EVIDENCE OF COVERAGE

A complete explanation of your plan

For University of California Medicare Retirees Effective 1/1/2013

Health Net Seniority Plus (Employer HMO)

Important benefit information – please read

Health Net
Medicare Programs

Material ID # Y0035_EG_2013_0006 (H0351, H0562)
Compliance Approved 07272012

(Plan 3D2)
EOCID: 377458

Schedule changes in 2013

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:

- Urgent Care copayment - The Urgent Care copayment has been changed from $15 to $20.
- Emergency Services copayment - The Emergency Services copayment has been changed from $50 to $65.
- Office Visit copayment - The Office Visit copayment has been changed from $15 to $20.
- Outpatient Surgery in hospital and non-hospital based ambulatory surgical center copayment - The Outpatient Surgery in hospital and non-hospital based ambulatory surgical centers copayment has been changed from $0 to $100.
- Routine Chiropractic Services copayment – The Routine Chiropractic Services copayment has been changed from $15 to $20.
- Outpatient Mental Health Care copayment - The Outpatient Mental Health Care copayment has been changed from $15 to $20 for individual therapy sessions and from $7.50 to $10 for group therapy sessions.
- Outpatient Substance Abuse Services copayment - The Outpatient Substance Abuse Services copayment has been changed from $15 to $20 for individual therapy sessions and from $7.50 to $10 for group therapy sessions.
- Smoking Cessation Drugs copayment – The Smoking Cessation Drugs copayment has been changed from $20 to $0.
- Pharmacy Drug copayment - The copayment has been changed from $5/$20/$35 to $5/$25/$40.

Note:
Once you enroll in Medicare, your behavioral health provider network will be different and you will need to obtain new authorizations/self referrals to

behavioral health providers. Please review your Health Net ID card for the appropriate phone number for Mental Health and Substance Abuse.

UNIVERSITY OF CALIFORNIA ELIGIBILITY, ENROLLMENT, TERMINATION AND PLAN ADMINISTRATION PROVISIONS

January 1, 2013

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

Individuals eligible to enroll in this Plan are described below, except that if the Plan is a Health Maintenance Organization (HMO) only those eligible individuals who they meet the Plan's geographic service area criteria may enroll. 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 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 defined benefit plan to which the University contributes.

You may be eligible for University medical plan coverage as a Retiree provided that you meet the following requirements:

(a) You meet the University's service credit requirements for Retiree medical eligibility;
(b) You elect to receive your retirement benefits in the form of monthly payments;
(c) The effective date of your retirement is within 120 calendar days of the date your University employment ends; and
(d) You elect to continue (or suspend) medical coverage prior to the effective date of your retirement.

For more information, see the UC *Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members* or the *Survivor and Beneficiary Handbook*.

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

UCRP Disabled Member: If you are approved for Disability Income from the University of California Retirement Plan (UCRP), you may be eligible to continue your University medical plan coverage after you separate from University employment, provided you were enrolled in medical coverage when you separated, your coverage is continuous until your Disability Income begins, and you meet any other University coverage requirements.

For more information, see the *University of California Retirement Plan Disability Handbook*.

Survivor: If you are a surviving Family Member of a deceased Employee or Retiree, and you are receiving monthly benefits from a defined benefit plan to which the University contributes, you may be eligible to receive medical coverage as set forth in the University's Group Insurance Regulations. (**Note**: Survivors receiving University-sponsored medical coverage may NOT enroll a spouse or domestic partner for coverage as a Family Member.)

For more information, see the applicable *Survivor and Beneficiary Handbook*.

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

Eligible Family Members

When you enroll any individual(s) in the Plan as a Family Member, you must provide documentation specified by the University verifying that the individual(s) you have enrolled meet(s) the eligibility requirements outlined below. The Plan may also require documentation verifying eligibility status. In addition, the University and/or the Plan reserve the right to

periodically request documentation to verify the continued eligibility of enrolled Family Members.

