plan." Our organization contracts with the Federal government.

This information may be available in a different format, including Spanish. Please call Member Services at the number listed above if you need plan information in another format or language.

Esta información puede estar disponible en un formato diferente, incluso en español. Si necesita información del plan en otro formato o idioma, llame al Departamento de Servicios al Afiliado al número indicado antes.

3. Health Net Seniority Plus Benefit Chart

University of California

January 1 – December 31, 2009

Part C Medical Services

Benefits chart – your covered services	What you must pay when you get these covered services
Inpatient Services	
Inpatient hospital care You are covered for unlimited days per Benefit period Covered services include: • Semi-private room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. . If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Physician Services	*Requires prior authorization (approval in advance) to be covered, except in an emergency* - You pay $250 copayment for each Medicare-covered hospital stay Hospital Copayments are required for the first three admissions per Calendar Year. Once the Copayment is met, no Copayment is required for further admissions in the same Calendar Year. A Benefit period begins the day you are admitted to a hospital or skilled nursing facility. The Benefit period ends when you have not received hospital and/or skilled nursing care for 60 consecutive days. If you go into the hospital after one Benefit period has ended, a new Benefit period begins. You must pay the inpatient hospital copayment for each Benefit period. There is no limit to the number of Benefit periods you can have.

Benefits chart – your covered services	What you must pay when you get these covered services
	If you get inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a plan hospital.
Inpatient Hospital Transgender Surgery/Services** (including hysterectomy, oophorectomy and mastectomy) • Travel, lodging and meals included. The transgender surgery must be performed by a Health Net qualified provider in conjunction with gender transformation treatment. The treatment plan must conform to Harry Benjamin International Gender Dysphoria Association (HBIGDA) standards. Psychotherapy and hormonal treatment are excluded from the lifetime maximum.	*Requires prior authorization (approval in advance) to be covered, except in an emergency* You pay a $250 Copayment for transgender services. Hospital Copayments are required for the first three admissions per Calendar Year. Once the Copayment is met, no Copayment is required for further admissions in the same Calendar Year. Transgender surgery and related services (including travel, lodging and meal expenses) approved by the plan are subject to a combined inpatient and outpatient lifetime benefit maximum of $75,000 for each Member.

Benefits chart – your covered services	What you must pay when you get these covered services
Inpatient mental health care Covered services include mental health care services that require a hospital stay. Medicare beneficiaries may only receive coverage for 190 days in a Psychiatric Hospital in a lifetime. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.	*Requires prior authorization (approval in advance) to be covered, except in an emergency* You pay: $250 copayment for each Medicare-covered hospital stay. Hospital Copayments are required for the first three admissions in each calendar year for covered services. Once the requirement is met, no Copayment is required for further admissions in the same calendar-year.
Inpatient Substance Abuse Care* • Residential care in a Hospital or substance abuse facility	*Requires prior authorization (approval in advance) to be covered, except in an emergency* You pay a $250 Copayment for services in a network Hospital. Hospital Copayments are required for the first three admissions in each calendar year for covered services. Once the requirement is met, no Copayment is required for further admissions in the same calendar-year.

Benefits chart – your covered services	What you must pay when you get these covered services
Acute Care Detoxification*	*Requires prior authorization (approval in advance) to be covered, except in an emergency* There is a $250 Copayment for acute care detoxification services. Hospital Copayments are required for the first three admissions in each calendar year for covered services. Once the requirement is met, no Copayment is required for further admissions in the same calendar-year.
Skilled nursing facility (SNF) care You are covered for 100 days each Benefit period Covered services include: • Semiprivate room (or a private room if medically necessary) • Meals, including special diets • Regular nursing services • Physical therapy, occupational therapy, and speech therapy • Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors) • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Medical and surgical supplies ordinarily provided by SNFs • Laboratory tests ordinarily provided by SNFs	*Requires prior authorization (approval in advance) to be covered, except in an emergency* There is no copayment for Medicare-covered Skilled Nursing Facility care. A Benefit period begins the day you are admitted to a hospital or skilled nursing facility. The Benefit period ends when you have not received hospital and/or skilled nursing care for 60 consecutive days. If you go into the skilled nursing facility after one Benefit period has ended, a new Benefit period begins. You must pay the applicable SNF copayment for each Benefit period. There is no limit to the number of Benefit periods you can have.

Benefits chart – your covered services	What you must pay when you get these covered services
Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a plan provider, if the facility accepts our Plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). A SNF where your spouse is living at the time you leave the hospital.	

Benefits chart – your covered services	What you must pay when you get these covered services
Inpatient services covered when the hospital or SNF days aren't, or are no longer, covered Covered services include: • Physician services • Tests (like X-ray or lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and Orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition • Physical therapy, speech therapy, and occupational therapy	*Requires prior authorization (approval in advance) to be covered, except in an emergency* There is no copayment for the Medicare-covered services listed.
Home health agency care Covered services include: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total less than eight hours per day and 35 or fewer hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical social services • Medical equipment and supplies	*Requires prior authorization (approval in advance) to be covered, except in an emergency* There is no copayment for Medicare-covered home health visits.

Benefits chart – your covered services	What you must pay when you get these covered services
Hospice care You may receive care from any Medicare-certified hospice program. The Original Medicare Plan (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. Covered services include: • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by the Original Medicare Plan • Home care Our Plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	When you enroll in a Medicare-certified Hospice program, your hospice services are paid for by the Original Medicare Plan, not your Medicare Advantage plan.

Benefits chart – your covered services	What you must pay when you get these covered services
Outpatient Services	
Physician services, including doctor office visits Covered services include: • Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center *The following require prior authorization (approval in advance) to be covered, except in an emergency* • Consultation, diagnosis, and treatment by a specialist • Hearing and balance exams, if your doctor orders it to see if you need medical treatment. • Telehealth office visits including consultation, diagnosis and treatment by a specialist • Second opinion by another network provider prior to surgery • Outpatient hospital services • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor)	You pay $15 for each primary care doctor office visit for Medicare-covered services. You pay $15 for each specialist visit for Medicare-covered services. You pay $15 for each Physician visit to your home.
Periodic Health Evaluations	There is no Copayment
Chiropractic services Covered services include: • Manual manipulation of the spine to correct subluxation	You pay $15 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).
• Routine Chiropractic care (non Medicare-covered).	You pay $15 per visit (20 visits per Calendar Year).

Benefits chart – your covered services	What you must pay when you get these covered services
Health and Fitness – Silver&Fit® This program is designed specifically for Medicare beneficiaries that incorporates exercise and health education to help you become physically fit. Silver&Fit is a fitness program at participating fitness clubs. Silver&Fit is provided through American Specialty Health Networks (ASH Networks), Inc. and Healthyroads, Inc., subsidiaries of American Specialty Health Incorporated. There are no copays, co-insurance, or deductibles for Silver&Fit programs. **Prior to proceeding in any exercise or weight management, it is important for you to seek the advice of a physician or other qualified health professional. Participation in the Silver&Fit program is at your own risk.** The standard fitness club membership, with Silver&Fit, includes all of the services and amenities included with your network fitness club membership, such as: • Cardiovascular equipment • Free weights or resistance training equipment • Exercise classes • Where available, amenities such as saunas, steamrooms, pools, and whirlpools It does not include any non-standard fitness club services that typically require an additional fee. **Services offered through the "service hotline"** Members may call Silver&Fit member services at 1-877 427-4788 or TTY/TDD 1-877-710-2746, Monday through Friday, 5 a.m. – 6 p.m. (Pacific Time), for information on any of the following: • Enrollment • Program design • Eligibility • Provider search • Changing clubs • Provider nominations	There is no copayment for health club and fitness benefits.

Benefits chart – your covered services	What you must pay when you get these covered services
The following services are not offered: • Services or supplies provided by any person, company or provider other than a Silver&Fit participating fitness club • All education materials other than those produced for Silver&Fit by Healthyroads or American Specialty Health • Telecommunications devices, telephone handset amplifiers, television recorders, and telephones compatible with hearing aids • Education program services for individuals other than the member • Prescription drugs, over-the-counter products, dietary supplements, herbal supplements, vitamins, minerals, weight control products, meal-replacement beverages or powders, prepackaged meals, or any other types of food or food product, whether or not it is recommended, prescribed, or supplied by a health care provider, fitness club, or program • All listening devices, including, but not limited to, audiotape and CD players • Services for members with serious medical conditions for which Silver&Fit services are not appropriate	
Podiatry services Covered services include: • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs. • Routine foot care (non Medicare-covered).	*Requires prior authorization (approval in advance) to be covered, except in an emergency* You pay $15 for each Medicare-covered visit for podiatry services. You pay $15 for each routine (non Medicare-covered) visit. Care is limited to one visit per calendar month. Additional visits or referrals must be arranged and approved by your PCP.

Benefits chart – your covered services	What you must pay when you get these covered services
Outpatient mental health care (including Partial Hospitalization Services) Covered services include: • Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. "Partial hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	*Requires prior authorization (approval in advance) to be covered, except in an emergency* For Medicare-covered Mental Health services, you pay: - $15 for each individual therapy - $7.50 for each group therapy visit For Medicare-covered Mental Health services with a psychiatrist, you pay: - $15 for individual therapy visit(s) - $7.50 for each group therapy visit(s). For partial hospitalization, you pay $250. Hospital Copayments are required for the first three admissions in each calendar year for covered services. Once the requirement is met, no Copayment is required for further admissions in the same calendar-year.

Benefits chart – your covered services	What you must pay when you get these covered services
Outpatient substance abuse services	*Requires prior authorization (approval in advance) to be covered, except in an emergency* For Medicare-covered Substance Abuse services, you pay: - $15 for each individual therapy visit. - $7.50 for each group therapy visit. For Medicare-covered Substance Abuse services with a psychiatrist, you pay: - $15 for individual visit(s). - $7.50 for group therapy visit(s).
Behavioral Health Care Telephonic clinical consultations (Limited to a maximum of 3 consultations per member per calendar year provided by licensed clinicians for non-crisis issues such as stress, anxiety, grief, depression, relationship issues and substance abuse concerns; sessions are scheduled and designed to manage a situation over time to a clinical resolution.). (Behavioral Health Care Telephonic clinical consultation services are provided by a licensed counselor - 1-800-663-9355.)	There is no Copayment for Telephonic clinical consultations.

Benefits chart – your covered services	What you must pay when you get these covered services
Outpatient surgery (including services provided at ambulatory surgical centers)	*Requires prior authorization (approval in advance) to be covered, except in an emergency* There is no Copayment for Medicare-covered visits to an outpatient Hospital facility.
Outpatient Transgender Surgery/Services** (including hysterectomy, oophorectomy and mastectomy) • Travel, lodging and meals included. The transgender surgery must be performed by a Health Net qualified provider in conjunction with gender transformation treatment. The treatment plan must conform to Harry Benjamin International Gender Dysphoria Association (HBIGDA) standards. Psychotherapy and hormonal treatment are excluded from the lifetime maximum.	*Requires prior authorization by Health Net (approval in advance) to be covered, except in an emergency* There is no Copayment for transgender surgery Transgender surgery and related services (including travel, lodging and meal expenses) approved by the plan are subject to a combined inpatient and outpatient lifetime benefit maximum of $75,000 for each Member.
Ambulance services Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health). The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required.	There is no Copayment for Medicare-covered ambulance services.

Benefits chart – your covered services	What you must pay when you get these covered services
Emergency care • Coverage in the United States* * United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.	**Coverage in the United States*** You pay $50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital. If you need inpatient care at a non-plan hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a plan hospital.
• World Wide Coverage	**Worldwide Coverage Outside the United States*** There is no copayment or deductible for worldwide Emergency Care services outside the United States.

Benefits chart – your covered services	What you must pay when you get these covered services
Urgently needed care • Coverage in the United States* * United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.	**Coverage in the United States*** You pay $50 for each Medicare-covered urgently needed care visit. You do not pay this amount if you are immediately admitted to the hospital. If you receive care from an urgent care center owned and operated by your Physician Group, the urgent care Copayment will not apply. However, a visit to one of its facilities will be considered an office visit, and any Copayment required for office visits will apply.
• Worldwide Coverage	**Worldwide Coverage Outside the United States*** There is no copayment or deductible for worldwide urgently needed care services outside the United States.
Outpatient rehabilitation services Covered services include: physical therapy, occupational therapy, speech language therapy, and cardiac rehabilitative therapy Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris.	*Requires prior authorization (approval in advance) to be covered, except in an emergency* You pay $15 for each Medicare-covered outpatient rehabilitation service visits.

Benefits chart – your covered services	What you must pay when you get these covered services
Durable medical equipment and related supplies Covered items include: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of "durable medical equipment" in Section 10.)	*Requires prior authorization (approval in advance) to be covered, except in an emergency* There is no Copayment for each Medicare-covered durable medical equipment or related supply.
Prosthetic devices and related supplies – (other than dental) that replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.	*Requires prior authorization (approval in advance) to be covered, except in an emergency* There is no Copayment for each Medicare-covered prosthetic device or related supply.
Diabetes self-monitoring, training and supplies – for all people who have diabetes (insulin and non-insulin users). Covered services include: • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts • Self-management training is covered under certain conditions • For persons at risk of diabetes: Fasting plasma glucose tests. Please call Member Services at the phone number in Section 11 for more information on how often we will cover these tests.	Requires prior authorization (approval in advance) to be covered, except in an emergency There is no Copayment for Diabetes supplies. There is no Copayment for therapeutic shoes for people with diabetes who have severe diabetic foot disease. There is no copayment for Diabetes Self-monitoring training. There is no Copayment for fasting plasma glucose tests for persons at risk of diabetes.

Benefits chart – your covered services	What you must pay when you get these covered services
Medical nutrition therapy – for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.	*Requires prior authorization (approval in advance) to be covered, except in an emergency* There is no copayment for Medicare-covered Medical Nutrition Therapy visit.
Outpatient diagnostic tests and therapeutic services and supplies Covered services include: • X-rays • Radiation therapy • Complex diagnostic radiology (PET Scan, CT Scan, MRI) • Surgical supplies, such as dressings • Supplies, such as splints and casts • Laboratory tests • Blood - - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests	*Requires prior authorization (approval in advance) to be covered, except in an emergency* There is no Copayment for the Medicare-covered service(s) listed.
Preventive Care and Screening Tests	
Abdominal Aortic Aneurysm Screening A one-time screening ultrasound for people at risk. Medicare only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" physical exam.	There is no copayment for each Medicare-covered Abdominal Aortic Aneurysm Screening.

Benefits chart – your covered services	What you must pay when you get these covered services
Bone-mass measurements For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	*Requires prior authorization (approval in advance) to be covered, except in an emergency* There is no copayment for each Medicare-covered Bone Mass Measurement.
Colorectal screening For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy	*Requires prior authorization (approval in advance) to be covered, except in an emergency* There is no copayment for Medicare-covered Colorectal Screening Exams.
Immunizations Covered services include: • Pneumonia vaccine • Flu shots, once a year in the fall or winter • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk • Immunizations for Foreign Travel and Occupational Purposes We also cover some vaccines under our outpatient prescription drug benefit**.**	*Requires prior authorization (approval in advance) to be covered, except in an emergency* There is no Copayment for the Pneumonia and Flu vaccines. There is no copayment for the Hepatitis B vaccine. You pay 20% of the charges travel or occupational purposes.

Benefits chart – your covered services	What you must pay when you get these covered services
Allergy Testing	You pay a $15 copayment for each Medicare-covered Allergy testing services.
Allergy desensitizing Serum	There is no Copayment for the Medicare-covered allergy desensitizing serum service.
Mammography screening Covered services include: • One baseline exam between the ages of 35 and 39 • One screening every 12 months for women age 40 and older	There is no copayment for Medicare-covered Mammogram Screenings.
Pap tests, pelvic exams, and clinical breast exam Covered services include: • For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months	There is no copayment for Medicare-covered Pap Tests and Pelvic Exams.
Prostate cancer screening exams For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	*Requires prior authorization (approval in advance) to be covered, except in an emergency* There is no copayment for Medicare-covered Prostate Cancer Screening exams.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). Please call Member Services at the phone number in Section 11 for more information on how often we will cover these tests.	*Requires prior authorization (approval in advance) to be covered, except in an emergency* There is no copayment for Medicare-covered cardiovascular screening blood tests.

Benefits chart – your covered services	What you must pay when you get these covered services
Physical exams For members whose Medicare Part B coverage begins on or after January 1, 2005: A one-time physical exam within the first 6 months that you have Medicare Part B. Includes measurement of height, weight and blood pressure; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services. Does not include lab tests.	There is no Copayment for the one-time Medicare-covered physical exam.
Routine physical exams	There is no Copayment for Medicare-covered routine physical exams. You are covered up to 1 exam every year.
Other Services	
Renal Dialysis (Kidney) • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Section 5) • Inpatient dialysis treatments (if you are admitted to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	*Requires prior authorization (approval in advance) to be covered, except in an emergency* There is no copayment for Medicare-covered Renal Dialysis (Kidney) services. There is no copayment for Medicare-covered home dialysis services.

Benefits chart – your covered services	What you must pay when you get these covered services
Medicare Part B Prescription Drugs These drugs are covered under Part B of the Original Medicare Plan. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually are not self-administered by the patient and are injected while receiving physician services • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoisis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases • Injections for hormonal therapy related to a Gender Identity Disorder (GID). Section 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is listed later in this section.	There are no Copayments or coinsurances for Medicare-covered Drugs and Biologicals listed except for the Immunosuppressive drugs, certain oral anti-cancer drugs and anti-nausea drugs and injectable drugs for the treatment of osteoporosis for the home-bound who cannot self-administer and drugs used with Durable Medical Equipment: The applicable Brand Name, Generic, or Specialty Drug Copayment applies for Part B Drugs. There is no Copayment for injections or injectable substances obtained at a physician's office. Injections or injectable substances obtained through a retail pharmacy are subject to the applicable Injectable or Specialty Coinsurance.