Eligible Adult: You may enroll one eligible adult Family Member, in addition to yourself

Spouse: Your legal spouse.

Domestic Partner:

You may enroll your same-sex domestic partner if your partnership is registered with the State of California or otherwise meets criteria as a domestic partnership as set forth in the University of California Group Insurance Regulations. Same-sex domestic partners from jurisdictions other than California will be covered to the extent required by law. You may enroll your opposite-sex domestic partner only if either you or your domestic partner is age 62 or older and eligible to receive Social Security benefits based on age.

Note: An adult dependent relative is not eligible for coverage in UC plans **unless enrolled prior to December 31, 2003 and <u>continuously eligible</u> and enrolled since that date.** To review the ongoing eligibility requirements for enrolled adult dependent relatives, see the *Group Insurance Eligibility Factsheet for Employees and Eligible Family Members or the Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members.*

Also, remember: If your eligible adult dependent relative is still enrolled in the Plan, you *cannot* also enroll your spouse or domestic partner.

Child: All eligible children must be under the limiting age of 26 (18 for legal wards except for a child who is incapable of self support due to a mental or physical disability. The following categories are eligible:

(a) your natural or legally adopted children;
(b) your spouse's natural or legally adopted children (your stepchildren);
(c) your eligible domestic partner's natural or legally adopted children;
(d) grandchildren of you, your spouse or your eligible domestic partner if unmarried, living with you, dependent on you, your spouse or your eligible domestic partner for at least 50% of their support and are your, your spouse's, or your eligible domestic partner's dependents for income tax purposes;
(e) children for whom you are the legal guardian if unmarried, living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.
(f) 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 26 provided:

- the plan-certified disability began before age 26, the child was enrolled in a UC group medical plan before age 26 and coverage is continuous;
- the child is chiefly dependent upon you, your spouse, or your eligible domestic partner for support and maintenance; (50% or more) and
- the child is claimed as your, your spouse's, or your eligible domestic partner's dependent for income tax purposes, or if not claimed as such dependent for income tax purposes, 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.

Except as provided below, application for coverage beyond age 26 due to disability must be made to the Plan 60 days prior to the date coverage is to end due to reaching limiting age. If application is received timely but the 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 the Plan's determination. The Plan may periodically request proof of continued disability, but not more than once a year after the initial certification. Disabled 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; however, the new Plan may require proof of continued disability, but not more than once a year.

If you are a newly hired Employee with a disabled child over age 26 or if you newly acquire a disabled child over age 26 (through marriage, adoption, or domestic partnership), you may also apply for coverage for that child. The child's disability must have begun prior to the child turning age 26. Additionally, the child must have had continuous group medical coverage since age 26, and you must apply for University coverage during your Period of Initial Eligibility. The Plan will ask for proof of continued disability, but not more than once a year after the initial certification.

Important Note: The University complies with federal and state law in administering its group insurance programs. Health and welfare benefits and eligibility requirements, including dependent eligibility requirements are subject to change (e.g., for compliance with applicable laws and regulations). The University also complies with federal and state income tax laws which are subject to change. Requirements may include laws mandating that the employer contribution for coverage provided to certain Family Members be treated as imputed income to the Employee or Retiree. See At Your Service online for related information. Contact your tax advisor for additional information.

No Dual Coverage

Eligible individuals may be covered under only one of the following categories: as an Employee, a Retiree, a Disabled Member, a Survivor or a Family Member. If an Employee and the Employee's spouse or domestic partner are both eligible for coverage, each may enroll separately or one may enroll and 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 the person who handles benefits for your location or the University of California's (UC) Customer Service Center at (800) 888-8267. You may also access eligibility factsheets on UC's *At Your Service* web site: http://atyourservice.ucop.edu.

ENROLLMENT

For information about enrolling yourself or an eligible Family Member, contact the person at who handles benefits for your location. If you are a Retiree or a surviving Family Member, contact the UC Customer Service Center. Enrollment transactions may be completed by paper form or electronically, according to current University practice, during a Period of Initial Eligibility (PIE), which may occur when you first become eligible or when you have another enrollment opportunity.

During a Period of Initial Eligibility (PIE)

A PIE begins the day you become eligible and ends 31 days after it began (but see exception under "Special Circumstances" paragraph 1.d below). Also see "At Other Times for Employees and Retirees" below. Electronic enrollment transactions must be completed online by the last day of the applicable PIE. Paper enrollment forms must be received at the location specified on the form by the last day of the applicable PIE, except that if the last day of the PIE falls on a weekend or holiday, the PIE is extended to the following business day.

Employee

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

Retiree
If you are a Retiree who is eligible for Retiree medical coverage, keep in mind that retirement alone does not entitle you to a PIE to change your medical plan or to enroll yourself and/or your eligible Family Members in medical plan coverage.

If you and any eligible Family Members were enrolled in a University-sponsored medical plan immediately before your retirement, and you are eligible for Retiree medical, you may continue coverage in that plan (or, if applicable, its Medicare version upon completion of Medicare assignment) for yourself and your enrolled Family Members; you may change plans and/or add eligible Family Members during the University's next open enrollment period or at certain other times, as described below (See "At Other Times for Employees and Retirees").

If you are eligible for Retiree medical coverage when you retire, but you are enrolled, or enroll, in non-University sponsored medical coverage at that time (e.g., medical coverage provided by your spouse's or domestic partner's employer), you may elect to suspend your Retiree coverage.

You must elect to continue or suspend enrollment before the effective date of your retirement. For more information, see the UC *Group Insurance Eligibility Factsheet for Retirees and Eligible Family Members.*

Similar rules apply to **Survivors.** For more information, see the *Survivor and Beneficiary Handbook*.

Family Members

A newly eligible Family Member's PIE starts the day he or she becomes eligible, as described below. During this PIE, you may enroll the newly eligible Family Member as well as yourself and/or any other eligible Family Member(s) if not already enrolled. If you are already enrolled in this Plan, you may add your current and newly eligible Family Member(s) to the Plan or you may enroll yourself and all eligible Family Members in a different University-sponsored plan. However, you must enroll yourself in order to enroll any eligible Family Members, and you and all eligible Family Members must be enrolled in the same plan.

Note: If you are a Survivor receiving University-sponsored medical coverage, you may NOT enroll a spouse or domestic partner for coverage as a Family Member.

Family Member Eligibility Dates

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

(b) For a Domestic Partner, on the date the domestic partnership is legally established. Also see "At Other Times for Employees and Retirees" below.

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

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

(i) the date the child is placed for adoption with the Employee/Retiree, or
(ii) the date the Employee/Retiree or Spouse/Domestic Partner has the legal right to control the child's health care.

A child is "placed for adoption" with the Employee/Retiree as of the date the Employee/Retiree assumes and retains a legal obligation for the child's total or partial support in anticipation of the child's adoption.

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.

(e) For a legal ward, the effective date of the legal guardianship
(f) Where there is more than one eligibility requirement, the date all requirements are satisfied.

If you are in a Health Maintenance Organization 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 the time period specified under the terms of the Plan, you will have a PIE to enroll yourself and your eligible Family Members in another University medical plan available in the new location. Your PIE starts with the effective date of the move or the date you leave the Plan's service area. If you return to your original location, and the plan providing coverage prior to your return is not available in that location, you will again have a PIE to enroll in any University medical plan. Otherwise, you may change plans during the University's next open enrollment period or at certain other times, as described below under "At Other Times for Employees and Retirees."

At Other Times for Employees and Retirees

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

90-Day Waiting Period. If you are an Employee and miss an opportunity 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 unless one of the "**Special Circumstances**" described below applies.

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 unless one of the "**Special Circumstances**" described below applies.

The 90-day waiting period starts on the date the completed enrollment form is received at the location specified on the form and ends 90 consecutive calendar days later.