Benefits chart – your covered services	What you must pay when you get these covered services
Part D Prescription Drugs Prescription drugs that are covered if you are enrolled in Health Net's PFFS Plan because you have enrolled for Medicare Prescription Drug coverage. With few exceptions, **you must use network pharmacies to get your prescription drugs covered.** This plan uses a formulary. A formulary is a preferred list of drugs selected to meet patient needs at a lower cost. If the formulary changes, you will be notified, in writing, before the change. To view the plan's formulary, go to www.healthnet.com/uc on the web. Section 8 explains about the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. Section 8 also tells about drugs that are not covered by this benefit. **Notes** • If you receive a brand-name drug when a generic equivalent is available, you may be responsible for a higher copayment or the difference in cost between the generic and brand drug. • In some cases, the plan requires you to first try one drug to treat your medical condition before they will cover another drug for that condition. • Certain prescription drugs will have maximum quantity limits. • Your provider must get prior authorization from Health Net Life for certain prescription drugs. • Covered 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. You may also incur an additional cost for drugs received at an out-of-network pharmacy.	People who have low incomes, who live in long term care facilities, or who have access to Indian/Tribal/Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact our Member Services for details. **One-month (30-day) supply of Part D Drugs purchased at local pharmacies** - $10 Copayment – Tier 1 - $20 Copayment – Tier 2 - $35 Copayment – Tier 3 25% Coinsurance – Tier 4 Injectable 25% Coinsurance – Tier 5 – Specialty 50% Coinsurance – Erectile Dysfunction drugs, up to 4 doses. **Three-month (90-day) supply of Part D Drugs purchased at local pharmacies:** - $30 Copayment – Tier 1 - $60 Copayment – Tier 2 - $105 Copayment –Tier 3 25% Coinsurance –Tier 4 Injectable 25% Coinsurance –Tier 5 Specialty

Benefits chart – your covered services	What you must pay when you get these covered services
Part D Prescription Drugs (Continued) Copayments and coinsurances are combined for prescriptions that are filled through mail order or retail pharmacies. The $2000 does not include charges you may have paid for by requesting a brand drug when a generic was available.	**Three-month (90-day) supply of Part D Drugs purchased via mail order or obtained through the UC Walk –Up Service:** - $20 Copayment – Tier 1 - $40 Copayment – Tier 2 - $70 Copayment – Tier 3 After your yearly out-of-pocket drug costs reach $4,350 you will qualify for Catastrophic Coverage and you will pay the greater of: - $2.25 for generic or a preferred brand drug that is a multi-source drug and - $5.60 for all other drugs, or - 5% coinsurance. Certain Prescription Drugs will have maximum quantity limits and may have a pre-authorization requirement. Contact plan for details.
Additional Benefits	
Dental Services Services by a dentist or oral surgeon are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.	You pay 100% for Medicare-covered dental services. Preventive dental services are not covered

Benefits chart – your covered services	What you must pay when you get these covered services
Hearing Services • Diagnostic hearing exams • Routine hearing exams.	*Requires prior authorization (approval in advance) to be covered, except in an emergency* 2 Standard Hearing Aids (analog or digital, one pair) are covered every 36 months that adequately meet the Member's medical needs and are determined to be Medically Necessary. A standard hearing aid (analog or digital) is one that restores adequate hearing to the member and is determined medically necessary. No benefits will be provide for hearing aid charges which exceeds specifications prescribed for the correction of hearing loss. Hearing screenings, provided as part of a periodic health evaluation, are covered at no charge. You pay $15 for each Medicare-covered hearing exam (diagnostic hearing exams). You pay $15 for each routine hearing test up to 1 test every year.

Benefits chart – your covered services	What you must pay when you get these covered services
Vision care Covered services include, but aren't limited to, the following: • Outpatient physician services for eye care. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year • Routine vision exams. One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	*Requires prior authorization (approval in advance) to be covered, except in an emergency* You pay $15 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye). Vision screenings, provided as part of a periodic health evaluation, are covered at no charge. You pay $15 for each Routine eye exam, limited to 1 exam(s) every year. There is no copayment for Medicare-covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery). Lenses are covered (in full or subject to an eyewear allowance) $100 allowance for frames every 2 years. No Referral necessary for eyewear for any Network Providers.

Benefits chart – your covered services	What you must pay when you get these covered services
Health and wellness education programs These are programs focused on clinical health conditions such as hypertension, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, smoking cessation, fitness, and stress management. Covered Services Include: - Written health education materials, including newsletter - Nutritional Training - Disease Management - Smoking Cessation - Nursing Hotline (Decision Power) Ask Health Net of California for details. No Referral necessary for Network Providers.	There is no copayment for Medicare-covered health and wellness education programs.

Additional information about your benefits.

Mental Health Care and Chemical Dependency Benefits

The Mental Health and Chemical Dependency benefits are administered by Managed Health Network and contracts with Health Net to underwrite and administer these benefits.

To be covered, MHN must authorize these services and supplies.

MHN will refer you to a nearby Contracted Mental Health Professional. That professional will evaluate you to determine if additional treatment is necessary. If you need treatment, the Contracted Mental Health Professional will develop a Treatment Plan and submit that plan to MHN for review. When authorized by MHN, the proposed services will be covered by this Plan.

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

Transition of Care For New Enrollees

If you are receiving ongoing care for an Acute, serious, or chronic mental health condition from a non-Contracted Mental Health Professional at the time you enroll with Health Net, we may temporarily cover services from a provider not affiliated with MHN, subject to applicable copayments and any other exclusions and limitations of this Plan.

Your non-Contracted Mental Health Professional must be willing to accept MHNs standard mental health provider contract terms and conditions, including, but not limited to rates, credentialing, hospital privileging, utilization review, peer review and quality assurance requirements, 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 Seniority Plus ID Card or on the front of this booklet.

The following benefits are provided:

The following services are covered under Health Net Seniority Plus. Please refer to the Evidence of Coverage for copayment and coinsurance information.

Outpatient Services

Outpatient crisis intervention, short-term evaluation and therapy, longer-term specialized therapy and any rehabilitative care that is related to Chemical Dependency may be covered with unlimited visits, subject to Medical Necessity review as determined by MHN. Medication management care is also covered when appropriate. Refer to the "Outpatient mental health care", "Outpatient substance abuse services" and "Outpatient Substance Abuse" portions in the Evidence of Coverage for member cost shares.

Second Opinion

MHN may, as a condition of coverage, require that a Member obtain a second opinion from an appropriate Contracted Mental Health Professional to verify the Medical Necessity or appropriateness of a Covered Service. In addition, you as a Member, have the right to request a second opinion when:

- Your Contracted 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 rendered;
- 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; or
- Your Contracted Mental Health Professional is unable to diagnose your condition or test results are conflicting.
- The clinical indications are complex or confusing, a diagnosis is in doubt due to conflicting test results, or the Contracted Mental Health Professional is unable to diagnose the condition.
- The Treatment Plan in progress is not improving your medical condition within an appropriate period of time for the diagnosis and plan of care.

- If you have attempted to follow the plan of care or consulted with the initial Contracted Mental Health Professional due to serious concerns about the diagnosis or plan of care.

To request an authorization for a second opinion contact MHN. MHN will review the request, and if a second opinion is considered Medically Necessary, MHN will authorize a referral to a Contracted Mental Health Professional. When you request a second opinion, you will be responsible for any applicable copayments.

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

If the Member faces an imminent and serious threat to health, including, but not limited to, the potential loss of life, limb or other major bodily function, or lack of timeliness would be detrimental to the ability to regain maximum function, the second opinion will be rendered in a timely fashion appropriate to the nature of the condition not to exceed 72 hours of MHNs receipt of the request, whenever possible. For a complete copy of this policy, contact MHN at **1-800-646-5610** (TDD/TTY **1-800-327-0801**).

Any service recommended must be authorized by MHN in order to be covered.

Inpatient Services

If you think you require Inpatient services, you must obtain preauthorization from MHN. You must provide all necessary information concerning your problem before you begin treatment.

Inpatient treatment of a Mental Disorder or Chemical Dependency is covered, subject to a combined lifetime maximum of 190 days per Member. The 190-day limit does not apply to Mental Health or Chemical Dependency services provided in a psychiatric unit of a general hospital. Refer to the "Inpatient mental health care" portion in the Evidence of Coverage for member cost shares.

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.

Except in an emergency, services and supplies provided without preauthorization will not be covered by MHN – even if those services or supplies would have been covered had the Member requested preauthorization.

Detoxification

Inpatient services for Acute detoxification and treatment of Acute medical conditions relating to Chemical Dependency are covered, except as stated in the "Mental Disorders and Chemical Dependency" portion of "Exclusion and Limitations."

Serious Emotional Disturbances of a Child (SED)

This plan may cover the diagnosis and treatment of Medically Necessary services for Serious Emotional Disturbances of a Child to the same extent that medical or surgical conditions are covered by your medical plan.

This means that, for services rendered by MHN Participating Providers only, your copayments, deductibles and annual and lifetime maximums applicable to certain mental health conditions will not be less favorable to you than coverage under your medical plan for physical conditions. Please refer to the Definitions section of this Rider for details on applicable conditions and levels of coverage.

Severe Mental Illness

This Plan may cover the diagnosis and treatment of Medically Necessary services for Severe Mental Illness of a person of any age. Please refer to the Definitions section of this Rider for details on applicable conditions and levels of coverage.

Mental Disorders and Chemical Dependency Exclusions and Limitations

Mental health care as a condition of parole, probation or court-ordered testing for Mental Disorders is limited to Medically Necessary services and subject to this Plan's visit limits described earlier in this section.
Services and supplies for treating Mental Disorders and Chemical Dependency are covered only as specified in the Evidence of Coverage under "Inpatient mental health care," "Outpatient mental health care" and "Outpatient substance abuse services." The treatment and diagnosis of Serious Emotional Disturbances of a Child under the age of 18 is also covered.

The following items and services are limited or excluded under the Mental Disorders and Chemical Dependency Services:

- Court-ordered testing and treatment, except when Medically Necessary and within the allowable visits under the plan contract.
- Private Hospital rooms and/or private duty nursing, unless determined to be a Medically Necessary Service and Authorization from MHN is obtained.
- Ancillary services such as:
    a. Vocational rehabilitation and other rehabilitation services.
    b. Behavioral training.
    c. Speech or occupational therapy.
    d. Sleep therapy and employment counseling.

e. Training or educational therapy or services.
f. Other education services.
g. Nutrition services

- Treatment by providers other than those within licensing categories then recognized by MHN as providing Medically Necessary Services in accordance with applicable medical community standards.
- Services in excess of those with respect to which Authorization by MHN is obtained.
- Psychological testing except as conducted by a licensed psychologist for assistance in Treatment Planning, including medication management or diagnostic clarification and specifically excluding all educational, academic and achievement tests, psychological testing related to medical conditions or to determine surgical readiness and automated computer based reports.
- All prescription or non-prescription drugs and laboratory fees, except for drugs and laboratory fees prescribed by a practitioner in connection with Inpatient treatment.
- Inpatient services, treatment, or supplies rendered without Authorization, except in the event of Emergency Care Services.
- Healthcare services, treatment, or supplies rendered in a non-emergency by a provider who is not a Contracted Mental Health Professional, unless Authorization by MHN has been received or as otherwise provided by the Plan.
- Damage to a hospital or facility caused by the Member.
- Healthcare services, treatment or supplies determined to be Experimental by MHN in accordance with accepted mental health standards, except as otherwise required by law.
- Treatment for biofeedback, acupuncture or hypnotherapy.
- Healthcare services, treatment, or supplies rendered to the Member which are not Medically Necessary Services. This includes, but is not limited to, services, treatment, or supplies primarily for rest or convalescence, Custodial Care or Domiciliary Care as determined by MHN.
- Services received before the Member's effective date, during an Inpatient stay that began before the Member's effective date or services received after the Member's coverage ended, except as specifically stated herein.
- Professional services received from a person who lives in the Member's home or who is related to the Member by blood or marriage.
- Services performed in any emergency room which are not directly related to the treatment of a Mental Disorder.
- Services received out of the Member's primary state of residence except in the event of Emergency Services and Care and as otherwise authorized by MHN.

- Electro-Convulsive Therapy (ECT) except as authorized by MHN according to MHN policies and procedures.
- All other services, confinements, treatments or supplies not provided primarily for the treatment of specific covered benefits and/or specifically included as Covered Services elsewhere in this Plan.

In most cases your mental health provider will submit your claims to MHN. To file a claim you may have, please send us a letter or complete an MHN Claim Form. If you need a claim form, go online to www.mhn.com or contact MHN at **1-800-646-5610** (TDD/TTY **1-800-327-0801** for the hearing and speech impaired) 24 hours a day, seven days a week.

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

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

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.

When a Member Receives Emergency/Urgent Services From a Non-Contracting MHN Provider/Facility

A member may be hospitalized at a non-MHN facility due to an immediate medical emergency. The Member may be transferred to an MHN facility as soon as the member's medical condition is stable enough for such a move. If MHN arranges a transfer, MHN will be financially responsible for the cost of the transportation to an MHN facility. When receiving Emergency Care from a non-MHN provider, the member should request that the provider bill MHN directly for services. If the provider bills you directly, MHN will reimburse you charges paid for emergency services and out-of-area urgent care services less any applicable copayments. In order to receive reimbursement, the member should submit an itemized bill and completed claim form to MHN. A claim form can be obtained online at www.mhn.com or by contacting MHN at **1-800-646-5610** (TDD/TTY **1-800-327-0801** for the hearing and speech impaired) 24 hours a day, seven days a week. Completed claim forms should be submitted to:

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

QUESTIONS?

For up-to-date provider information or to obtain authorization to receive services, please contact MHN at **1-800-646-5610** (TDD/TTY **1-800-327-0801** for the hearing and speech impaired) 24 hours a day, seven days a week. Or visit MHNs web site at www.mhn.com for a list of MHN Contracted Mental Health Professionals in your area.

Chiropractic Care Services

American Specialty Health Plans of California, Inc. (ASH Plans) will arrange covered Chiropractic Services for you. You may access any ASH Contracted Chiropractor without a physician referral, including without a referral from your PCP. All covered Chiropractic Services require prior authorization by ASH Plans, except as listed below. The ASH Contracted Chiropractor you select will provide the initial examination and will contact ASH Plans for authorization of the treatment plan he/she develops for you. For a list of ASH Contracted Chiropractors, please call ASH Plans at **1-800-678-9133** (TDD/TTY **877-710-2746**), Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays.

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

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

All covered Chiropractic Services require prior authorization by ASH Plans except:

- An initial examination by an ASH Contracted Chiropractor and the provision or commencement, in the initial examination, of Medically Necessary services that are covered Chiropractic Services, to the extent consistent with professionally recognized standards of practice; and
- Emergency Chiropractic 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 authorized services but also a brief re-examination, in each subsequent office visit, if deemed necessary by the ASH Contracted Chiropractor, without additional approval by ASH Plans**.**

What Chiropractic Services are Covered?

Office Visits

- An initial examination is performed by an ASH Contracted Chiropractor to determine the nature of your problem, to provide or commence, in the initial examination, Medically 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. An initial examination will be provided to you if you seek services from an ASH 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 ASH Contracted Chiropractor. A $15 copayment will be required.
- Subsequent office visits, as set forth in a treatment plan approved by ASH Plans, may involve an adjustment, a brief re-examination, and other services, in various combinations. A copayment will be required for each visit to the office.
- Adjunctive therapies, 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.
- A re-examination may be performed by the ASH Contracted Chiropractor to assess the need to continue, extend or change a treatment plan approved by ASH Plans. A re-evaluation 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 an ASH Contracted Chiropractor, you will have direct access to any other ASH Contracted Chiropractor. Your visit to an ASH Contracted Chiropractor for purposes of obtaining a second opinion generally will count as one visit, for purposes of any maximum benefit, and you must pay any copayment that applies for that visit on the same terms and conditions as a visit to any other ASH Contracted Chiropractor.

However, if the first ASH Contracted Chiropractor *refers you* to a second ASH Contracted Chiropractor to obtain a second opinion, this visit will not count as a visit, for purposes of any maximum benefit. The visit to the first ASH Contracted Chiropractor will count toward any maximum benefit.

X-ray and Laboratory Tests

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

Chiropractic Services Exclusions and Limitations

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

- Chiropractic Services are covered up to a maximum number of 30 visits (combined with Acupuncture Services) per Calendar Year for each Member.
- Outpatient Prescription Drugs or over-the-counter drugs are not covered as part of your Chiropractic benefits. Please refer to your Evidence of Coverage for more information about outpatient prescription drugs under your medical or prescription drug (Part D) benefits.
- Durable Medical Equipment is not covered.
- Educational programs, non-medical self-care, self-help training or any self-help physical exercise training or related diagnostic testing are not covered.
- Hypnotherapy, behavior training, sleep therapy and weight programs are not covered.
- Services provided 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.
- Examinations or treatments for conditions unrelated to Neuromusculo-skeletal Disorders are not covered. This means physical therapy not associated with spinal, muscle and joint manipulation, is not covered.
- Services provided by a chiropractor practicing outside California are not covered, except with regard to Emergency Chiropractic Services.
- Services that are not within the scope of licensure for a licensed chiropractor in California, as defined by the Knox Keene Health Care Service Plan Act of 1975.
- The diagnostic measuring and recording of body heat variations (thermography) are not covered.
- Transportation costs are not covered, including local ambulance charges.
- Services or treatments that are not documented as Medically Necessary chiropractic care are not covered.
- Vitamins, minerals, nutritional supplements or other similar products are not covered.

How to File a Claim for Chiropractic Services

In most cases your Chiropractic service provider will submit your claims to ASH Plans. To file a claim you may have, please send us a letter or complete an ASH Plans claim form. If you need a claim form, go online to www.ashcompanies.com or contact ASH Plans at **1-800-678-9133** (TDD/TTY **1-877-710-2746**), Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays.

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

ASH Plans
P.O. Box 509002
San Diego, CA 92150-9002

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.

When a Member Receives Emergency/Urgent Services From a Non-Contracting ASH Plans Provider/Facility

When receiving Emergency Care from a non-ASH Plans Provider, the member should request that the provider bill ASH Plans directly for services. If the provider bills you directly, ASH Plans will reimburse you charges paid for emergency services and out-of-area urgent care services less any applicable copayments. In order to receive reimbursement, the member should submit an itemized bill and completed claim form to ASH Plans. A claim form can be obtained online at www.ashcompanies.com or by contacting ASH Plans at **1-800-678-9133** (TDD/TTY **1-877-710-2746**), Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays. Completed claim forms should be submitted to:

ASH Plans
P.O. Box 509002
San Diego, CA 92150-9002

QUESTIONS?

For up-to-date provider information or to obtain authorization to receive services, please contact ASH Plans at 1-800-678-9133 (TDD/TTY 1-877-710-2746), Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays. Or visit ASH Plans' web site at www.ashcompanies.com for a list of ASH Plans participating providers in your area.

Health and Fitness - SILVER&FIT

How do I enroll?

To enroll, you can go on-line at www.SilverandFit.com or call Silver&Fit at 1-877- 427-4788 or TTY/TDD phone 1-877-710-2746 (Monday – Friday, 5 a.m. – 6 p.m. (Pacific Time). During the enrollment process, you will choose a fitness club or exercise center from the list of contracted facilities or Silver&Fit Home Fitness Program for members who do not have access to a Silver&Fit fitness facility or prefer to workout at home.

Once enrollment is complete, if you have selected the fitness facility option, you will present your Silver&Fit ID card to the fitness facility and will sign a membership agreement with the fitness facility. You may begin accessing services at that time. The membership agreement that you will be required to sign at the fitness facility is for a no-cost "standard fitness facility membership," which includes the covered services available through the program, described below. If you choose to access fitness facility services otherwise available by the facility at an additional fee, then the agreement may reflect costs associated with those non-program related services.

Exercise Centers

The standard exercise center membership, with Silver&Fit, includes at least thirty minutes of strength, cardiovascular, and/or flexibility training, depending on what is available at the exercise center. Exercise centers may include Jazzercise centers, master swimming programs, rowing clubs, Pilates, yoga studios, or others.

Explanation of Covered Services (i.e. what is "the Silver&Fit Home Fitness Program")
If during enrollment you chose to participate in the Silver&Fit Home Fitness Program, you will receive one or both of the following kits:

- Walking Kit (pedometer and walking program instructions)
- Exercise Kit (two exercise classes on DVD, an exercise cord, and handheld weights)

Silver&Fit Web Site

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

- Utilize the fitness club locator and enrollment change features in the event you wish to change fitness clubs
- Access fitness literature to help you make better health decisions
- Obtain discounts on health and wellness products
- Choose from dozens of health trackers to track your progress
- Access Silver&Fit member newsletters, The Silver Slate™

Vision Care

NOTE: All Health Net Seniority Plus members have Medicare covered Vision benefits. Only Health Net members who have purchased the Optional Supplemental Benefit Package 1 or 2 have non-Medicare covered routine Vision benefits. Please see the Evidence of Coverage under "Extra benefits you can buy (these are called "optional supplemental benefits")" for copayment and benefit information.

Using your coverage for Vision Care

Eyewear

You can obtain an annual eye exam with your basic medical benefit through your Health Net Seniority Plus contracting medical group. In addition to an annual routine eye exam and Medicare-covered eye exams (diagnosis and treatment for diseases and conditions of the eye), we also offer coverage for your eyewear. Please refer to the "Vision Care" portion of the Benefit Chart in your Evidence of Coverage for Medicare-covered and non Medicare-covered member cost shares for eyewear. The Health Net Vision Plan is serviced by EyeMed Vision Care, LLC. Eyemed will pay your provider its share of the bill for any covered services that are determined to have been Medically Necessary and let you know what, if anything, you must pay your provider.

How to use the plan

- Make arrangements for your routine annual eye exam through your contracting Medical Group or Primary Care Physician (PCP). For referral to a specialist (ophthalmologist or optometrist), please contact your PCP directly. Vision care provided by someone other than a Health Net Medical Seniority Plus contracted optometrist or ophthalmologist will not be covered.

- Go to your eye exam and if you require eyeglasses or contact lenses, a prescription will be written. You are able to purchase eyewear from a list of Health Net Vision participating eyewear providers in California. Please note that the specialist who is authorized to provide your eye exam may not be a Health Net Vision contracting provider. Eyewear supplied by providers other than Health Net Vision Participating Eyewear providers are not covered. For more information or a list of Health Net Vision participating eyewear providers in California, please contact Health Net Vision at 1-866-392-6058 Monday through Saturday, 5:00 a.m. – 8:00 p.m. and Sunday 8:00 a.m. – 5:00 p.m. Pacific time (or 1-866-308-5375 TDD/TTY for the hearing and speech impaired Monday through Friday from 5:00 a.m. to 2:00 p.m. Pacific time) or visit our website at www.healthnet.com/uc.

- Payment for the prescription order eyewear received from a Health Net Vision participating eyewear provider will be made directly to that Health Net Vision participating provider.

That's all you need to do to get your new eyeglasses or contact lenses. The Health Net Vision participating provider will take care of all of the paperwork and billing for you.

If you have questions about your Vision Care benefits or would like a list of Health Net Vision participating Eyewear providers, you may call the Health Net Vision Customer Service Department at **1-866-392-6058**. Normal business hours are Monday-Saturday, 5:00 a.m. to 8:00 p.m. and Sunday, 8:00 a.m. to 5:00 p.m. TDD/TTY services are available Monday-Friday during the hours of 5:30 a.m. to 2:00 p.m. at **1-866-308-5375**.

Eyewear Benefits

Eyewear benefits differ from all others in that no copayment is specified. However, you must pay the difference between the retail price of Eyewear and the Eyewear allowance described below. When the cost sharing column states "Health Net Vision pays in full," you owe nothing.

Eyewear Schedule:

Cost Sharing:

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
Standard Progressive Lenses.....	Member pays $65.00, Health Net Vision pays the remaining balance.

**Multi year benefits may not be available in subsequent years.*

Contact Lenses - in lieu of eyeglass lenses
(contact lens allowance includes materials only):

Conventional / Cosmetic (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

(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 ** (one pair every 24 months*)

Conventional or Disposable.....Health Net Vision pays in full.

**Multi year benefits may not be available in subsequent years.*

*** 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 one of the above conditions, the Health Net Vision provider will submit a request for pre-authorization to Health Net Vision. The Health Net Vision Medical Director reviews all requests for Medically Necessary contact lenses. If approved, the individual will be covered for Medically Necessary contact lenses in full.

Additional Purchases and Out-of-Pocket Discounts

Member receives a 20% discount on items not covered by the plan at network Providers, which cannot be combined with any other discounts or promotional offers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Retail prices may vary by location. Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time use benefits; no remaining balance. Lost or broken materials are not covered.

Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used. Members also receive 15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization please call 1-877-5LASER6. After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at *www.eyemedvisioncare.com*. The contact lens benefit allowance is not applicable to this service.

Vision Care Exclusions and Limitations

The following items and services are limited or excluded under Health Net Vision Care:

- Eye exams are not covered under the Vision Care benefit. Routine eve exams are covered as part of your plan's medical benefit. Please refer to the Benefits Chart in the Evidence of Coverage.
- The fitting or dispensing of more than one set of Frames and one pair of Standard Plastic Eyeglass Lenses or Contact Lenses during any 24-month period is not covered, except in cases where the member's prescription changes significantly (refer to the Eyewear Schedule for more information). Please note that Health Net of California, Inc. contracts with Medicare each year and that this benefit may/may not be available next year.
- Lenses that correct the vision defect known as aniseikonia are not covered.
- Diagnostic services, and medical or surgical treatment of the eye are not covered. For covered surgical treatments please refer to the Benefits Chart in the Evidence of Coverage.
- Services or supplies provided by a provider other than a Health Net Vision Participating Eyewear provider are not covered.
- Nonprescription vision devices and sunglasses are not covered.
- Additional fitting and measurement charges, or special consultation charges due to the purchase of optional Frames, are not covered.
- Orthoptics or vision training aids are not covered.
- Outpatient Prescription Drugs or over-the-counter drugs are not covered as part of your Vision Care benefits. Please refer to your Evidence of Coverage for more information about outpatient prescription drugs under your medical or prescription drug (Part D) benefits.
- Vision aids (other than Eyeglasses or Contact Lenses) are not covered.
- The Eyewear benefit for Standard Progressive Lenses is Member pays $65.00. Any difference between this amount and the retail price is Health Net Vision's responsibility.
- Cost Sharing amounts are a one-time use benefit; Health Net will not pay any remaining balances.
- Lost or broken materials are not covered.

LIABILITY FOR PAYMENT

You will be responsible for the cost of any vision services received from a Health Net Vision nonparticipating provider, as well as any charges for services received from Health Net Vision participating providers that exceed the benefits listed in your Evidence of Coverage.

QUESTIONS?

For up-to-date provider information, to obtain authorization to receive services, or if you have any questions concerning claims about vision care services, please contact Health Net Vision at **1-866-392-6058** Monday through Saturday, 5:00 a.m. – 8:00 p.m. and Sunday 8:00 a.m. – 5:00 p.m. Pacific time (or **1-866-308-5375** TDD/TTY for the hearing and speech impaired Monday through Friday from 5:00 a.m. to 2:00 p.m. Pacific time). Or visit the Health Net Vision web site at www.healthnet.com/uc for a list of Health Net Vision participating providers in your area.

Part D Prescription Drugs

You will pay the following for your covered prescription drugs:

Drug Tier	Retail Copayment/ Coinsurance (30 day supply)	Retail Copayment/ Coinsurance (90 day Supply)	Mail-Order Copayment/ Coinsurance (90-day supply)	Out of Network Copayment/ Coinsurance (30 day supply)
Tier 1 Preferred Generic Drug	$10	$30	$20	$10
Tier 2 Preferred Brand Name Drug	$20	$60	$40	$20
Tier 3 Non-preferred Generic or Brand Name Drug	$35	$105	$70	$35
Tier 4 Injectable Drugs	25%	25%	N/A	25%
Tier 5 Specialty Drugs	25%	25%	N/A	25%
Erectile Dysfunction Drugs	50%	N/A	N/A	N/A

Amounts in this chart may vary according to your individual out-of-network cost-sharing responsibility. 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.

See "Catastrophic Coverage" below for more information

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 $2,000 out-of-pocket maximum will automatically be calculated by Health Net. Generic substitution costs for Part D drugs will apply towards the $4,350 Medicare Catastrophic Coverage limit, stated below.

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 $4,350 out-of-pocket for the year. When the total amount you have paid toward your deductible (if applicable), co-payments, and the cost for covered Part D drugs after you reach the initial coverage limit reaches $4,350, you will qualify for catastrophic coverage. During catastrophic coverage you will pay: the greater of $2.40 for generics or drugs that are treated like generics and $6.00 for all other drugs or 5% coinsurance. We will pay the rest.

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 your physician indicates in writing that you must have the brand name medication over the generic medication, you will only have to pay the Brand Name Drug Copayment.
- 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 erectile dysfunction are limited to one dose per week or four tablets per month. Erectile 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.

Note: 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, 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).

For more information please refer to the "Benefits chart" and "Drug exclusions" to see if the medications not covered by the Medicare Prescription Drug Plan is covered under Health Net's enhanced Prescription Drugs Benefits.

4. Introduction

Thank you for being a member of our Plan!

This is your Evidence of Coverage, which explains how to get your Medicare health care and drug coverage through our Plan, a Medicare Advantage/Prescription Drug **H**ealth **M**aintenance **O**rganization "HMO"; you are still covered by Medicare, but you are getting your health care and/or Medicare prescription drug coverage through our Plan.

This Evidence of Coverage will explain to you:

- What is covered by our Plan and what isn't covered.
- How to get the care you need or your prescriptions filled, including some rules you must follow.
- What you will have to pay for your health care or prescriptions.
- What to do if you are unhappy about something related to getting your covered services or prescriptions filled.
- How to leave our Plan, and other Medicare options that are available, including your options for continuing Medicare prescription drug coverage.

This Section of the EOC has important information about:

- Eligibility requirements
- The geographic service area of our Plan
- Keeping your membership record up-to-date
- Materials that you will receive from our Plan
- Paying your plan premiums
- Late enrollment penalty
- Extra help available from Medicare to help pay your plan costs.

Eligibility Requirements

This Plan is 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 Part A and enrolled in Medicare Part B;
- 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" may also include the member's domestic partner as defined, as required by the law in your State.)

However, individuals with End Stage Renal Disease are not eligible to enroll in Health Net unless you develop End Stage Renal Disease while a current Health Net Life member, or meet other regulatory exceptions, including exceptions applicable to employer group sponsored plans.

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 remain a member of this plan.

The geographic service area for our Plan.

The counties and parts of counties in our service area are listed below
Alameda County

Contra Costa County

Fresno County

Kern County

Los Angeles County

Orange County

Placer County, the following ZIP codes only: 95602, 95603, 95604, 95631, 95648, 95650, 95658, 95661, 95663, 95677, 95678, 95681, 95701, 95703, 95713, 95714, 95715, 95717, 95722, 95736, 95746, 95747, 95765

Riverside County

Sacramento County

San Bernardino County

San Diego County

San Francisco County

San Joaquin County

San Mateo County

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

Santa Clara County

Santa Cruz County

Solano County

Sonoma County

Stanislaus County

Yolo County

How do I keep my membership record up to date?

We have a membership record about you. Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific Plan coverage and other information. Doctors, hospitals, pharmacists, and other network providers use your membership record to know what services or drugs are covered for you. Section 6 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up to date by telling Member Services if there are changes to your name, address, or phone number, or if you go into a nursing home. Also, tell Member Services about any changes in other health insurance coverage you have, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims from an automobile accident.

Materials that you will receive from our Plan

Plan membership card

While you are a member of our Plan, you must use our membership card for services covered by this plan and prescription drug coverage at network pharmacies. While you are a member of our Plan you must not use your red, white, and blue Medicare card to get covered services, items or drugs. Keep your red, white, and blue Medicare card in a safe place in case you need it later. If you get covered services using your red, white, and blue Medicare card instead of using our membership card while you are a plan member, the Medicare Program won't pay for these services and you may have to pay the full cost yourself.

Please carry your membership card that we gave you at all times and remember to show your card when you get covered services, items and drugs. If your membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

The Provider Directory gives you a list of network providers

Every year that you are a member of our Plan, we will send you either a Provider Directory or an update to your Provider Directory, which lists our network providers. If you don't have the Provider Directory, you can get a copy from Member Services. You may ask Member Services for more information about our network providers, including their qualifications. Member Services can give you the most up-to-date information about changes in our network providers and about which ones are accepting new patients. A complete list of network providers is available on our website at www.healthnet.com/uc.

You must use network providers for services to be covered by us at plan cost-sharing levels, except in emergencies, for urgently needed care out-of-area, or for out of the area dialysis services. See the Health Net Seniority Plus Benefits Chart at the beginning of this booklet for more specific out-of-network coverage information.

The Pharmacy Directory gives you a list of Plan network pharmacies.

As a member of our Plan we will send you a complete Pharmacy Directory, which gives you a list of our network pharmacies, at least every three years, and an update of our Pharmacy Directory every year that we don't send you a complete Pharmacy Directory. 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 Services. They can also give you the most up-to-date information about changes in this Plan's pharmacy network, which can change during the year. You can also find this information on our website.

Part D Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits (EOB) is a document you will get for each month you use your Part D prescription drug coverage. The EOB will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your prescription drugs. You will get your Explanation of Benefits in the mail each month that you use the benefits that we provide. An Explanation of Benefits is also available upon request. To get a copy, please contact Member Services.

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 that will occur at least 60 days in the future and affect the prescriptions you have gotten filled;
- A summary of your coverage this year, including information about:
  - **Annual Deductible (if applicable) -**The amount paid before you start getting prescription coverage.
  - **Amount Paid For Prescriptions-**The amounts paid that count towards your initial coverage limit.
  - **Total Out-Of-Pocket Costs that count toward 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 coinsurance or copayments, and payments made on covered Part D drugs after you reach the initial coverage limit. (This amount doesn't include payments made by your current or former employer/union, another insurance plan or policy, a government-funded health program or other excluded parties.)

Your monthly plan premium

As a member of our Plan, you pay:

Your monthly Medicare Part B premium. Most people will pay the standard premium amount, which is $96.40 in 2008. (Your Part B premium is typically deducted from your Social Security payment.) (If you receive benefits from your state Medicaid program, all or part of your Part B premium may be paid for you.)

Your monthly premium will be higher if you are single (file an individual tax return) and your yearly income is more than $82,000, or if you are married (file a joint tax return) and your yearly income is more than $106,000.

If your Yearly Income is*		**In 2008, you pay***
File individual tax return	File joint tax return	
$82,000 or below	$164,000 or below	$96.40
$82,001-$102,000	$164,001-$204,000	$122.20
$102,001-$153,000	$204,001-$306,000	$160.90
$153,001-$205,000	$306,001-$410,000	$199.70
Above $205,000	Above $410,000	$238.40

*The above income and Part B premium amounts are for 2008 and will change for 2009. If you pay a Part B late-enrollment penalty, the premium amount is higher.

Your monthly Medicare Part A premium, if necessary (most people don't have to pay this premium).

1) Please contact your employer/union benefits administrator for information about your Plan premium.

The monthly premium amount does not include any late enrollment penalty you may be responsible for paying (see "What is the Medicare Prescription Drug Plan late enrollment penalty?" later in this section for more information)."

Note: If you are getting extra help (LIS) with paying for your drug coverage, the premium amount that you pay to your employer or union is reduced by the amount listed in your "Evidence of Coverage Rider for those who Receive Extra Help for their Prescription Drugs".

What is the Medicare Prescription Drug Plan late enrollment penalty?

If you don't join a Medicare drug plan when you are first eligible, and/or you go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a late enrollment penalty when you enroll in a plan later. The Medicare drug plan will let you know what the amount is and it will be added to your monthly premium. This penalty amount changes every year, and you have to pay it as long as you have Medicare prescription drug coverage. However, if you qualify for extra help, 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 2009, the national base beneficiary premium is $30.36. This amount may change in 2010). 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 Services to find out more about the late enrollment penalty reconsideration process and how to ask for such a review.

If you have a late enrollment penalty, call Member Services for more information on your monthly plan premium payment options.

You won't have to pay a late enrollment penalty if:

- You had creditable coverage (coverage that expects to pay, on average, at least as much as Medicare's standard prescription drug coverage)
- You had prescription drug coverage but you were not adequately informed that the coverage was not creditable (as good as Medicare's drug coverage)
- Any period of time that you didn't have creditable prescription drug coverage was less than 63 continuous days
- You lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) 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.

What extra help is available to help pay my plan costs?

Medicare provides "extra help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you will get help paying for any Medicare drug plan's monthly premium, and prescription copayment. If you qualify, this extra help will count toward your out-of-pocket costs.

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 a letter to people who automatically qualify for extra help.

2 **You apply and qualify for extra help.** You may qualify if your yearly income in 2008 is less than $15,600 (single with no dependents) or $21,000 (married and living with your spouse with no dependents), and your resources are less than $11,990 (single) or $23,970 (married and living with your spouse). These resource amounts include $1,500 per person for burial expenses. 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 (TTY users should call 1-800-325-0778) or visit www.socialsecurity.gov on the Web. You may also be able to apply at your State Medical Assistance (Medicaid) office. 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 and resource amounts are for 2008 and will change in 2009. If you live in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

How do costs change when you qualify for extra help?

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. If the amount of your extra help changes during the year, we will also mail you an updated "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs".

What if you believe you have qualified for extra help and you believe that you are paying an incorrect copayment amount?

If you believe you have qualified for extra help and you believe that you are paying an incorrect copayment amount when you get your prescription at a pharmacy, our Plan has established a process that will allow you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

Contact the Member Service number in Section 11 of this EOC and advise the representative that you believe you qualify for extra help and are paying an incorrect copayment. You may be required to provide one of the following:

- A copy of your Medicaid card that includes your name and your eligibility date during a month after June of the previous calendar year;
- A copy of a state document that confirms your active Medicaid status during a month after June of the previous calendar year;
- A print out from the State electronic enrollment file showing your Medicaid status during a month after June of the previous calendar year;
- A screen print from the State's Medicaid systems showing your Medicaid status during a month after June of the previous calendar year;
- Other documentation provided by the State showing your Medicaid status during a month after June of the previous calendar year; or
- If you are not deemed eligible, but applied for and are determined to be LIS eligible, a copy of the award letter you received from the Social Security Administration.