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

Special Circumstances. You may enroll before the end of the 90-day waiting period or 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 COBRA or Cal-COBRA (or similar program in another state), the Children's Health Insurance Program or "CHIP" (called the Healthy Families Program in California), or Medicaid (called Medi-Cal in California).

    b. You stated at the time you became eligible for coverage under a University-sponsored Plan that you were opting out or if applicable, suspending, coverage under this Plan because you were covered under another health plan as stated above.

    c. Coverage under another health plan for you and/or your eligible Family Members ended because you/they lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, your coverage under COBRA or Cal-COBRA continuation was exhausted, or coverage under CHIP or Medicaid was lost because you/they were no longer eligible for those programs.

    d. You properly file an application with the University during the PIE which starts on the day after the other coverage ends. **Note that if you lose coverage under CHIP or Medicaid, your PIE is 60 days.**

2. You or your eligible Family Members are not currently enrolled and in the UC-sponsored medical coverage you or your eligible Family Members become eligible for premium assistance under the Medi-Cal Health Insurance Premium Payment (HIPP) Program or a Medicaid or CHIP premium assistance program in another state. Your PIE is 60 days from the date you are determined eligible for premium assistance. If the last day of the PIE falls on a weekend or holiday, the PIE is extended to the following business day if you are enrolling with paper forms.

3. A court has ordered coverage be provided for a dependent child under your UC-sponsored medical plan pursuant to applicable law and an application is filed within the PIE which begins the date the court order is issued. The child must also meet UC eligibility requirements.

4. 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 establishment of a domestic partnership, you and your new spouse or domestic partner must enroll during the PIE. Your new spouse or domestic partner's eligible children may also enroll at that time. Coverage will be effective as of the date of marriage or domestic partnership provided you enroll during the PIE.

    b. If you are enrolling following the birth, adoption, or placement for adoption of a child, your spouse or domestic partner, who is eligible but not enrolled, may also enroll at that

time. Application must be made during the PIE; coverage will be effective as of the date of birth, adoption, or placement for adoption provided you enroll during the PIE.

5. For Employees, you and/or an eligible Family Member experiences an event not otherwise covered by paragraphs 1 through 4, above, that would permit enrollment under the terms of the University of California Tax-Savings on Insurance Premiums Plan and Section 125 of the Internal Revenue Code. For more information on permitted change events, see the *Tax Savings on Insurance Premiums (TIP) Summary Plan Description*.

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 completed enrollment form is received, unless the enrollee is Medicare-eligible. Coverage for Medicare-eligible enrollees will be effective as of the first of the month following the end of the 90-day waiting period.

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 form is received by the person who handles benefits for your location (or the UC Customer Service Center if you are a Retiree or Survivor).

Change in Coverage

In order to make any of the changes described above, contact the person who handles benefits for your location (or the UC Customer Service Center if you are a Retiree or Survivor).

Effect of Medicare on Enrollment

Except as provided below, if you are a Retiree or Survivor and you and/or an enrolled Family Member is or becomes eligible for premium-free Medicare Part A (Hospital Insurance) as primary coverage, then you and/or your Family Member must also enroll in and remain in Medicare Part B (Medical Insurance). **This includes individuals eligible for Medicare benefits**

through their own or their spouse's employment. If an individual (Retiree or Family Member) fails to enroll at the earliest opportunity, he or she will still be required to do so even if a Medicare late enrollment penalty applies.

Individuals enrolled in both Part A and Part B are then eligible for the Medicare premium applicable to this plan.

Retirees or Survivors 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 and continue Part B will permanently lose their UC-sponsored medical coverage.

Retirees or Survivors and their Family Members who were eligible for premium-free Medicare Part A between July 1, 1991 and 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 Survivors 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 if they remain ineligible to enroll based on their own or their spouse's employment. Documentation attesting to their ineligibility for Medicare Part A will be required.

An exception to the above rules applies to Retirees or Survivors 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.