If you are institutionalized and believe you qualify for zero cost-sharing, contact the Member Service number in Section 11 of this EOC and advise the representative that you believe you qualify for extra help and are paying an incorrect copayment. You may be required to provide one of the following:

- A remittance from the facility showing Medicaid payment on your behalf for a full calendar month during a month after June of the previous calendar year;
- A copy of a state document that confirms Medicaid payment on your behalf to the facility for a full calendar month after June of the previous calendar year; or
- A screen print from the State's Medicaid systems showing your institutional status based on at least a full calendar month stay for Medicaid payment purposes during a month after June of the previous calendar year.

When we receive the evidence showing your co-payment level, we will update our system or implement other procedures so that you can pay the correct co-payment when you get your next prescription at the pharmacy. Please be assured that if you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. Of course, if the pharmacy hasn't collected a copayment from you and is carrying your copayment 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 Service if you have questions.

Important Information

We will send you a Health Net Employer Status/Coordination of Benefits Survey so that we can know what other health and/or drug coverage you have besides our Plan. Medicare requires us to collect this information from you, so when you get the survey, please fill it out and send it back. If you have additional health and/or drug coverage, you must provide that information to our Plan. The information you provide helps us calculate how much you and others have paid for your prescription drugs. In addition, if you lose or gain additional health and/or prescription drug coverage, please call Member Services to update your membership records.

5. How You Get Care and Prescription Drugs

How You Get Care

What are "providers"?

"Providers" is the term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed by the state and as appropriate eligible to receive payment from Medicare.

What are "network providers"?

A provider is a "network provider" when they participate in our Plan. When we say that network providers "participate in our Plan," this means that we have arranged with them (for example, by contracting with them) to coordinate or provide covered services to members in our Plan. Network providers may also be referred to as "plan providers."

What are "covered services"?

"Covered services" is the term we use for all the medical care, health care services, supplies, and equipment that are covered by our Plan. Covered services are listed in the Health Net Seniority Plus Benefit Chart.

What do you pay for "covered services"?

The amount you pay for covered services is listed in Health Net Seniority Plus Benefit Chart.

Providers you can use to get services covered by our Plan

While you are a member of our Plan, you must use our network providers to get your covered services except in limited cases such as emergency care, urgently needed care when our network is not available, or out of service area dialysis. We list the providers that participate with our Plan in our provider directory. If you get non-emergency care from non-plan (out-of-network) providers without prior authorization you must pay the entire cost yourself, unless the services are urgent and our network is not available, or the services are out-of-area dialysis services. If an out-of-network provider sends you a bill that you think we should pay for emergency services, please contact Member Services or send the bill to us for payment.

Choosing Your Primary Care Physician (PCP)

What is a "PCP"?

When you become a member of our Plan, you must choose a plan provider to be your PCP. Your PCP is a health care professional who meets state requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a member of our Plan. For example, in order for you to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist). Example: Your PCP will provide most of

your care and will help you arrange or coordinate the rest of the covered services you get as a member of our Plan.
This includes:

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

"Coordinating" your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your PCP (such as giving you a referral to see a specialist). In some cases, your PCP will need to get prior authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Section 6 tells you how we will protect the privacy of your medical records and personal health information.

What types of providers may act as a Primary Care Physician (PCP)?

Providers that can act as your PCP are those that provide a basic level of care. These include doctors providing general and/or family medical care, internists who provide internal medical care, obstetricians who provide care for pregnant women, and pediatricians who provide care for children. A nurse practitioner (NP), a State licensed registered nurse with special training, providing a basic level of health care, can act as your PCP.

How do you choose a PCP?

When you enroll in our Plan, you will select a contracting Medical Group from our network. You'll also choose a PCP from this contracting Medical Group, which you will need to indicate on your enrollment form and submit to our Plan. You can find a list of all contracting Medical Groups (and their affiliated PCP's and hospital affiliations) from the Provider Directory. To confirm the availability of a provider, or to ask about a specific PCP, please contact Member Services at the phone number in See Section 11 of this booklet.

If there is a particular Plan specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist, or uses that hospital. The name and office telephone number of your PCP is printed on your membership card.

For information on how to change your PCP, please see the "How can you switch to another PCP?" portion of this section.

How do you get care from your PCP?

You will usually see your PCP first for most of your routine health care needs. There are only a few types of covered services you may get on your own, without contacting your PCP first except as we explain below.

How do you get care from doctors, specialists and hospitals?

When your PCP thinks that you need specialized treatment, he/she will give you a referral (approval in advance) to see a plan specialist or certain other providers. A specialist is a doctor who provides health care services for a specific disease or part of the body. Specialists include but are not limited to such doctors as:

- oncologists (who care for patients with cancer)
- cardiologists (who care for patients with heart conditions),
- orthopedists (who care for patients with certain bone, joint, or muscle conditions).

For some types of referrals, your PCP may need to get approval in advance from our Plan (this is called getting "prior authorization"). Please refer to the Health Net Seniority Plus Benefit Chart for specific benefits that require prior authorization.

It is very important to get a referral (approval in advance) from your PCP before you see a plan specialist or certain other providers (there are a few exceptions, including routine women's health care that we explain later in this section). **If you don't have a referral (approval in advance) before you get services from a specialist, you may have to pay for these services yourself.**

If the specialist wants you to come back for more care, check first to be sure that the referral (approval in advance) you got from your PCP for the first visit covers more visits to the specialist.

If there are specific specialists you want to use find out whether your PCP sends patients to these specialists. Each plan PCP has certain plan specialists they use for referrals. This means that the PCP you select may determine the specialists you may see. You may generally change your PCP at any time if you want to see a Plan specialist that your current PCP can't refer you to. Later in this section, under "How can you switch to another PCP," we tell you how to change your PCP. If there are specific hospitals you want to use, you must first find out whether your PCP uses these hospitals.

How can you switch to another PCP?

You may change your PCP for any reason, and your request for a transfer on or before the 15th day of the month, the transfer will occur on the first 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.) To change your PCP, call Member Services at the number shown in Section 11.

When you call, be sure to tell Member Services if you are seeing Specialists or getting other Covered Services that needed your PCP's approval (such as home health services and Durable Medical Equipment). Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change to a new PCP. They will check to be sure the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP, and will tell you when the change to your new PCP will go into effect. They will also send you a new membership card that shows the name and phone number of your new PCP.

What services can you get on your own, without getting a referral (approval in advance) from your Primary Care Physician (PCP)?

You may get the following services on your own, without a referral (approval in advance) from your PCP. You still have to pay your share of the cost, as appropriate, for these services.

- Routine women's health care, which include breast exams, mammograms (x-rays of the breast), Pap tests, and pelvic exams. This care is covered without a referral from a plan provider.
- Flu shots and pneumonia vaccinations (as long as you get them from a plan provider).
- Emergency services, whether you get these services from plan providers or non-plan providers
- Urgently needed care that you get from non-plan providers when you are temporarily outside the Plan's service area. Also, urgently needed care that you get from non-plan providers when you are in the service area but, because of unusual or extraordinary circumstances, the Plan providers are temporarily unavailable or inaccessible.
- Dialysis (kidney) services that you get at a Medicare certified dialysis facility when you are temporarily outside the Plan's service area. If possible, please let us know before you leave the Service Area where you are going to be so we can help arrange for you to have maintenance dialysis while outside the Service Area.

You may get care when you are outside the service area. You will usually pay higher costs for the care because you will get your care from non-plan providers, but you won't pay extra if you are getting care for a medical emergency. If you have questions about what medical care is covered when you travel, please call Member Services.

What if your doctor or other provider leaves your plan?

Sometimes a network provider you are using might leave the Plan. If this happens, you will have to switch to another provider who is part of our Plan. Member Services can assist you in finding and selecting another provider.

Getting care if you have a medical emergency or an urgent need for care

What is a "medical emergency"?

A "medical emergency" is when you believe that your health is in serious danger. A medical emergency includes severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting much worse.

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room, hospital, or urgent care center. You don't need to get approval or a referral first from your doctor or other network provider.
- As soon as possible, make sure that we know about your emergency, because we need to be involved in following up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. This number is located on your membership card.

We will talk with the doctors who are giving you emergency care to help manage and follow up on your care. When the doctors who are giving you emergency care say that your condition is stable and the medical emergency is over then you are still entitled to follow-up post stabilization care. Your follow-up post stabilization care will be covered according to Medicare guidelines. In general, if your emergency care is provided out-of-network we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What is covered if you have a medical emergency?

- You may get covered emergency medical care whenever you need it, anywhere in the United States. We discuss filling prescriptions when you cannot access a network pharmacy later in this section.
- **Ambulance** services are covered in situations where other means of transportation in the United States would endanger your health. (See the Health Net Seniority Plus Benefit Chart for more detailed information.)
- We offer covered emergency medical care outside of the United States (Worldwide coverage). Please refer to your Health Net Seniority Plus Benefit Chart for more information.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If this happens, you are still covered for the care you got to determine what was wrong, as long as you thought your health was in serious danger, as explained in "What is a 'medical emergency'" above. If you get any extra care after the doctor says it wasn't a medical emergency, the Plan will pay its portion of the covered additional care **only if you get it from a network provider.** We will pay our portion of the covered additional care from an out-of-network provider if you are out of our service area, as long as the additional care you get meets the definition of "urgently needed care" that is given below.

What is urgently needed care?

Urgently needed care refers to a non-emergency situation when you are:

- Inside the United States. Please refer to Health Net Seniority Plus Benefit Chart for more information about Urgently Needed Care outside of the United States.
- Temporarily absent from the Plan's authorized service area
- In need of medical attention right away for an unforeseen illness, injury, or condition**,** and
- It isn't reasonable given the situation for you to obtain medical care through the Plan's participating provider network.

Under unusual and extraordinary circumstances, care may be considered urgently needed and paid for by our Plan when the member is in the service area, but the provider network of the Plan is temporarily unavailable or inaccessible.

What is the difference between a "medical emergency" and "urgently needed care"?

The two main differences between urgently needed care and a medical emergency are in the danger to your health and your location. A "medical emergency" occurs when you reasonably believe that your health is in serious danger, whether you are in or outside of the service area. "Urgently needed care" is when you need medical help for an unforeseen illness, injury, or condition, but your health is not in serious danger and you are generally outside of the service area.

How to get urgently needed care

If, while temporarily outside the Plan's service area, you require urgently needed care, then you may get this care from any provider.

Note: If you have a pressing, non-emergency medical need while in the service area, you generally must obtain services from the Plan according to its procedures and requirements as outlined earlier in this section.

How to submit a paper claim for emergency or urgently needed care

When you receive emergency or urgently needed health care services from a provider who is not part of our network, you are responsible for paying your plan cost sharing amount and you should tell the provider to bill our Plan for the balance of the payment they are due. However, if you have received a bill from the provider, please send that claim to:

ACS Seniority Plus
P O Box 14703
Lexington, KY 40512

So we can pay the provider the amount they are owed. If you have any questions about what to pay a provider or where to send a paper claim you may call Member Services.

What is your cost for services that aren't covered by our Plan?

Our Plan covers all of the medically-necessary services that are covered under Medicare Part A and Part B. Our Plan uses Medicare's coverage rules to decide what services are medically necessary. You are responsible for paying the full cost of services that aren't covered by our Plan. Other sections of this booklet describe the services that are covered under our Plan and the rules that apply to getting your care as a plan member. Our plan might not cover the costs of services that aren't medically necessary under Medicare, even if the service is listed as covered by our Plan.

If you need a service that our Plan decides isn't medically necessary based on Medicare's coverage rules, you may have to pay all of the costs of the service if you didn't ask for an advance coverage determination. However, you have the right to appeal the decision.

If you have any questions about whether our Plan will pay for a service or item, including inpatient hospital services, you have the right to have an organization determination or a coverage determination made for the service. You may call Member Services and tell us you would like a decision on whether the service will be covered before you get the service.

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

How can you participate in a clinical trial?

A "clinical trial" is a way of testing new types of medical care, like how well a new cancer drug works. A clinical trial is one of the final stages of a research process that helps doctors and researchers see if a new approach works and if it is safe.

The Original Medicare Plan pays for routine costs if you take part in a clinical trial that meets Medicare requirements (meaning it's a "qualified" clinical trial and Medicare-approved). Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if you weren't in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, the Original Medicare Plan (and not our Plan) pays the clinical trial doctors and other providers for the covered services you get that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in our Plan and continue to get the rest of your care, like diagnostic services, follow-up care, and care that is unrelated to the clinical trial through our Plan. Our Plan is still responsible for coverage of certain investigational devices exemptions (IDE), called Category B IDE devices, needed by our members.

You will have to pay the same coinsurance amounts charged under Original Medicare for the services you receive when participating in a qualifying clinical trial. You do not have to pay the Original Medicare Part A or Part B deductibles, because you are enrolled in our Plan.

You don't need to get a referral (approval in advance) from a network provider to join a clinical trial, and the clinical trial providers don't need to be network providers. However, please be sure to **tell us before you start participation in a clinical trial** so that we can keep track of your health care services. When you tell us about starting participation in a clinical trial, we can let you know whether the clinical trial is Medicare-approved, and what services you will get from clinical trial providers instead of from our plan.

You may view or download the publication "Medicare and Clinical Trials" at www.medicare.gov under "Search Tools" select "Find a Medicare Publication." Or, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Using your travel, lodging and meal benefits for services related to transgender surgery or services

Travel, lodging and meal expenses are only available for the patient (companion not covered), which includes coverage for the following:

- Pre-operation;
- Operation;
- Post-operation visits;
- Meals at a maximum of $55 per day;
- Coach airfare (patient will pay the difference to upgrade); and
- Airport parking limited to long term parking rates for all overnight trips in excess of one night.

The traveling distance must be 100 miles or more from the provider in order for Health Net to cover the travel, lodging and meal expenses.

Health Net will not prepay for travel, lodging or meal expenses. Reimbursement will be provided with submission of the Claims Reimbursement form along with receipts for pre-approved expenses; authorization needs to be indicated on the form. For use of personal car, the Member must provide: purpose of trip, date, location, receipts for tolls and parking (mileage will be reimbursed at federal mileage allowance rates).

How to access care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by our Plan under certain conditions. Covered services in an RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital or skilled nursing facility care. You may get services furnished in the home, but only items and services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "non-excepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state or local law. "Non-excepted" medical treatment is any other medical care or treatment.) Your stay in the RNHCI is not covered by our Plan unless you obtain authorization (approval) in advance from our Plan. ***Note:*** there is unlimited coverage for this benefit.

How you get prescription drugs

What do you pay for covered drugs?

The amount you pay for covered drugs is listed in the Health Net Seniority Plus Benefits Chart.

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 qualify for Medicaid benefits.

What drugs are covered by this Plan?

What is a formulary?

A formulary is a list of the 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 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 later in this section under "Utilization Management."

The drugs on the formulary are selected by our Plan with the help of a team of health care providers. Both brand name drugs and generic drugs are included on the formulary. A generic drug is a prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Not all drugs are covered by our plan. In some cases, the law prohibits Medicare coverage of certain types of drugs. (See Section 14 for more information about the types of drugs that are not normally covered under a Medicare Prescription Drug Plan.) In other cases, we have decided not to include a particular drug on our formulary.

In certain situations, prescriptions filled at an out-of-network pharmacy may also be covered. See information later in this section about filling a prescription at an out-of-network pharmacy.

How do you find out what drugs are on the formulary?

Each year, we send you an updated formulary so you can find out what drugs are on our formulary. You can get updated information about the drugs our Plan covers by visiting our website. You may also call Member Services to find out if your drug is on the formulary or to request an updated copy of our formulary.

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your coinsurance or copayment depends on which drug tier your drug is in.

You may ask us to make an exception (which is a type of coverage determination) to your drug's tier placement. See Section 8 to learn more about how to request an exception.

What is reference based pricing?

Our plan uses reference based pricing for certain drugs on our formulary. We apply reference based pricing to most generic drugs that are available from multiple manufacturers. This means we set one price for each generic drug. In the event that you receive a brand name drug when a generic equivalent with a reference based price is available, you may be charged a product selection penalty. This means you may be charged the copayment applicable to the brand drug plus the difference between the price of the brand name drug and the reference based price of the generic drug. To avoid a product selection penalty, make sure to ask your pharmacy to dispense generic drugs whenever they are available. Please see our abridged or comprehensive formulary for a list of those formulary drugs impacted by reference based pricing. You can call Member Services for more information on reference based pricing and the impact it may have on drugs you are taking.

Can the formulary change?

We may make certain changes to our formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. The kinds of formulary changes we may make include:

- Adding or removing drugs from the formulary
- Adding prior authorizations, quantity limits, and/or step-therapy restrictions on a drug
- Moving a drug to a higher or lower cost-sharing tier

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, you will be permitted to continue taking that drug at the same level of cost-sharing for the remainder of the Plan year. However, if a brand name drug is replaced with a new generic drug, or our formulary is changed as a result of new information on a drug's safety or effectiveness, you may be affected by this change. We will notify you of the change at least 60 days before the date that the change becomes effective or provide you with a 60-day supply at the pharmacy. This will give you an opportunity to work with your physician to switch to a different drug that we cover or request an exception. (If a drug is removed from our formulary because the drug has been recalled from the pharmacies, we will not give 60 days notice before removing the drug from the formulary. Instead, we will remove the drug immediately and notify members taking the drug about the change as soon as possible.)

What if your drug isn't on the formulary?

If your prescription isn't listed on your copy of our formulary, you should first check the formulary on our website which we update at least monthly (if there is a change). In addition, you may contact Member Services to be sure it isn't covered. If Member Services confirms that we don't cover your drug, you have two options:

1. You may 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 Services or go to our formulary on our website.
2. You or your doctor may ask us to make an exception (a type of coverage determination) to cover your drug. If you pay out-of-pocket for the drug and request an exception that we approve, the Plan will reimburse you. If the exception isn't approved, you may appeal the Plan's denial. See Section 8 for more information on how to request an exception or appeal.

In some cases, we will contact you if you are taking a drug that isn't 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.

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 isn't on our formulary.

Transition Policy

New members in our Plan may be taking drugs that aren't on our formulary or that are subject to certain restrictions, such as prior authorization or step therapy. Current members may also be affected by changes in our formulary from one year to the next. Members should talk to their doctors to decide if they should switch to a different drug that we cover or request a formulary exception in order to get coverage for the drug. See Section 8 under "What is an exception?" to learn more about how to request an exception. Please contact Member Services if your drug is not on our formulary, is subject to certain restrictions, such as prior authorization or step therapy, or will no longer be on our formulary next year and you need help switching to a different drug that we cover or requesting a formulary exception.