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 UC Customer Service Center or from the web site: http://atyourservice.ucop.edu. Completed forms should be returned to University of California, Human Resources, 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 (including Part D) to that plan or lose UC-sponsored medical coverage. Anyone enrolled concurrently in a non-University Medicare Advantage Managed Care contract will be deenrolled from this health plan. Any individual enrolled in a University-sponsored Medicare Part D Prescription Drug Plan must assign his/her Part D benefit to the plan or

lose UC-sponsored medical coverage. Anyone enrolled concurrently 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 a large employer group health plan. Employees or their opposite-sex spouses, age 65 or over, and UC Retirees re-hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to the MSP rules. Under those rules, Medicare becomes the secondary payer and the employer plan becomes the primary payer. The MSP rules do not apply to an Employee's or Retiree's same-sex spouse or domestic partner, age 65 or over, who is covered as a Family Member under a University-sponsored plan. Medicare is primary for those individuals.

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 month in which eligibility status is lost. 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 services yourself. You may be entitled to continued benefits under terms which are specified elsewhere in this document. (If you apply for a HIPAA individual plan or a conversion plan, the benefits may not be the same as you had under this Plan.)

If you are a Retiree or Survivor and your monthly retirement payments terminate, your coverage and that of any enrolled Family Member stops at the end of the last month in which you are eligible for the retirement income.

Also, if you are enrolled in a medical plan that requires premium payments (in addition to amounts subtracted from your monthly retirement payments), and you do not continue payment, your coverage will be terminated at the end of the month for which you paid.

If your Family Member loses eligibility, and you wish to make a permitted change in your health or flexible spending account coverage, you must complete the appropriate transaction to delete him or her within 31 days of the eligibility loss event, although for purposes of COBRA eligibility, notice may be provided to UC within 60 days of the family member's loss of coverage. For information on deenrollment procedures, contact the person who handles benefits for your location (or the UC Customer Service Center if you are a Retiree or Survivor).

Other Deenrollments

Coverage for you and/or your Family Members may be suspended for up to 12 months if you and/or a Family Member misuse the Plan, as described in the Group Insurance Regulations. Misuse includes, but is not limited to, actions such as falsifying enrollment or claims information, allowing others to use the Plan identification card, intentionally enrolling, or failing to deenroll, individuals who are not/no longer eligible Family Members, threats or abusive behavior toward Plan providers or representatives. You may also be deenrolled for up to 12 months if you fail to provide upon request documentation specified by the University or the Plan verifying that the individual(s) you have enrolled are eligible Family Members. Individuals whose eligibility has not been verified will be deenrolled until verification is provided. Individuals who are not eligible Family Members will be permanently deenrolled.

Leave of Absence, Layoff, Change in Employment Status or Retirement
Contact the person who handles benefits for your location for information about continuing your coverage in the event of an authorized leave of absence, layoff, change of employment status, or retirement.

Optional Continuation of Coverage
As an enrollee in this Plan you and/or your covered Family Members may be entitled to continue health care coverage if there is a loss of coverage under the plan as a result of a qualifying event under the terms of the federal COBRA continuation requirements under the Public Health Service Act, as amended, and, if that continued coverage ends, you may be eligible for further continuation under California law. You or your Family Members will have to pay for such coverage. You may direct questions about these provisions the person who handles benefits for your location (or the UC Customer Service Center if you are a Retiree or Survivor) or visit the website http://atyourservice.ucop.edu/employees/health_welfare/cobra.html

Contract Termination

Coverage under the Plan is terminated when the group contract between the University and the Plan Vendor is terminated. Benefits will cease to be provided as specified in the contract and you may have to pay for the cost of those benefits incurred after the contract terminates. You may be entitled to continued benefits under terms which are specified elsewhere in this document. (If you apply for an individual HIPAA or conversion plan, the benefits may not be the same as you had under this Plan.)

PLAN SPONSORSHIP AND PLAN AND CLAIMS ADMINISTRATION

Plan Sponsor and Administor
The University of California is the Plan Sponsor and the President of the University (or his/her delegates) is the Plan Administrator for the Plan eligibility and enrollment provisions described in this insert to the Plan Evidence of Coverage booklet. If you have a question about eligibility or enrollment, you may direct it to:

University of California
Human Resources
300 Lakeside Drive
Oakland, CA 94612
(800) 888-8267

Any appeals regarding coverage denials that relate to eligibility or enrollment requirements are subject to the University of California Group Insurance Regulations. To obtain a copy of the

Eligibility Claims Appeal Process, please contact the person who handles benefits for your location (or the UC Customer Service Center if you are a Retiree or Survivor).

Claims Administrator

Claims and appeals for benefits under the Plan are processed by Health Net has full and final discretion and authority to determine whether and to what extent enrollees are entitled to benefits under the Plan. If you have a question about benefits under the Plan or about a specific claim, please refer to the appeal section found later in this document and/or contact Health Net at the following address and phone number:

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

This Plan is administered in accordance with the University of California Group Insurance Regulations, applicable contracts/service agreements, evidence of coverage booklets, and applicable 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 Plan Administrator or Claims Administrator, as applicable. 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 insurance contracts. 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.

Group Contract Number

The Group Contract Number for this Plan is: 5047BQ, MW, 5047RA, B, K, L, Q, U, Y, 5047SC, G, H, M, R, V, Z, 5047TA, F, G, L, Q, R, V, W, 5047UA, F, K, L, R, S, W, 5047VA, F, G, 5047ZX, 5522AM, N, S, 5522SM, Q, R, S, T, U.

Type of Plan

This Plan provides group medical care benefits. This Plan is one of the benefits offered under the University of California Health and Welfare Programs for eligible Faculty and Staff.

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 indefinitely but reserves the right to terminate or amend the benefits provided under this or any University-sponsored plan at any time. Plan benefits are not accrued or vested benefit entitlements. Any such amendment or termination shall be carried out by the President or his or her delegates. 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 Standardized Contract.
The cost of the premiums is 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 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 Standardized Contract, at a time and location mutually convenient to the participant and the Plan Administrator.

- Obtain copies of all Plan documents and other information for a reasonable charge upon written request to the Plan Administrator.

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 Systemwide AA/EEO Policy Coordinator, University of California Office of the President, 1111 Franklin Street, 5th Floor, Oakland, CA 94607 and for faculty to the Office of Academic Personnel, University of California Office of the President, 1111 Franklin Street, Oakland, CA 94607.

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

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

Effect of Medicare
If you are covered under a UC retiree group medical plan and eligible for Medicare, you must enroll in Medicare according to UC's Medicare Rules. If you are a retiree becoming Medicare-eligible, you should contact the University's Customer Service Center to transfer to the Medicare version of your plan. Once you and/or a family member are transferred to the Medicare version of your plan, your prescription drug coverage will change to a Part D + UC Rx wrap plan. You will also be ineligible for mental health and chemical dependency benefits through OptumHealth. Once you are enrolled in Medicare and transferred to the Medicare version of your plan, you should review your new Evidence of Coverage booklet for information on how to access behavioral health services and properly use your UC retiree Medicare plan benefits.

Transferring to Another Contracting Medical Group
As stated in Section "Using the plan's coverage for your medical services," each person must select a contracting Medical Group from our network. Each person must select a Contracting Medical Group close enough to his or her residence or place of work to allow reasonable access to care. Please call the Customer Contact Center at the telephone number on your Health Net ID Card if you have questions involving reasonable access to care.

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

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

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

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

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

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

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

For a newly eligible child who has been automatically assigned to a Contracting Medical Group, the transfer will not take effect until the first day of the calendar month following the date the child first becomes eligible.

Evidence of Coverage:

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

This booklet gives you the details about your Medicare health care and prescription drug coverage for your 2013 benefit period. It explains how to get coverage for the health care services and prescription drugs you need. **This is an important legal document. Please keep it in a safe place.**

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

Health Net of California, Inc. is a Medicare Advantage organization with a Medicare contract.