During the period of time members are talking to their doctors to determine the right course of action, we may provide a temporary supply of the non-formulary drug if those members need a refill for the drug during the first 90 days of new membership in our Plan. If you are a current member affected by a formulary change from one year to the next, we will provide a temporary supply of the non-formulary drug if you need a refill for the drug during the first 90 days of the new plan year.

When a member goes to a network pharmacy and we provide a temporary supply of a drug that isn't on our formulary, or that has coverage restrictions or limits (but is otherwise considered a "Part D drug"), we will cover a 30-day supply (unless the prescription is written for fewer days). After we cover the temporary 30-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 a new member is a resident of a long-term-care facility (like a nursing home), we will cover a temporary 34-day transition supply (unless the prescription is written for fewer days). If necessary, we will cover more than one refill of these drugs during the first 90 days a new member is enrolled in our Plan. If the resident has been enrolled in our Plan for more than 90 days and needs a drug that isn't on our formulary or is subject to other restrictions, such as step therapy or dosage limits, we will cover a temporary 34-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.

Members who experience a change in level of care, e.g., hospital discharge, will be granted a transition supply of up to a 30-day supply at home or up to a 34-day supply at Long Term Care (LTC) facility so members can continue to receive their drug(s) while a formulary exception request is being processed. Each time a member experiences a change in level of care to home, the member is eligible to receive a 30-day transition supply of each affected drug. Each time a member experiences a change in level of care to an LTC facility, the member is eligible to receive a 34-day transition supply of each affected drug.

Please note that our transition policy applies only to those drugs that are "Part D drugs" and bought at a network pharmacy. The transition policy can't be used to buy a non-Part D drug or a drug out-of-network, unless you qualify for out-of-network access. See Section 14 for information about non-Part D drugs.

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/or pharmacists developed these requirements and limits for our Plan to help us provide quality coverage to our members. Please consult your copy of our formulary or the formulary on our website for more information about these requirements and limits.

The requirements for coverage or limits on certain drugs are listed as follows:

Prior Authorization: We require you to get prior authorization (prior approval) for certain drugs. This means that your provider will need to contact us before you fill your prescription. If we don't get the necessary information to satisfy the prior authorization, 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 9 tablets per 30-day period for Imitrex.

Step Therapy: In some cases, 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 may recommend and/or provide you the generic version, unless your doctor has told us that you must take the brand name drug and we have approved this request.

You can find out if the drug you take is subject to these additional requirements or limits by looking in the formulary or on our website, or by calling Member Services. If your drug is subject to one of these additional restrictions or limits and your physician determines that you aren't able to meet the additional restriction or limit for medical necessity reasons, you or your physician may request an exception (which is a type of coverage determination). See Section 8 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 getting 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 to 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 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 don't 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?

We cover drugs under both Parts A and B of Medicare, as well as Part D. The Part D coverage we offer doesn't affect Medicare coverage for drugs that would normally be covered under Medicare Part A or Part B. Depending on where you may receive your drugs, for example in the doctor's office versus from a network pharmacy, there may be a difference in your cost-sharing for those drugs. You may contact our Plan about different costs associated with drugs available in different settings and situations.

If you are a member of an employer or retiree group

If you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact your benefits administrator to determine how your current prescription drug coverage will work with this Plan. In general, if you are currently employed, the prescription drug coverage you get from us will be secondary to your employer or retiree group coverage.

Using network pharmacies to get your prescription drugs

With few exceptions, which are noted later in this section under "How do you fill prescriptions outside the network?", **you must use network pharmacies to get your prescription drugs covered.** A network pharmacy is a pharmacy that has a contract with us to provide your covered prescription drugs. The term "covered drugs" means all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in our formulary.

In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. You aren't required to always go to the same pharmacy to fill your prescription; you may go to any of our network pharmacies. However, if you switch to a different network pharmacy than the one you have previously used, you must either have a new prescription written by a doctor or have the previous pharmacy transfer the existing prescription to the new pharmacy if any refills remain. To find a network pharmacy in your area, please review your Pharmacy Directory. You can also visit our website or call Member Services.

What is a Preferred Pharmacy?

Preferred pharmacies are pharmacies in our network in which our Plan has negotiated lower cost-sharing for its plan members for covered prescription drugs than at non-preferred pharmacies. However, you will still have access to lower drug prices at non-preferred pharmacies than at out-of-network pharmacies. You may go to either of these types of network pharmacies to receive your covered prescription drugs.

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 Services to find another network pharmacy in your area.

How do you 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 don't have your membership card with you when you fill your prescription, you may have the pharmacy call Member Services to obtain the necessary information. If the pharmacy is unable to obtain the necessary information, you may have to pay the full cost of the prescription. If you pay the full cost of the prescription (rather than paying just your coinsurance or copayment) you may 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 in the subsection below called "How do you submit a paper claim?"

How do you fill a prescription through our Plan's network mail order pharmacy service?

You can use our network mail order service to fill prescriptions for some drugs. These drugs are marked as maintenance drugs on the formulary list. These are drugs that you take on a regular basis, for a chronic or long-term medical condition. The formulary list tells you which drugs are available through our mail-order service.

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 the mail order pharmacy 14 days to process your order and ship it to you. However, sometimes your mail order may be delayed. If you run out of medication before your mail order prescription arrives, call Member Services at the phone number in Section 11 of this booklet to obtain an authorization to get a refill from a retail pharmacy.

You are not required to use mail order prescription drug services to obtain an extended supply of maintenance/ mail order medications. Instead, you have the option of using another network retail pharmacy in our network to obtain a supply of maintenance/ mail order medications. Some of these retail pharmacies may agree to accept the mail order cost-sharing amount for an extended supply of maintenance/ mail order medications, which may result in no out-of-pocket payment difference to you. Other retail pharmacies may not agree to accept the mail order cost-sharing amounts for an extended supply of maintenance/ mail order medications. In this case, you will be responsible for the difference in price. Your Pharmacy Directory contains information about retail pharmacies in our network at which you can obtain an extended supply of maintenance/ mail order medications. You can also call Member Services for more information.

To get order forms and information about filling your prescriptions by mail, call Member Services. Please note that you must use our network mail order service. Prescription drugs that you get through any other mail order services are not covered.

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.

How do you fill 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. Generally, we only cover drugs filled at an out-of-network pharmacy in limited, non-routine 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 Services 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 coinsurance or copayment) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a paper claim. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy, as any amount you pay for a covered Part D drug will help you qualify for catastrophic coverage. To learn how to submit a paper claim, please refer to the paper claims process described in the subsection below called "How do you submit a paper claim?" If we do pay for the drugs you get at an out-of-network pharmacy, you may still pay more for your drugs than what you would have paid if you had gone to an in-network pharmacy.

Note: If we do pay for the drugs you get at an out-of-network pharmacy, you may still pay more for your drugs than what you would have paid if you had gone to an in-network pharmacy.

We will cover your prescription at an out-of-network pharmacy if at least one of the following applies:

- If you are traveling outside the Service area and within the United States, we will cover urgent or emergency drugs.
- If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail order pharmacy (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.

Please note that prescriptions filled at an out-of-network mail order pharmacy will not be covered.

How do you submit a paper claim?

You may submit a paper claim for reimbursement of your drug expenses in the situations described below:

- **Drugs purchased out-of-network.** When you go to a network pharmacy and use our membership card, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy and attempt to use our membership card for one of the reasons listed in the section above ("How do you fill prescriptions outside the network?), 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 and submit a

paper claim to us. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 8.

- **Drugs paid for in full when you don't have your membership card.** If you pay the full cost of the prescription (rather than paying just your coinsurance or copayment) because you don't have your membership card with you when you fill your prescription, you may ask us to reimburse you for our share of the cost by submitting a paper claim to us. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 8.

- **Drugs paid for in full in other situations.** If you pay the full cost of the prescription (rather than paying just your coinsurance or copayment) because it is not covered for some reason (for example, the drug is not on the formulary or is subject to coverage requirements or limits) and you need the prescription immediately, you may ask us to reimburse you for our share of the cost by submitting a paper claim to us. In these situations, your doctor may need to submit additional documentation supporting your request. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 8.

- **Copayments for drugs provided under a drug manufacturer patient assistance program**. If you get help from, and pay copayment under, a drug manufacturer patient assistance program outside our Plan's benefit, you may submit a paper claim to have your out-of-pocket expense count toward qualifying you for catastrophic coverage.

You may ask us to reimburse you for our share of the cost of the prescription by sending a written request to us. Although not required, you may use our reimbursement claim form to submit your written request. You can get a copy of our reimbursement claim form on our website or by calling Member Services**. Please include your receipt(s) with your written request.**

Please send your written reimbursement request to the address listed under **Part D Coverage Determinations** in Section 8.

UC members can also obtain their mail order prescriptions at a designated UC Medical Center pharmacy. To locate a UC Medical Center pharmacy, a listing is provided on the HR/Benefits website or contact Health Net customer 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, our Plan's medical (Part C) benefit should generally cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, our plan's Part D benefit will cover your prescription drugs as long as the drugs meet all of our coverage requirements (such as that the drugs are on our formulary, filled at a network pharmacy, and they aren't covered by our medical benefit (Part C)). We will also cover your prescription drugs if they are approved under the Part D coverage determination, exceptions, or appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay: After our plan's medical benefit (Part C) stops paying for your prescription drug costs as part of a Medicare-covered skilled nursing facility stay, our plan's Part D benefit will cover your prescription drugs as long as the drug meets all of our coverage requirements (such as that the drugs are on our formulary, the skilled nursing facility pharmacy is in our pharmacy network, and the drugs aren't otherwise covered by our plan's medical benefit (Part C)). 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 Advantage Plan, Prescription Drug Plan, or the Original Medicare Plan. See Section 9 for more information about leaving this Plan and joining a new Medicare Plan.

Long-term care (LTC) pharmacies

Generally, residents of a long-term-care facility (like a nursing home) may get their prescription drugs through the facility's LTC pharmacy or another network LTC pharmacy. Please refer to your Pharmacy Directory to find out if your LTC pharmacy is part of our network. If it isn't, or for more information, contact Member Services.

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 our Plan's pharmacy network. Others may be able to use 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, contact Member Services.

Home infusion pharmacies

Please refer to your Pharmacy Directory to find a home infusion pharmacy provider in your area. For more information, contact Member Services.

Some vaccines and drugs may be administered in your doctor's office

We may cover vaccines that are preventive in nature and aren't already covered by our Plan's medical benefit (Part C). This coverage includes the cost of vaccine administration. See Section 13 for more information about your costs for covered vaccinations.

6. Your Rights and Responsibilities as a Member of our Plan

Introduction to your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this section, we explain your Medicare rights and protections as a member of our Plan and we explain what you can do if you think you are being treated unfairly or your rights are not being respected.

Your right to be treated with dignity, respect and fairness

You have the right to be treated with dignity, respect, and fairness at all times. Our Plan must obey laws that protect you from discrimination or unfair treatment. We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If you need help with communication, such as help from a language interpreter, please call Member Services. Member Services can also help if you need to file a complaint about access (such as wheel chair access). You may also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or your local Office for Civil Rights.

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 protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people don't 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 isn't 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 Plan will release your information, including your prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

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. You have the right to look at medical records held at the Plan, and to get a copy of your 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 figure out 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 privacy of your personal information and medical records, please call Member Services.

Your right to see network providers, get covered services, and get your prescriptions filled within a reasonable period of time

As explained in this booklet, you will get most or all of your care from network providers, that is, from doctors and other health providers who are part of our Plan. You have the right to choose a network provider (we will tell you which doctors are accepting new patients). You have the right to go to a women's health specialist in our Plan (such as a gynecologist) without a referral. You have the right to timely access to your providers and to see specialists when care from a specialist is needed. "Timely access" means that you can get appointments and services within a reasonable amount of time.

You have the right to timely access to your prescriptions at any network pharmacy.

Your right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your providers when you go for medical care, and the right to participate fully in decisions about your health care. Your providers must explain things in a way that you can understand. Your rights include knowing about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our Plan. This includes the right to know about the different Medication Therapy Management Programs we offer and in which you may participate. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a provider has denied care that you believe you were entitled to receive or care you believe you should continue to receive. In these cases, you must request an initial decision called an organization determination or a coverage determination. Organization determinations and coverage determinations are discussed in Section 8.

You have the right to refuse treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of your refusing treatment.

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about

how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "advance directives." There are different types of advance directives and different names for them. Documents called "living will" and "power of attorney for health care" are examples of advance directives.

If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. Section 11 of this booklet tells how to contact Health Insurance Counseling and Advocacy Program (HICAP). Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital. If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you. If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with:

California Department of Health Services
P.O. Box 997413, M.S. 3200
Sacramento, California 95899-7413

The telephone number for the California Department of Health Services is **1-916-636-1980**.

Your right to get information about our Plan

You have the right to get information from us about our Plan. This includes information about our financial condition, and how our Plan compares to other health plans. To get any of this information, call Member Services.

Your right to get information in other formats

You have the right to get your questions answered. Our plan must have individuals and translation services available to answer questions from non-English speaking beneficiaries, and must provide information about our benefits that is accessible and appropriate for persons eligible for Medicare because of disability. If you have difficulty obtaining information from your plan based on language or a disability, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your right to get information about our network pharmacies and/or providers

You have the right to get information from us about our network pharmacies, providers and their qualifications and how we pay our doctors. To get this information, call Member Services.

Your right to get information about your prescription drugs, Part C medical care or services, and costs

You have the right to an explanation from us about any prescription drugs or Part C medical care or service not covered by our Plan. We must tell you in writing why we will not pay for or approve a prescription drug or Part C medical care or service, and how you can file an appeal to ask us to change this decision. See Section 8 for more information about filing an appeal. You also have the right to this explanation even if you obtain the prescription drug, or Part C medical care or service from a pharmacy and/or provider not affiliated with our organization. You also have the right to receive an explanation from us about any utilization-management requirements, such as step therapy or prior authorization, which may apply to your plan. Please review our formulary website or call Member Services for more information.

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. See Section 7 and Section 8 for more information about complaints. If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against our Plan in the past. To get this information, call Member Services.

How to get more information about your rights

If you have questions or concerns about your rights and protections, you can

1. Call Member Services at the number on the cover of this booklet.
2. Get free help and information from your State Health Insurance Assistance Program (SHIP). Contact information for your SHIP is in Section 11 of this booklet.
3. Visit www.medicare.gov to view or download the publication "Your Medicare Rights & Protections."
4. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, you may call Member Services or:

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call your local Office for Civil Rights.
- If you have any other kind of concern or problem related to your Medicare rights and protections described in this section, you can also get help from your SHIP.

Your responsibilities as a member of our Plan include:

- Getting familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet to learn about your coverage, what you have to pay, and the rules you need to follow. Call Member Services if you have questions.
- Using all of your insurance coverage. If you have additional health insurance coverage or prescription drug coverage besides our Plan, it is important that you use your other coverage in combination with your coverage as a member of our Plan to pay your health care or prescription drug expenses. This is called "coordination of benefits" because it involves coordinating all of the health or drug benefits that are available to you.
- **You are required to tell our Plan if you have additional health insurance or drug coverage. Call Member Services.**
- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in our Plan and you must present your plan membership card to the provider.
- Giving your doctor and other providers the information they need to care for you, and following the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and have them explain your treatment in a way you can understand.
- Acting in a way that supports the care given to other patients and helps the smooth running of your doctor's office, hospitals, and other offices.
- Paying your plan premiums and coinsurance or co-payment for your covered services. You must pay for services that aren't covered.
- Notifying us if you move. If you move within our service area, we need to keep your membership record up-to-date. If you move outside of our plan service area, you cannot remain a member of our plan, but we can let you know if we have a plan in that area.
- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services.

7. How to File a Grievance

What is a Grievance?

A grievance is any complaint, other than one that involves a request for an initial determination or an appeal as described in Section 8 of this manual.

Grievances do not involve problems related to approving or paying for Part D drugs, Part C medical care or services, problems about having to leave the hospital too soon, and problems about having Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending too soon.

If we will not pay for or give you the Part C medical care or services or Part D drugs you want, you believe that you are being released from the hospital or SNF too soon, or your HHA or CORF services are ending too soon, you must follow the rules outlined in Section 8.

What types of problems might lead to your filing a grievance?

- Problems with the service you receive from Member Services.
- If you feel that you are being encouraged to leave (disenroll from) the Plan.
- If you disagree with our decision not to give you a "fast" decision or a "fast" appeal. We discuss these fast decisions and appeals in Section 8.
- We don't give you a decision within the required time frame.
- We don't give you required notices.
- You believe our notices and other written materials are hard to understand.
- Waiting too long for prescriptions to be filled.
- Rude behavior by network pharmacists or other staff.
- We don't forward your case to the Independent Review Entity if we do not give you a decision on time.
- Problems with the quality of the medical care or services you receive, including quality of care during a hospital stay.
- Problems with how long you have to wait on the phone, in the waiting room, or in the exam room.
- Problems getting appointments when you need them, or waiting too long for them.
- Rude behavior by doctors, nurses, receptionists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance."

Who may file a grievance?

You or someone you name may file a grievance. The person you name would be your "representative." You may name a relative, friend, lawyer, advocate, doctor, or anyone else to act for you. Other persons may already be authorized by the Court or in accordance with State law to act for you. If you want someone to act for you who is not already authorized by the Court or under State law, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may call Member Services.

Filing a grievance with our Plan

If you have a complaint, you or your representative may call the phone number for **Part C Grievances** (for complaints about Part C medical care or services) or **Part D Grievances** (for complaints about Part D drugs) in Section 11. We will try to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or your complaint is related to quality of care, 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.** To make a complaint – or if you have questions about this procedure – please call the Member Services at the phone number in Section 11 of this booklet. Or you may send or fax us a written request to the address or fax number listed under Part C Grievances in Section 11 of this booklet.

You may also submit your complaint in writing or via facsimile to Health Net at:

Health Net Seniority Plus
Appeals & Grievances Department
Post Office Box 10344
Van Nuys, CA 91410-0344
Fax: **1-818-676-8179**

How soon must you file your complaint?

You need to file your complaint within 60 calendar days after the event. We can give you more time if you have a good reason for missing the deadline.

Expedited Grievance Procedure

You are 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 medical care**.**
- We deny your request for a fast review of an appeal of denied services.
- We decide additional time is needed to review your request for medical care.
- We decide additional time is needed to review your appeal of denial medical care.

Requests for Expedited Grievances may be submitted telephonically at the Member Services number shown in Section 11. You may also submit your complaint in writing or via facsimile to Health Net at:

Health Net Seniority Plus
Appeals & Grievances Department
Post Office Box 10344
Van Nuys, CA 91410-0344

Fax: **1-818-676-8179**
Once the Expedited Grievance is received by Health Net, a Clinical Practitioner will review the case to determine the circumstances surrounding the denial of your request for expedited review or if the case extension was appropriate.