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

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

Benefits, formulary, pharmacy network, premium, deductible, and/or copayments/coinsurance may change for the 2014 plan year.

Table of Contents

GETTING STARTED AS A MEMBER

Introduction

You are enrolled in Health Net Seniority Plus (Employer HMO), which is a Medicare HMO

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

There are different types of Medicare health plans. Health Net Seniority Plus (Employer HMO) is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization). Like all Medicare health plans, this Medicare HMO is approved by Medicare and run by a private company.

What is the *Evidence of Coverage* booklet about?

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

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

The words "coverage" and "covered services" refer to the medical care and services and the prescription drugs available to you as a member of Health Net Seniority Plus (Employer HMO).

What does this section tell you?

Look through this section of your *Evidence of Coverage* to learn:

- What makes you eligible to be a plan member?
- What is your plan's service area?
- What materials will you get from us?
- What is your plan premium and how can you pay it?

- How do you keep the information in your membership record up to date?

What if you are new to our plan?

If you are a new member, then it's important for you to learn what the plan's rules are and what services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

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

Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with your employer or retiree group about how we cover your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in Health Net Seniority Plus (Employer HMO).

Medicare must approve our plan each year

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

What makes you eligible to be a plan member?

Your eligibility requirements

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

- You live in our geographic service area (see the "Here is the plan service area for our plan" portion below for description of our service area)
- -- *and* -- you have both Medicare Part A
- -- *and* -- Medicare Part B
- -- *and* -- you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

- -- *and* – you meet any additional eligibility requirements of your employer's or union's benefit administrator.

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

For additional information, see: "University of California - Eligibility, Enrollment, Termination and Plan Administration Provisions" section

What are Medicare Part A and Medicare Part B?

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

- Medicare Part A generally helps cover services furnished by institutional providers such as hospitals (for inpatient services), skilled nursing facilities or home health agencies.

- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment and supplies).

Here is the plan service area for our plan

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

Our service area includes these counties in California:

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

If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this booklet). When you move, you will have a Special Enrollment Period that will allow you to switch to Original Medicare or enroll in a Medicare health or drug plan that is available in your new location.

What other materials will you get from us?

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

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

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

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

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

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

What are "network providers"?

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

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

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. In addition, you may be limited to providers within your Primary Care Provider's

(PCP's) and/or Medical Group's network. This means that the PCP and/or Medical Group that you choose may determine the specialists and hospitals you can use. See the "Using the plan's coverage for your medical services" section of this booklet for more information about choosing a PCP. The only exceptions are emergencies, urgently needed care when the network is not available (generally, when you are out of the area), out-of-area dialysis services, and cases in which our plan authorizes use of out-of-network providers. See the "Using the plan's coverage for your medical services" section of this booklet for more specific information about emergency, out-of-network, and out-of-area coverage.

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

The *Pharmacy Directory*: Your guide to pharmacies in our network

What are "network pharmacies"?

Our *Pharmacy Directory* gives you a complete list of our network pharmacies – that means all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the *Pharmacy Directory* to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to cover (help you pay for) them.

If you don't have the *Pharmacy Directory*, you can get a copy from Member Services (phone numbers are printed on the back cover of this booklet). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at www.healthnet.com/uc.

The plan's List of Covered Drugs (Formulary)

The plan has a *List of Covered Drugs (Formulary)*. We call it the "Drug List" for short. It tells which prescription drugs are covered by our plan. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the Health Net Seniority Plus (Employer HMO) Drug List.

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

We will send you a copy of the Drug List each year. To get the most complete and current information about which drugs are covered, you can visit the plan's website

(www.healthnet.com/uc) or call Member Services (phone numbers are printed on the back cover of this booklet).

The *Explanation of Benefits* (the "EOB"): Reports with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Explanation of Benefits* (or the "EOB").

The *Explanation of Benefits* tells you the total amount you have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. See the "What you pay for your prescription drugs" section of this booklet which gives more information about the Explanation of Benefits and how it can help you keep track of your Part D drug coverage.