You will be notified of the outcome of the Expedited Grievance case verbally and in writing within 24 hours of initial receipt of the case.

Complaints about a decision regarding payment for, or provision of, Covered Services that you believe are covered by Original Medicare and should be provided or paid for by Health Net must be appealed through Health Net's Medicare Appeals procedure.

The grievance must be submitted within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have.

Fast Grievances

In certain cases, you have the right to ask for a "fast grievance," meaning we will answer your grievance within 24 hours. We discuss situations where you may request a fast grievance in Section 8.

For quality of care problems, you may also complain to QIO

You may complain about the quality of care received under Medicare, including care during a hospital stay. You may complain to us using the grievance process, to the Quality Improvement Organization (QIO), or both. If you file with QIO, we must help QIO resolve the complaint. See Section 11 for more information about QIO and for the name and phone number of QIO in your state.

8. Complaints and Appeals about your Part D Prescription Drug(s) and/or Part C Medical Care and Service(s)

Introduction

This section explains how you ask for coverage of your Part D drug(s) and Part C medical care or service(s) or payments in different situations. This section also explains how to make complaints when you think you are being asked to leave the hospital too soon, or you think your skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon. These types of requests and complaints are discussed below in Part 1, Part 2, or Part 3.

Other complaints that do not involve the types of requests or complaints discussed below in Part 1, Part 2, or Part 3 are considered **grievances**. You would file a grievance if you have any type of problem with us or one of our network providers that does not relate to coverage for Part D drugs and/or Part C medical care or services. For more information about grievances, see Section 7.

Part 1. Requests for Part D drugs and Part C medical care or services or payments.

Part 2. Complaints if you think you are asked to leave the hospital too soon.

Part 3. Complaints if you think your skilled nursing facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

PART 1. Requests for Part D drugs and/or medical care or services or payment

This part explains what you can do if you have problems getting the Part D drugs and/or Part C medical care or service you request, or payment (including the amount you paid) for a Part D drug and/or Part C medical care or service you already received.

If you have problems getting the Part D drugs and/or Part C medical care or services you need, or payment for a Part D drug and/or Part C service you already received, you must request an initial determination with the plan.

Initial Determinations

The initial determination we make is the starting point for dealing with requests you may have about covering a Part D drug and/or Part C medical care or service you need, or paying for a Part D drug and/or Part C medical care or service you already received. Initial decisions about Part D drugs are called "**coverage determinations**." Initial decisions about Part C medical care or services are called "**organization determinations**." With this decision, we explain whether we will provide the Part D drug and/or Part C medical care or service you are requesting, or pay for the Part D drug and/or Part C medical care or service you already received.

The following are examples of requests for initial determinations:

- You ask us to pay for a prescription drug you have received.
- You ask for a Part D drug that is not on your plan sponsor's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." **See "What is an exception?" below for more information about the exceptions process.**
- You ask for an exception to our 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. **See "What is an exception?" below for more information about the exceptions process.**
- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering exception." **See "What is an exception?" below for more information about the exceptions process.**
- You ask us to pay you back for the cost of a drug you bought at an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician's office, will be covered by the Plan. See "Filling Prescriptions Outside of Network" in Section 5 for a description of these circumstances.
- You are not getting Part C medical care or services you want, and you believe that this care is covered by the Plan.
- We will not approve the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by the Plan.
- You are being told that a medical treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
- You have received Part C medical care or services that you believe should be covered by the Plan, but we have refused to pay for this care.

What is an exception?

An exception is a type of initial determination (also called a "coverage determination") involving a Part D drug. You or your doctor may ask us to make an exception to our Part D coverage rules in a number of situations.

- You may ask us to cover your Part D drug even if it is not on our formulary. Excluded drugs cannot be covered by a Part D plan unless coverage is through an enhanced plan that covers those excluded drugs.
- You may ask us to waive coverage restrictions or limits on your Part D drug. For example, for certain Part D drugs, we limit the amount of the drug that we will cover. If your Part D drug has a quantity limit, you may ask us to waive the limit and cover more. See Section 5 ("Utilization Management") to learn more about our additional coverage restrictions or limits on certain drugs."
- You may ask us to provide a higher level of coverage for your Part D drug. If your Part D drug is contained in our non-preferred or injectable tier, you may ask us to cover it at the cost-sharing amount that applies to drugs in the preferred brand tier instead. This would lower the coinsurance/copayment amount you must pay for your Part D drug. Please note, if we grant your request to cover a Part D 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 Part D drugs that are in the specialty tier.

Generally, we will only approve your request for an exception if the alternative Part D drugs included on the Plan formulary or the Part D drug in the preferred brand tier would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

Your doctor must submit a statement supporting your exception request. In order to help us make a decision more quickly, the supporting medical information from your doctor should be sent to us with the 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 Part D drug for you and it continues to be safe for treating your condition. If we deny your exception request, you may appeal our decision.

Note: If we approve your exception request for a Part D non-formulary drug, you cannot request an exception to the copayment or coinsurance amount we require you to pay for the drug.

You may call us at the phone number shown under **Part D Coverage Determinations** in Section 11 to ask for any of these requests.

Who may ask for an initial determination?

You, your prescribing physician, or someone you name may ask us for an initial determination. The person you name would be your "appointed representative." You may name a relative, friend, advocate, doctor, or anyone else to act for you. Other persons may already be authorized under State law to act for you. If you want someone to act for you who is not already authorized under State law, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. If you are requesting Part C medical care or services, this statement must be sent to us at the address or fax number listed under "**Part C Organization Determinations**" in Section 11. If you are requesting Part D drugs, this statement must be sent to us at the address or fax number listed under "**Part D Coverage Determinations**" in Section 11. To learn how to name your appointed representative, you may call Member Services.

You also have the right to have a lawyer act for you. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify.

Asking for a "standard" or "fast" initial determination

A decision about whether we will give you, or pay for, the Part D drug and/or Part C medical care or service you are requesting can be a "standard" decision that is made within the standard time frame, or it can be a "fast" decision that is made more quickly. A fast decision is also called an "expedited" decision.

Asking for a standard decision

To ask for a standard decision for a Part D drug and/or Part C medical care or service you, your doctor, or your representative should call, fax, or write us at the numbers or address listed under **Part D Coverage Determinations** (for appeals about Part D drugs) or **Part C Organization Determinations** (for appeals about Part C medical care or services) in Section 11.

Requests received after business hours are handled on the next business day.

Asking for a fast decision

You may 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 benefits that you have not yet received. You cannot get a fast decision if you are asking us to pay you back for a benefit that you already received.)

If you are requesting a Part D drug and/or Part C medical care or service that you have not yet received, you, your doctor, or your representative may ask us to give you a fast decision by calling, faxing, or writing us at the numbers or address listed under **Part D Coverage Determinations** (for appeals about Part D drugs) or **Part C Organization Determinations** (for appeals about Part C medical care or services) in 11.

Requests received after business hours are handled on the next business day.

Be sure to ask for a "fast," or "expedited" 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 decision 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 decision, 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 "fast grievance." You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 7). If we deny your request for a fast initial determination, we will give you a standard decision.

What happens when you request an initial determination?

- For a <u>standard</u> initial determination about a Part D drug (including a request to pay you back for a Part D drug that you have already received):

  Generally, we must give you our decision no later than 72 hours after we receive your request, but we will make it sooner if your request is for a Part D drug that you have not received yet and your health condition requires us to. 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 limits, quantity limits, or

step therapy requirements), we must give you our decision no later than 72 hours after we receive your physician's "supporting statement" explaining why the drug you are asking for is medically necessary.

If you have not received an answer from us within 72 hours after we receive your request (or your physician's supporting statement if your request involves an exception), your request will automatically go to Appeal Level 2.

- For a fast initial determination about a Part D drug that you have not yet received:

  If we give you a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review. We will give you the decision sooner if your health condition requires us to. If your request involves a request for an exception, we will give you our decision no later than 24 hours after we have received your physician's "supporting statement," which explains why the drug you are asking for is medically necessary.

  If we decide you are eligible for a fast review and you have not received an answer from us within 24 hours after receiving your request (or your physician's supporting statement if your request involves an exception), your request will automatically go to Appeal Level 2.

- For a decision about payment for Part C medical care or services you already received.

  If we do not need more information to make a decision, we have up to 30 days to make a decision after we receive your request, although a small number of decisions may take longer. However, if we need more information in order to make a decision, we have up to 60 days from the date of the receipt of your request to make a decision. You will be told in writing when we make a decision.

  If you have not received an answer from us within 60 days of your request, you have the right to appeal.

- For a standard decision about Part C medical care or services you have not yet received.

  We have 14 days to make a decision after we receive your request. However, we can take up to 14 more days if you ask for additional time, or if we need more information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a “fast grievance”. For more information about fast grievances, see Section 7.

  If you have not received an answer from us within 14 days of your request (or by the end of any extended time period), you have the right to appeal.

- For a fast decision about Part C medical care or services you have not yet received.

  If you receive a "fast" decision, we will give you our decision about your requested medical care or services within 72 hours after we receive the request. However, we can take up to 14 more days if we find that some information is missing that may benefit you, or if you need more time to prepare for this review. If we take additional days, we will notify you in writing. If you believe that we should not take any extra days, you can file a fast grievance. We will call you as soon as we make the decision.

  If we do not tell you about our decision within 72 hours (or by the end of any extended time period), you have the right to appeal. If we deny your request for a fast decision, you may file a "fast grievance." For more information about fast grievances, see Section 7.

What happens if we decide completely in your favor?

- For a standard decision about a Part D drug (including a request to pay you back for a Part D drug that you have already received):

  We must cover the Part D drug you requested as quickly as your health requires, but no later than 72 hours after we receive the request. If your request involves a request for an exception, we must cover the Part D drug you requested no later than 72 hours after we receive your physician's "supporting statement." If you are asking us to pay you back for a Part D drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request (or supporting statement if your request involves an exception).

- For a fast decision about a Part D drug that you have not yet received:

  We must cover the Part D drug you requested no later than 24 hours after we receive your request. If your request involves a request for an exception, we must cover the Part D drug you requested no later than 24 hours after we receive your physician's "supporting statement."

- For a decision about payment for Part C medical care or services you already received.

  Generally, we must send payment no later than 30 days after we receive your request, although a small number of decisions may take up to 60 days. If we need more information in order to make a decision, we have up to 60 days from the date of the receipt of your request to make payment.

- For a standard decision about Part C medical care or services you have not yet received.

  We must authorize or provide your requested care within 14 days of receiving your request. If we extended the time needed to make our decision, we will authorize or provide your medical care before the extended time period expires.

- For a fast decision about Part C medical care or services you have not yet received.

  We must authorize or provide your requested care within 72 hours of receiving your request. If we extended the time needed to make our decision, we will authorize or provide your medical care before the extended time period expires.

What happens if we decide against you?

If we decide against you, we will send you a written decision explaining why we denied your request. If an initial determination does not give you all that you requested, you have the right to appeal the decision. (See **Appeal Level 1**.)

Appeal Level 1: Appeal to the Plan

You may ask us to review our initial determination, even if only part of our decision is not what you requested. An appeal to the plan about a Part D drug is also called a plan "**redetermination**." An appeal to the plan about Part C medical care or services is also called a plan "**reconsideration**." When we receive your request to review the initial determination, we give the request to people at our organization who were not involved in making the initial determination. This helps ensure that we will give your request a fresh look.

Who may file your appeal of the initial determination?

If you are appealing an initial decision about a Part D drug, you or your representative may file a **standard appeal** request, or you, your representative, or your doctor may file a **fast appeal** request. Please see "Who may ask for an initial determination?" for information about appointing a representative.

If you are appealing an initial decision about Part C medical care or services, the rules about who may file an appeal are the same as the rules about who may ask for an organization determination. Follow the instructions under "Who may ask for an initial determination?" However, providers who do not have a contract with the Plan may also appeal a payment decision as long as the provider signs a "waiver of payment" statement saying it will not ask you to pay for the Part C medical care or service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

You must file the appeal request within 60 calendar days from the date included on the notice of our initial determination. We may give you more time if you have a good reason for missing the deadline.

How to file your appeal

1. Asking for a standard appeal
To ask for a standard appeal about a Part D drug and/or Part C medical care or service a signed, written appeal request must be sent to the address listed under **Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about medical care or services) in Section 11.

2. Asking for a fast appeal
If you are appealing a decision we made about giving you a Part D drug and/or Part C medical care or service that you have not received yet, you and/or your doctor will need to decide if you need a fast appeal. The rules about asking for a fast appeal are the same as the rules about asking for a fast initial determination. You, your doctor, or your representative may ask us for a fast appeal by calling, faxing, or writing us at the numbers or address listed under **Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about Part C medical care or services) in Section 11.

Requests received after business hours are handled on the next business day.

Be sure to ask for a "fast" or "expedited" review. Remember, if your doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically give you a fast appeal. If you ask for a fast decision 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 decision, 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 "fast grievance." You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 7). If we deny your request for a fast appeal, we will give you a standard appeal.

Note: While the process for deciding on a standard or fast appeal is the same as the process at the initial determination level, the place where the appeal is sent is different. Please see Part D Appeals in Section 11 for more information regarding where to submit your Appeal.

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 or your representative. You have the right to obtain 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 may give us your additional information to support your appeal by calling, faxing, or writing us at the numbers or address listed under **Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about Part C medical care or services) in Section 11.

You may also deliver additional information in person to the address listed under **Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about Part C medical care or services) in Section 11.

You also have the right to ask us for a copy of information regarding your appeal. You may call or write us at the phone number or address listed under **Part D Appeals** (for appeals about Part D drugs) and/or **Part C Appeals** (for appeals about Part C medical care or services) in Section 11.

How soon must we decide on your appeal?

- For a standard decision about a Part D drug that includes a request to pay you back for a Part D drug you have already paid for and received.

  We will give you our decision within seven calendar days of receiving the appeal request. We will give you the decision sooner if you have not received the drug yet and your health condition requires us to. If we do not give you our decision within seven calendar days, your request will automatically go to Appeal Level 2.

- For a fast decision about a Part D drug that you have not yet received.

  We will give you our decision within 72 hours after we receive the appeal request. We will give you the decision sooner if your health condition requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2.

- For a decision about payment for Part C medical care or services you already received.

  After we receive your appeal request, we have 60 days to decide. If we do not decide within 60 days, your appeal automatically goes to Appeal Level 2.

- For a standard decision about Part C medical care or services you have not yet received.

  After we receive your appeal, we have 30 days to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

- For a fast decision about Part C medical care or services you have not yet received.

  After we receive your appeal, we have 72 hours to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not decide within 72 hours (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

What happens if we decide completely in your favor?

- For a standard decision about a Part D drug (including a request to pay you back for a Part D drug that you have already received).

  We must cover the Part D drug you requested as quickly as your health requires, but no later than 7 calendar days after we receive the request. If you are asking us to pay you back for a Part D drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

- For a fast decision about a Part D drug that you have not yet received.

  We must cover the Part D drug you requested no later than 72 hours after we receive your request.

- For a decision about payment for Part C medical care or services you already received.

  We must pay within 60 days of receiving your appeal request.

- For a standard decision about Part C medical care or services you have not yet received.

  We must authorize or provide your requested care within 30 days of receiving your appeal request. If we extended the time needed to decide your appeal, we will authorize or provide your requested care before the extended time period expires.

- For a fast decision about Part C medical care or services you have not yet received.

  We must authorize or provide your requested care within 72 hours of receiving your appeal request. If we extended the time needed to decide your appeal, we will authorize or provide your requested care before the extended time period expires.

Appeal Level 2: Independent Review Entity (IRE)

At the second level of appeal, your appeal is reviewed by an outside, Independent Review Entity (IRE) that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The IRE has no connection to us. You have the right to ask us for a copy of your case file that we sent to this entity.

How to file your appeal

If you asked for Part D drugs or payment for Part D drugs and we did not rule completely in your favor at Appeal Level 1, you may file an appeal with the IRE. If you choose to appeal, you must send the appeal request to the IRE. The decision you receive from the plan (Appeal Level 1) will tell you how to file this appeal, including who can file the appeal and how soon it must be filed.

If you asked for Part C medical care or services, or payment for Part C medical care or services, and we did not rule completely in your favor at Appeal Level 1, your appeal is automatically sent to the IRE.

How soon must the IRE decide?

The IRE has the same amount of time to make its decision as the plan had at **Appeal Level 1**.

If the IRE decides completely in your favor:

The IRE will tell you in writing about its decision and the reasons for it.

- For a decision to pay you back for a Part D drug you already paid for and received, we must send payment to you within 30 calendar days from the date we receive notice reversing our decision.

- For a standard decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 72 hours after we receive notice reversing our decision.

- For a fast decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 24 hours after we receive notice reversing our decision.

- For a decision about payment for Part C medical care or services you already received.

  We must pay within 30 days after we receive notice reversing our decision.

- For a standard decision about Part C medical care or services you have not yet received.

  We must authorize your requested Part C medical care or service within 72 hours, or provide it to you within 14 days after we receive notice reversing our decision.

- For a fast decision about Part C medical care or services.

  We must authorize or provide your requested Part C medical care or services within 72 hours after we receive notice reversing our decision.

Appeal Level 3: Administrative Law Judge (ALJ)

If the IRE does not rule completely in your favor, you or your representative may ask for a review by an Administrative Law Judge (ALJ) if the dollar value of the Part D drug and/or Part C medical care or service you asked for meets the minimum requirement provided in the IRE's decision. During the ALJ review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel.

How to file your appeal

The request must be filed with an ALJ within 60 calendar days of the date you were notified of the decision made by the IRE (Appeal Level 2). The ALJ may give you more time if you have a good reason for missing the deadline. The decision you receive from the IRE will tell you how to file this appeal, including who can file it.

The ALJ will not review your appeal if the dollar value of the requested Part D drug and/or Part C medical care or service does not meet the minimum requirement specified in the IRE's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

How soon will the Judge make a decision?

The ALJ will hear your case, weigh all of the evidence, and make a decision as soon as possible.

If the Judge decides in your favor:

See the section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" below for information about what we must do if our decision denying what you asked for is reversed by an ALJ.

Appeal Level 4: Medicare Appeals Council (MAC)

If the ALJ does not rule completely in your favor, you or your representative may ask for a review by the Medicare Appeals Council (MAC).

How to file your appeal

The request must be filed with the MAC within 60 calendar days of the date you were notified of the decision made by the ALJ (Appeal Level 3). The MAC may give you more time if you have a good reason for missing the deadline. The decision you receive from the ALJ will tell you how to file this appeal, including who can file it.

How soon will the Council make a decision?

The MAC will first decide whether to review your case (it does not review every case it receives). If the MAC reviews your case, it will make a decision as soon as possible. If it decides not to review your case, you may request a review by a Federal Court Judge (see Appeal Level 5). The MAC will issue a written notice explaining any decision it makes. The notice will tell you how to request a review by a Federal Court Judge.

If the Council decides in your favor:

See the section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" below for information about what we must do if our decision denying what you asked for is reversed by the MAC.

Appeal Level 5: Federal Court

You have the right to continue your appeal by asking a Federal Court Judge to review your case if the amount involved meets the minimum requirement specified in the Medicare Appeals Council's decision, you received a decision from the Medicare Appeals Council (Appeal Level 4), and:

- The decision is not completely favorable to you, or
- The decision tells you that the MAC decided not to review your appeal request.

How to file your appeal

In order to request judicial review of your case, you must file a civil action in a United States district court within 60 calendar days after the date you were notified of the decision made by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Medicare Appeals Council will tell you how to request this review, including who can file the appeal.

Your appeal request will not be reviewed by a Federal Court if the dollar value of the requested Part D drug and/or Part C medical care or service does not meet the minimum requirement specified in the MAC's decision.

How soon will the Judge make a decision?

The Federal Court Judge will first decide whether to review your case. If it reviews your case, a decision will be made according to the rules established by the Federal judiciary.

If the Judge decides in your favor:

See the section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" below for information about what we must do if our decision denying what you asked for is reversed by a Federal Court Judge.

If the Judge decides against you:

You may have further appeal rights in the Federal Courts. Please refer to the Judge's decision for further information about your appeal rights.

Favorable Decisions by the ALJ, MAC, or a Federal Court Judge

This section explains what we must do if our initial decision denying what you asked for is reversed by the ALJ, MAC, or a Federal Court Judge.

- For a decision to pay you back for a Part D drug you already paid for and received, we must send payment to you within 30 calendar days from the date we receive notice reversing our decision.

- For a standard decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 72 hours after we receive notice reversing our decision.

- For a fast decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 24 hours after we receive notice reversing our decision.

- For a decision about Part C medical care or services, we must pay for, authorize, or provide the medical care or service you have asked for within 60 days of the date we receive the decision.

PART 2. Complaints (appeals) if you think you are being discharged from the hospital too soon

When you are admitted to the hospital, you have the right to get all the hospital care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your discharge date) is based on when your stay in the hospital is no longer medically necessary. This part explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

Within two days of admission as an inpatient or during pre-admission, someone at the hospital must give you a notice called the Important Message from Medicare (call Member Services or 1-800 MEDICARE (1-800-633-4227) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI). This notice explains:

- Your right to get all medically necessary hospital services paid for by the Plan (except for any applicable copayments or deductibles).
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital services and who will pay for them.
- Your right to get services you need after you leave the hospital.
- Your right to appeal a discharge decision and have your hospital services paid for by us during the appeal (except for any applicable copayments or deductibles).

You (or your representative) will be asked to sign the Important Message from Medicare to show that you received and understood this notice. **Signing the notice does not mean that you agree that the coverage for your services should end – only that you received and understand the notice.** If the hospital gives you the Important Message from Medicare more than 2 days before your discharge day, it must give you a copy of your signed Important Message from Medicare before you are scheduled to be discharged.

Review of your hospital discharge by the Quality Improvement Organization

You have the right to request a review of your discharge. You may ask a Quality Improvement Organization to review whether you are being discharged too soon.

What is HSAG "Quality Improvement Organization, QIO"?

"QIO" stands for Quality Improvement Organization. HSAG 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. They are not part of the Plan or the hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. The QIO in California is Health Services Advisory Group, Inc. (HSAG). The doctors and other health experts in HSAG review certain types of complaints made by Medicare patients. These include complaints from Medicare patients who think their hospital stay is ending too soon.

Getting HSAG to review your hospital discharge

You must quickly contact HSAG. The Important Message from Medicare gives the name and telephone number of HSAG and tells you what you must do.

- You must ask HSAG for a **"fast review"** of your discharge. This "fast review" is also called an "immediate review."
- You must request a review from HSAG no later than the day you are scheduled to be discharged from the hospital. **If you meet this deadline, you may stay in the hospital after your discharge date without paying for it while you wait to get the decision from HSAG.**
- HSAG will look at your medical information provided to HSAG by us and the hospital.
- During this process you will get a notice, called the Detailed Notice of Discharge, giving the reasons why we believe that your discharge date is medically appropriate. Call Member Services or 1-800-MEDICARE (1-800-633-4227 - TTY users should call 1-877-486-2048) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI/).
- HSAG will decide, within one day after receiving the medical information it needs, whether it is medically appropriate for you to be discharged on the date that has been set for you.

What happens if HSAG decides in your favor?

We will continue to cover your hospital stay (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in the Health Net Seniority Plus Benefit Chart or Section 13.

What happens if HSAG agrees with the discharge?

You will not be responsible for paying the hospital charges until noon of the day after HSAG gives you its decision. However, you could be financially liable for any inpatient hospital services provided after noon of the day after HSAG gives you its decision. You may leave the hospital on or before that time and avoid any possible financial liability.

If you remain in the hospital, you may still ask HSAG to review its first decision if you make the request within 60 days of receiving HSAG's first denial of your request. However, you could be financially liable for any inpatient hospital services provided after noon of the day after HSAG gave you its first decision.

What happens if you appeal HSAG decision?

HSAG has 14 days to decide whether to uphold its original decision or agree that you should continue to receive inpatient care. If HSAG agrees that your care should continue, we must pay for or reimburse you for any care you have received since the discharge date on the Important Message from Medicare, and provide you with inpatient care (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in the Health Net Seniority Plus Benefit Chart.

If HSAG upholds its original decision, you may be able to appeal its decision to an Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds the decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date, and provide you with inpatient care (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in the Health Net Seniority Plus Benefit Chart.

What if you do not ask HSAG for a review by the deadline?

If you do not ask HSAG for a fast review of your discharge by the deadline, you may ask us for a "fast appeal" of your discharge, which is discussed in Part 1 of this section. If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in the Health Net Seniority Plus Benefit Chart.
- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received after the discharge date.

If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the IRE appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in the Health Net Seniority Plus Benefit Chart.

PART 3. Complaints (appeals) if you think coverage for your skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation facility services, is ending too soon

When you are a patient in a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF), you have the right to get all the SNF, HHA or CORF care covered by the Plan that is necessary to diagnose and treat your illness or injury. The day we end coverage for your SNF, HHA or CORF services is based on when these services are no longer medically necessary. This part explains what to do if you believe that coverage for your services is ending too soon.

Information you will receive during your SNF, HHA or CORF stay

Your provider will give you written notice called the Notice of Medicare Non-Coverage at least 2 days before coverage for your services ends (call Member Services or 1-800 MEDICARE (1-800-633-4227) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI/). You (or your representative) will be asked to sign and date this notice to show that you received it. **Signing the notice does not mean that you agree that coverage for your services should end – only that you received and understood the notice.**

Getting HSAG review of our decision to end coverage

You have the right to appeal our decision to end coverage for your services. As explained in the notice you get from your provider, you may ask the Quality Improvement Organization (the "QIO") to do an independent review of whether it is medically appropriate to end coverage for your services.

How soon do you have to ask for HSAG review?

You must quickly contact HSAG. The written notice you got from your provider gives the name and telephone number for HSAG and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must contact HSAG no later than noon of the day after you get the notice.
- If you get the notice more than 2 days before your coverage ends, you must make your request no later than noon of the day before the date that your Medicare coverage ends.

What will happen during HSAG's review?

HSAG will ask why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish. HSAG will also look at your medical information, talk to your doctor, and review information that we have given to HSAG. During this process, you will get a notice called the Detailed Explanation of Non-Coverage giving the reasons why we believe coverage for your services should end. Call Member Services or 1-800-MEDICARE (1-800-633-4227 - TTY users should call 1-877-486-2048) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI/).

HSAG will make a decision within one full day after it receives all the information it needs.

What happens if HSAG decides in your favor?

We will continue to cover your SNF, HHA or CORF services (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in the Health Net Seniority Plus Benefit Chart or Section 13.

What happens if HSAG agrees that your coverage should end?

You will not be responsible for paying for any SNF, HHA, or CORF services provided before the termination date on the notice you get from your provider. You may stop getting services on or before the date given on the notice and avoid any possible financial liability. If you continue receiving services, you may still ask HSAG to review its first decision if you make the request within 60 days of receiving HSAG's first denial of your request.

What happens if you appeal HSAG decision?

HSAG has 14 days to decide whether to uphold its original decision or agree that you should continue to receive services. If HSAG agrees that your services should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in the Health Net Seniority Plus Benefit Chart or Section 13.

If HSAG upholds its original decision, you may be able to appeal its decision to an Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ appeal. If the ALJ upholds our decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal Court. If either the MAC or Federal Court agrees that your stay should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in the Health Net Seniority Plus Benefit Chart or Section 13.

What if you do not ask HSAG for a review by the deadline?

If you do not ask HSAG for a review by the deadline, you may ask us for a fast appeal, which is discussed in Part 1 of this section.

If you ask us for a fast appeal of your coverage ending and you continue getting services from the SNF, HHA, or CORF, you may have to pay for the care you get after your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that coverage for your services should continue, we will continue to cover your SNF, HHA, or CORF services (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in the Health Net Seniority Plus Benefit Chart or Section 13.

- If we decide that you should not have continued getting services, we will not cover any services you received after the termination date.

If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the IRE appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for (except for any applicable copayments or deductibles) for as long as it is medically necessary and you have not exceeded our Plan coverage limitations as described in the Health Net Seniority Plus Benefit Chart or Section 13.

9. Ending your Membership

Ending your membership in our Plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our Plan because you have decided that you *want* to leave.
- There are also limited situations where we are required to end your membership. For example, if you move permanently out of our geographic service area.

Voluntarily ending your membership

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

- Please contact your employer/union benefits administrator for information regarding other plan options and/or questions about your employer/union open enrollment season.
- There may be other limited times during which you may make changes. For more information about these times and the options available to you, please refer to the "Medicare & You" handbook you receive each fall. You may also call 1-800-MEDICARE (1-800-633-4227), or visit www.medicare.gov to learn more about your options.

Until your membership ends, you must keep getting your Medicare services and/or prescription drug coverage through our Plan

If you leave our Plan, it may take some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect earlier in this section). While you are waiting for your membership to end, you are still a member and must continue to get your care and/or prescription drugs as usual through our Plan. If you happen to be hospitalized on the day your membership ends, generally you will be covered by our Plan until you are discharged. Call Member Services for more information and to help us coordinate with your new plan.

Until your prescription drug coverage with our Plan ends, use our network pharmacies to fill your prescriptions. 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 prescriptions are covered only if they are filled at a network pharmacy including our mail-order-pharmacy service, are listed on our formulary, and you follow other coverage rules.

We cannot ask you to leave the Plan because of your health.

We cannot ask you to leave your health plan for any health-related reasons. 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), which is the national Medicare help line. TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Involuntarily ending your membership

If any of the following situations occur, we will end your membership in our Plan.

- If you do not stay continuously enrolled in Medicare A and B.
- If you move out of the service area or are away from the service area for more than 6 months you cannot remain a member of our Plan. And we must end your membership ("disenroll" you)". If you plan to move or take a long trip, please call Member Services to find out if the place you are moving to or traveling to is in our Plan's service area.
- If you knowingly falsify or withhold information about other parties that provide reimbursement for your prescription drug coverage.
- If you intentionally give us incorrect information on your enrollment request that would affect your eligibility to enroll in our Plan.
- If you behave in a way that is disruptive, to the extent that you continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of our Plan. We cannot make you leave our Plan for this reason unless we get permission first from Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.
- If you do not pay the Plan premiums, we will tell you in writing that you have a 90-day grace period during which you may pay the Plan premiums before your membership ends.

Involuntarily ending your membership due to termination of the Group Service Agreement

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

If the Group Service Agreement between the Group and Health Net is canceled because the Group failed to pay the required premiums when due, then coverage for all Members and Family Members will end retroactively back to the last day of the month for which premiums were paid. However, this retroactive period will not exceed the 60 days before the date Health Net mails you a Notice Confirming Termination of Coverage.

Health Net will mail your employer a Prospective Notice of Cancellation 15 days before any cancellation of coverage. This Prospective Notice of Cancellation will provide information to your employer regarding the consequences of your employer's failure to pay the premiums due within 15 days of the date of mailing of the Prospective Notice of Cancellation.

You have the right to make a complaint if we end your membership in our Plan

If we end your membership in our Plan we will tell you our reasons in writing and explain how you may file a complaint against us if you want to.

10. Definitions of Important Words Used in the EOC

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 and/or prescription drugs or payment for services and/or prescription drugs 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 our Plan doesn't pay for a drug/item/service you think you should be able to receive. Section 8 explains appeals, including the process involved in making an appeal.

Benefit period – For both our Plan and the Original Medicare Plan, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

The type of care that is covered depends on whether you are considered an inpatient for hospital and SNF stays. You must be admitted to the hospital as an inpatient, not just under observation. You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both.

Brand Name Drug – 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 generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage - The phase in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent the catastrophic coverage amount listed in your Health Net Benefit Chart in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 11 explains how to contact CMS.

Cost-sharing - Cost-sharing refers to amounts that a member has to pay when drugs/services are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs/services are covered; (2) any fixed "copayment" amounts that a plan may require be paid when specific drugs/services are received; or (3) any "coinsurance" amount that must be paid as a percentage of the total amount paid for a drug/service.

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 term we use to mean all of the prescription drugs covered by our Plan.

Covered services – The general term we use in this EOC to mean all of the health care services and supplies that are covered by our Plan.

Creditable Prescription Drug Coverage – Coverage (for example, from an employer or union) that is at least as good as Medicare's prescription drug coverage.

Custodial care -- Care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who don't have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Medicare does not cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

Deductible -- The amount you must pay for the health care services or drugs you receive before our Plan begins to pay its share of your covered services or drugs.

Disenroll or **Disenrollment** – The process of ending your membership in our Plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice). Section 9 discusses disenrollment.

Durable medical equipment – Certain medical equipment that is ordered by your doctor for use in the home. Examples are walkers, wheelchairs, or hospital beds.

Emergency care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our Plan.

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.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand name drug. Generally, generic drugs cost less than brand name drugs.

Grievance - A type of complaint you make about us or one of our network providers/pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 7 for more information about grievances.

Home health aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home health care -- Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Health Net Seniority Plus Benefit Chart under the heading "Home health care." If you need home health care services, our Plan will cover these services for you provided the Medicare coverage requirements are met. Home health care can include services from a **home health aide** if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice care -- A special way of caring for people who are terminally ill and providing counseling 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 in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care visit www.medicare.gov and under "Search Tools" choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call 1-800-MEDICARE (1-800-633-4227. TTY users should call 1-877-486-2048)

Inpatient Care – Health care that you get when you are admitted to a hospital.

Initial Coverage Limit – The maximum limit of coverage under the initial coverage period.

Initial Coverage Period – This is the period after you have met your deductible (if applicable) and before your total drug expenses, have reached the initial coverage limit amount listed in your Health Net Benefit Chart, including amounts you've paid and what our Plan has paid on your behalf.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that expects to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions.

Medically necessary – Services or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

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

Medicare Advantage (MA) Plan– Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. A MA plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. Medicare Advantage Organizations can offer one or more Medicare Advantage plan in the same service area. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) Plan, or a Medicare Medical Savings Account (MSA) plan. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

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

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

Member (member of our Plan, or "plan member") – A person with Medicare who is eligible to get covered services, who has enrolled in our Plan and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 11 for information about how to contact Member Services.

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.

Network provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them "**network providers**" when they have an agreement with our Plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our Plan. Our Plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Organization Determination - The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about MA services or payment that you believe you should receive.

Original Medicare Plan – ("Traditional Medicare" or "Fee-for-service" Medicare) The Original Medicare Plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Pocket Maximum – is the maximum dollar amount you must pay for certain covered health care service. After you reach that maximum, you will no longer have to pay for these health care services. Please see your Health Net Benefit Chart for more information on which services count toward the out-of-pocket maximum.

Out-of-network provider or out-of-network facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our Plan. Out-of-network providers are providers that are not employed, owned, or operated by our Plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this EOC in Section 5.

Out-of-network pharmacy – A pharmacy that doesn't 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 drugs you get from out-of-network pharmacies are not covered by our Plan unless certain conditions apply.

Part C – see "Medicare Advantage (MA) Plan"

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

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, barbiturates, and over-the-counter drugs were specifically excluded by Congress from the standard prescription drug package (see your Health Net Benefits Chart for a listing of these drugs). These drugs are not considered Part D drugs.

Primary Care Physician (PCP) – A health care professional you select to coordinate your health care. Your PCP is responsible for providing or authorizing covered services while you are a plan member. Section 5 tells more about PCPs.

Prior authorization – Approval in advance to get services AND/OR certain drugs that may or may not be on our formulary. In an HMO with a referral model and in the network portion of a PPO, some in-network services are covered only if your doctor or other network provider gets "prior authorization" from our Plan. Covered services that need prior authorization are marked in the Health Net Seniority Plus Benefit Chart.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Section 11 for information about how to contact HSAG in your state and Section 8 for information about making complaints to HSAG.

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.

Rehabilitation services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service area – "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan.

Skilled nursing facility (SNF) care - A level of care in a SNF ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services are physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to perform usual daily activities, such as eating and dressing by yourself.

Step Therapy - A utilization tool that requires you to first try another drug to treat your medical condition before we will cover the drug your physician may have initially prescribed.

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 mental health care facility that is licensed to provide Substance Abuse detoxification services or rehabilitation services.

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.

Urgently needed care – Section 5 explains about "urgently needed" services. These are different from emergency services.

11. Helpful Phone Numbers and Resources

Contact Information for our Plan Member Services

If you have any questions or concerns, please call or write to our Plan Member Services. We will be happy to help you.

CALL **1-800-539-4072.** Calls to this number are free.
Hours of Operation: 8:00 am to 8:00 p.m., 7 days a week.

TTY/TDD **1-800-929-9955** This number requires special telephone equipment. Calls to this number are free.

FAX **1-818-676-8100**

WRITE Health Net Medicare Programs
Post Office Box 10198
Van Nuys, California, 91410-0198.

VISIT 21281 Burbank Blvd
Woodland Hills, CA 91367

WEBSITE www.healthnet.com/uc

Contact Information for Grievances, Organizations Determinations, Coverage Determinations and Appeals

Part C Organization Determinations (about your Medical Care and Services)

CALL 1-800-539-4072. Calls to this number are free.

TTY/TDD **1-800-929-9955**. This number requires special telephone equipment. Calls to this number are free.

FAX **1-800-793-4473** (elective requests) or **1-800-672-2135** (urgent requests).

WRITE Health Net Medical Management
180 Grand Avenue, 5th Floor
Oakland, CA 94612.

For information about Part C organization determinations, see Section 8.

Part C Grievances (about your Medical Care and Services)

CALL **1-800-539-4072.** Calls to this number are free.

TTY/TDD **1-800-929-9955**. This number requires special telephone equipment. Calls to this number are free.

FAX **1-818-676-8179**

WRITE Health Net Seniority Plus, Appeals & Grievances Department
Post Office Box 10344
Van Nuys, CA 91410-0344.

For information about Part C grievances, see Section 7.

Part C Appeals (about your Medical Care and Services)

CALL **1-800-539-4072**. Calls to this number are free.

TTY/TDD **1-800-929-9955**. This number requires special telephone equipment. Calls to this number are free.

FAX **1-818-676-8179**

WRITE Health Net Seniority Plus, Appeals and Grievance Department
Post Office Box 10344
Van Nuys, California 91410-0344

For information about Part C appeals, see Section 8.

Part D Coverage Determinations (about your Part D Prescription Drugs)

CALL **1-800-539-4072** Calls to this number are free.

TTY/TDD **1-800-929-9955**. This number requires special telephone equipment. Calls to this number are free.

FAX **1-916-463-9754**

WRITE Health Net Pharmaceutical Services
Attn: Pharmacy Service Center
10540 White Rock Road, Suite 280
Rancho Cordova, CA 95670

For information about Part D coverage determinations, see Section 8.

Part D Grievances (about your Part D Prescription Drugs)

CALL **1-800-539-4072**. Calls to this number are free.

TTY/TDD **1-800-929-9955**. This number requires special telephone equipment. Calls to this number are free.

FAX **1-818-676-8179**

WRITE Health Net Seniority Plus, Appeals & Grievances Department
Post Office Box 10344
Van Nuys, CA 91410-0344

For information about Part D grievances, see Section 7.

Part D Appeals (about your Part D Prescription Drugs)

CALL **1-800-539-4072**. Calls to this number are free.

TTY/TDD **1-800-929-9955**. This number requires special telephone equipment. Calls to this number are free.

FAX **1-800-956-0883**

WRITE Health Net Seniority Plus, Appeals and Grievance Department
Post Office Box 10344
Van Nuys, California 91410-0344.

For information about Part D appeals, see Section 8.

Other important contacts

Below is a list of other important contacts. For the most up-to-date contact information, check your *Medicare & You* Handbook, visit www.medicare.gov and choose "Find Helpful Phone Numbers and Resources," or call 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048.

Health Insurance Counseling and Advocacy Program (HICAP) – a state program that gives free local health insurance counseling to people with Medicare

HICAP is a state program that gets money from the Federal government to give free local health insurance counseling 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 Advantage Plans, Medicare Prescription Drug Plans, Medicare Cost Plans, and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in a Medicare Advantage Plan and special Medigap rights for people who have tried a Medicare Advantage Plan for the first time.

You may contact HICAP at:
Health Insurance Counseling and Advocacy Program (HICAP)
California Health Advocates
5380 Elvas Avenue, Suite 104
Sacramento, CA 95819
1-800-434-0222 (in-state calls only)
1-916-231-5110 (out-of-state calls)

You may also find the website for HICAP at www.medicare.gov under "Search Tools" by selecting "Helpful Phone Numbers and Websites."

HSAG (Quality Improvement Organization – QIO) – a group of doctors and health professionals in your state that reviews medical care and handles certain types of complaints from patients with Medicare

"QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and health professionals in your state that reviews medical care and handles certain types of complaints from patients with Medicare, and is paid by the federal government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and appeals filed by Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Sections 7 and 8 for more information about complaints, appeals and grievances.

You may contact HSAG at HSAG , Attn: Beneficiary Protection, 5201 W. Kennedy Boulevard Suite 900, Tampa, Florida 33609-1822 , **1-800-841-1602** (**1-800-881-5980 TDD hearing impaired**).

How to contact the Medicare program

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). Our organization contracts with the federal government.

- Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Member service representatives are available 24 hours a day, including weekends.
- Visit www.medicare.gov for information. This is the official government website for Medicare**.** This website gives you up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare Prescription Drug Plans in your area. You can also search under "Search Tools" for Medicare contacts in your state. Select "Helpful Phone Numbers and Websites." If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer.

Medicaid

Medicaid is a state government program that helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid 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
To find out more about Medicaid and its programs, contact:

California Department of Health Services
P.O. Box 997413
Sacramento, CA 95899-7413
1-800-541-5555

Social Security

Social Security programs include retirement benefits, disability benefits, family benefits, survivors' benefits, and benefits for the aged and blind. You may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You may also visit **www.ssa.gov** on the Web.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you may call your local Railroad Retirement Board office or 1-800-808-0772. TTY users should call 312-751-4701. You may also visit www.rrb.gov on the Web.

12. Legal Notices

Notice about governing law

Many laws apply to this Evidence of Coverage and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other Federal laws may apply and, under certain circumstances, the laws of the state you live in.

Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like our Plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

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 believe something has occurred fraudulently, wastefully and/or abusively, in relation to your health coverage, please contact Health Net at **1-800-977-3565**. All calls will be kept confidential, and you may remain anonymous if you choose.

Member Non-Liability

In the event Health Net fails to reimburse a contracting medical provider's charges for covered services or in the event that we fail to pay a non-contracting medical provider for prior authorized services, you shall not be liable for any sums owed by Health Net.

If you go to a doctor, hospital, or other provider without the approval of your PCP --except in an emergency or when you need urgent care, out-of-area renal dialysis, or certain gynecological care or other self referred services as described in this Evidence of Coverage-- you will be responsible for paying any charges for these services. Neither Original Medicare nor Health Net will pay for non-emergency services or non-urgently needed care without the prior authorization of Health Net or your PCP.

Circumstances Beyond Health Net's Control

Except as otherwise required by applicable 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

Except as otherwise required by applicable law or regulation, 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.
- 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 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 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 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 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.
- Coordination of benefits protects you from higher plan premiums. The end result is more affordable health care.

Organ Donation

In the event that a person or a person's family is in the position to make a decision regarding organ donation, it should be taken into consideration that advancements allow many patients to benefit from organ transplants, but the supply of organs has not kept pace with the number of eligible patients. The benefits of organ donation to patients awaiting a transplant include the chance to lead a happier, more productive life.

A person can elect to be an organ donor by various methods that include provisions within Section 12811 (b) and 13005(b) of the California Vehicle Code, and Section 7150.5 of the California Health and Safety Code.

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 (referred to as "we" or "the Plan") may collect, use and disclose your protected health information and your rights concerning your protected health information. "Protected health information" is information about you, including demographic information, that can reasonably be used to identify you and that relates to your past, present or future physical or mental health or condition, the provision of health care to you or the payment for that care.

We are required by federal and state laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. 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 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 Member service.
- **Treatment**. We may use and disclose your protected health information to assist your health care providers (doctors, 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 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 health information to support its performance of such services which may include but are not limited to claims audits or Member 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/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 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, please contact:

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

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 Life Insurance Company
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 in Section 8.

13. How Much You Pay for Your Part C Medical Benefits and/or Part D Prescription Drugs

Your Monthly Premium for Our Plan

Please contact your employer/union benefits administrator for information about your Plan premium.

If you are getting extra help with paying for your drug coverage, the Part D premium amount that you pay as a member of this Plan is listed in your "Evidence of Coverage Rider for those who Receive Extra Help for their Prescription Drugs." You can also get that information by calling Member Services.

How Much You Pay for Part C Medical Benefits

This Health Net Seniority Plus Benefit Chart located in the beginning this booklet gives a list of your covered services and tells what you must pay for each covered service. These are the benefits and coverage you get as a member of our Plan. Later in this section under "General Exclusions" you can find information about services that are not covered. It also tells about limitations on certain services. Information about how much you pay for your Part D Prescription Drug Benefits is later in this section.

What do you pay for covered services?

"Deductibles," "copayments," and "coinsurance" are the amounts you pay for covered services.

- The **"deductible"** is the amount you must pay for the health care services you receive before our Plan begins to pay its share of your covered services. (Not all plans described in this EOC have a deductible. Check the Health Net Seniority Plus Benefit Chart for more information on each plan.)
- A **"copayment"** is a payment you make for your share of the cost of certain covered services you get. A copayment is a set amount per service. You pay it when you get the service.
- **"Coinsurance"** is a payment you make for your share of the cost of certain covered services you receive. Coinsurance is a percentage of the cost of the service. You pay your coinsurance when you get the service.
- Depending on your Medicaid benefit, you may not have to pay out-of-pocket costs for deductibles, co-payments and/or coinsurances. These costs may be covered by Medicaid, as long as you qualify for Medicaid benefits and the provider accepts Medicaid. The only exception is that you are responsible for your covered health care services "coinsurances or copayments" and your Medicaid copayments, if applicable.

Health Net Seniority Plus Benefit Chart

The Health Net Seniority Plus Benefit Chart located in the beginning of this booklet lists the services our Plan covers and what you pay for each service. The covered services listed in the Health Net Seniority Plus Benefit Chart are covered only when all requirements listed below are met:

- Services must be provided according to the Medicare coverage guidelines established by the Medicare Program.
- The medical care, services, supplies, and equipment that are listed, as covered services must be medically necessary. Certain preventive care and screening tests are also covered.
- Some of the covered services listed in the Health Net Seniority Plus Benefit Chart are covered only if your doctor or other network provider gets "prior authorization" (approval in advance) from our Plan. Covered services that need prior authorization are marked in the Health Net Seniority Plus Benefit Chart in italics.

See Section 5 for information on requirements for using network providers.

How Much You Pay for Part D Prescription Drugs

This section has a chart that tells you what you must pay for covered drugs. These are the benefits you get as a member of our Plan. (Covered Part B drugs were described earlier in this section. Later in this section under "General Exclusions" you can find information about drugs that are not covered.) For more detailed information about your benefits, please refer to our Summary of Benefits. If you do not have a current copy of the Summary of Benefits you can view it on our website or contact Member Services to request one.

How much do you pay for drugs covered by this Plan?

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., initial coverage period, the period after you reach your initial coverage limit, 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. Each phase of the benefit is described below. Refer to your plan formulary to see what drugs we cover and what tier they are on. (More information on the formulary is included later in this section.)

If you qualify for extra help with your drug costs, your costs for your drugs may be different from those described below. For more information, see the "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs." If you do not already qualify for extra help, see "Do you qualify for extra help?" in Section 4 for more information.

Vaccine Coverage (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.

The following chart describes some of these scenarios. 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, following our out-of-network paper claims policy (see Section 5), and then you will be reimbursed up to our normal coinsurance/copayment for that vaccine. In some cases you will be responsible for the difference between what we pay and what the out-of-network provider charges you. The following chart provides examples of how much it might cost to obtain a vaccine (including its administration) under our Plan. Actual vaccine costs will vary by vaccine type and by whether your vaccine is administered by a pharmacist or by another provider.

Remember you are responsible for all of the costs associated with vaccines (including their administration) during the coverage gap phase of your benefit.

If you obtain the vaccine at:	And get it administered by:	You pay (and/or are reimbursed)
The Pharmacy	The Pharmacy (not possible in all States)	You pay your normal coinsurance or copayment for the vaccine.
Your Doctor	Your Doctor	You pay up-front for the entire cost of the vaccine and its administration. You are reimbursed this amount less your normal coinsurance or co-payment for the vaccine (including administration) less any difference between the amount the Doctor charges and what we normally pay.*
The Pharmacy	Your Doctor	You pay your normal coinsurance or co-payment for the vaccine at the pharmacy and the full amount charged by the doctor for administering the vaccine. You are reimbursed the amount charged by the doctor less any applicable in-network charge for administering the vaccine less any difference between what the Doctor charges for administering the vaccine and what we normally pay."*

*If you receive extra help, we will reimburse you for this difference.

We can help you understand the costs associated with vaccines (including administration) available under our Plan before you go to your doctor. For more information, please contact Member Services.

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 may count toward your out-of-pocket costs and help you qualify for catastrophic coverage as long as the drug you are paying for is a Part D drug or transition drug, on the formulary (or if you get a favorable decision on a coverage determination request, 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
- Your coinsurance or copayments up to the initial coverage limit
- Any payments you make for drugs in the coverage gap
- Payments you made this year under another Medicare prescription drug plan prior to your enrollment in our plan

When you have spent a total of $4,350 for these items, you will reach the catastrophic coverage level.

What type of prescription drug payments will not count toward your out-of-pocket costs?

The amount you pay for your monthly premium doesn't count toward reaching the catastrophic coverage level. In addition, the following types of payments for prescription drugs **do 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
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare

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;
- Medicare programs that provide extra help with prescription drug coverage; and

- Most charities or charitable organizations that pay cost-sharing on your behalf. 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 don't 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, AIDS Drug Assistance Programs); 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 let us know.

We will be responsible for keeping track of your out-of-pocket expenses and will let you know when you have qualified for catastrophic coverage. If you are in a coverage gap or deductible period 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 toward qualifying you for catastrophic coverage. In addition, for every month in which you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

14. General Exclusions

Introduction

The purpose of this part of Section 14 is to tell you about medical care and services, items, and drugs that aren't covered ("are excluded") or are limited by our Plan. The list below tells about these exclusions and limitations. The list describes services, items, and drugs that aren't covered under any conditions, and some services that are covered only under specific conditions. (The Health Net Seniority Plus Benefits Chart earlier also explains about some restrictions or limitations that apply to certain services).

If you get services, items or drugs that are not covered, you must pay for them yourself

We won't pay for the exclusions that are listed in this section (or elsewhere in this EOC), and neither will the Original Medicare Plan, unless they are found upon appeal to be services, items, or drugs that we should have paid or covered (appeals are discussed in Section 8).

What services are not covered or are limited by our Plan?

In addition to any exclusions or limitations described in the Health Net Seniority Plus Benefit Chart, or anywhere else in this EOC or in the Vendor Benefit Rider, **the following items and services aren't covered under the Original Medicare Plan or by our plan:**

1. Services that aren't reasonable and necessary, according to the standards of the Original Medicare Plan, unless these services are otherwise listed by our Plan as a covered service.
2. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by the Original Medicare Plan or unless, for certain services, the procedures are covered under an approved clinical trial. The Centers for Medicare and Medicaid Services (CMS) will continue to pay through Original Medicare for clinical trial items and services covered under the September 2000 National Coverage Determination that are provided to plan members. Experimental procedures and items are those items and procedures determined by our Plan and the Original Medicare Plan to not be generally accepted by the medical community.
3. Surgical treatment of morbid obesity unless medically necessary and covered under the Original Medicare plan.
4. Private room in a hospital, unless medically necessary.
5. Private duty nurses.
6. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
7. Nursing care on a full-time basis in your home.
8. Custodial care unless it is provided in conjunction with covered skilled nursing care and/or skilled rehabilitation services. This includes care that helps people with activities of daily living like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
9. Homemaker services.

10. Charges imposed by immediate relatives or members of your household.
11. Meals delivered to your home.
12. Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: Weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.
13. Cosmetic procedures, beyond surgery, that are related to transgender services are not covered.
14. Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body.
15. Drugs prescribed for hormonal therapy for individuals who have been diagnosed with a covered Gender Identity Disorder (GID) may be covered
16. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. However, non-routine dental services received at a hospital may be covered. However these items are available under the Optional Supplemental Benefits.
17. Orthopedic shoes unless they are part of a leg brace and are included in the cost of the brace. Exception: Therapeutic shoes are covered for people with diabetic foot disease.
18. Supportive devices for the feet. Exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
19. Self-administered prescription medication for the treatment of erectile dysfunction, including erectile dysfunction, impotence, and anorgasmy or hyporgasmy.
20. Non-prescription contraceptive supplies and devices.
21. Acupuncture.
22. Naturopath services.
23. Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under our Plan, we will reimburse veterans for the difference. Members are still responsible for our Plan cost-sharing amount.
24. Any of the services listed above that aren't covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

Excluded Drugs

This part of Section 14 talks about drugs that are "excluded," meaning they aren't normally covered by a Medicare Prescription Drug Plan. If you get drugs that are excluded, you must pay for them yourself. We won't pay for the exclusions that are listed in this section unless they are listed in the Benefits Chart (or elsewhere in this EOC), and neither will the Original Medicare Plan, unless they are found upon appeal to be drugs that we should have paid or covered (appeals are discussed in Section 8).

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;
  - 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.
- Drugs such as Viagra, Cialis, Levitra, and Caverject, when used for the treatment of sexual or erectile dysfunction
- 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 can't cover a drug that would be covered under Medicare Part A or Part B. Also, while a Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug's label as approved by the Food and Drug Administration) 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.[1] If the use is not supported by one of these reference books (known as compendia), then the drug is considered a non-Part D drug and cannot be covered by our Plan

15. Appendix A: Complaints (Appeals) about your Employer-Sponsored Benefits

Employer-sponsored benefits are covered benefits that are beyond the Medicare-covered Part C services. This part explains what you can do if you have problems getting Employer-sponsored benefits you believe we should provide. The word "provide" includes such thing as authorizing care, paying for it, or arrange for someone to provide it.

NOTE: If your complaints involve Medicare-covered Part C benefits, please refer to Section 8 (Part C) for more details on how to file the complaints.

There are 4 possible steps for requesting care or payment of Employer-Sponsored Benefits.

STEP 1: The Initial Decision

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

STEP 2: Appealing the Initial Decision

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an "Appeal." You can file the Appeal by calling Health Net Member Services Department at
1-800-539-4072 or by sending information to:

Health Net
Appeals & Grievance Department
P.O. Box 10450
Van Nuys, CA 91410-0450

We will:

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

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

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

If you are not satisfied with the outcome of your appeal in Step 2, you can request for an independent review organization to review your case. This organization will review your request and make a decision about whether we must give you the care or payment you want. You may call Health Net Member Services Department at 1-800-539-4072 to request the independent review or by sending the request to:

Health Net
Appeals & Grievance Department
P.O. Box 10450
Van Nuys, CA 91410-0450

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

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

STEP 4: Binding Arbitration

If you continue to be dissatisfied after the independent review process in Step 3 has been completed, you may then initiate binding arbitration as described in Section 12 under "Binding Arbitration." Binding arbitration is generally the final process to resolve disputes concerning Employer-sponsored benefits.

16. Index

Health Net Medicare Programs
Post Office Box 10198
Van Nuys, California 91410-0198

Member Services Department

1.800.539.4072

Our office hours are from 8:00 a.m. to 8:00 p.m., 7 days a week.

Telecommunications Device for the Deaf

1.800.929.9955

Our office hours are from 8:00 a.m. to 8:00 p.m., 7 days a week.

Para los que hablan español

1.800.539.4072

Nuestras horas de negocio son de las de 8:00am a 8:00pm, siete días a la semana.

Dispositivo de telecomunicaciones para las personas con impedimentos auditivos

1.800.929.9955

Nuestras horas de negocio son de las de 8:00am a 8:00pm, siete días a la semana.

WWW.HEALTHNET.COM/UC.

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