An *Explanation of Benefits* summary is also available upon request. To get a copy, please contact Member Services (phone numbers are printed on the back cover of this booklet).

Your monthly premium for your plan

How much is your plan premium?

Your coverage is provided through contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator for information about your plan premium. In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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

The "Extra Help" program helps people with limited resources pay for their drugs. See the "Important phone numbers and resources" section of this booklet which tells more about this program. If you qualify, enrolling in the program might lower your monthly plan premium.

If you are already enrolled and getting help from one of these programs, **the payment information about premiums in this *Evidence of Coverage* may not apply to you**. We send you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Part D Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't receive this document, please call Member Services and ask for the LIS Rider. Phone numbers for Member Services are printed on the back cover of this booklet.

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

In some situations, your plan premium could be more than the amount communicated to you by your employer or retiree group. This situation is described below.

- Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn't have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.). For these members, the late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their late enrollment penalty.

    - If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. See the "What you pay for your prescription drugs" section of this booklet which explains the late enrollment penalty.

    - If you have a late enrollment penalty, it is part of your plan premium. If you do not pay the part of your premium that is the late enrollment penalty, you could be disenrolled for failure to pay your plan premium. Please contact your employer/union benefits administrator for information about your plan premium.

Many members are required to pay other Medicare premiums

Many members are required to pay other Medicare premiums. As explained in the "What makes you eligible to be a plan member?" portion above, in order to be eligible for our plan, you must maintain your eligibility for Medicare Parts A and B. For that reason, some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. And most plan members pay a premium for Medicare Part B. You must continue paying your Medicare premiums to remain a member of the plan.

Some people pay an extra amount for Part D because of their yearly income. If your income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, you must pay an extra amount directly to the government (not the Medicare plan) for your Medicare Part D coverage.

- **If you are required to pay the extra amount and you do not pay it, you <u>will</u> be disenrolled from the plan and lose prescription drug coverage.**

- If you have to pay an extra amount, Social Security, **not your Medicare plan,** will send you a letter telling you what that extra amount will be.

- For more information about Part D premiums based on income, go to the "Do you have to pay an extra Part D amount because of your income?" portion of the "What you pay for your prescription drugs" section in this booklet. You can also visit http://www.medicare.gov on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of *Medicare & You 2013* tells about the Medicare premiums in the section called "2013 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2013* from the Medicare website (http://www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Can your monthly plan premium change during the year?

In some cases, the part of the premium that you have to pay can change during the year. This happens if you become eligible for the Extra Help program or if you lose your eligibility for the Extra Help program during the year. If a member qualifies for Extra Help with their prescription drug costs, the Extra Help program will pay part of the member's monthly plan premium. So a member who becomes eligible for Extra Help during the year would begin to pay less toward their monthly premium. And a member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about the Extra Help program in the "Information about programs to help people pay for their Part D prescription drugs," under "Important phone numbers and resources" section of this booklet.

In addition, in some cases, you may need to start paying or may be able to stop paying a late enrollment penalty. (The late enrollment penalty may apply if you had a continuous period of 63 days or more when you didn't have "creditable" prescription drug coverage.) This could happen if you become eligible for the Extra Help program or if you lose your eligibility for the Extra Help program during the year:

- If you currently pay the late enrollment penalty and become eligible for Extra Help during the year, you would be able to stop paying your penalty.

- If the Extra Help program is currently paying your late enrollment penalty and you lose your eligibility during the year, you would need to start paying your penalty.

You can find out more about the Extra Help program in the "Important phone numbers and resources," section under the "Information about programs to help people pay for their Part D prescription drugs" portion of this booklet.

Please keep your plan membership record up to date

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

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

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

Call Customer Service to let us know about these changes or contact the University of California Benefits Customer Service at 1-800-888-8267 to make name, address or phone number changes:

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

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

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

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

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

Here are other ways you can tell us about any other medical or drug insurance coverage that you have:

- You can call Member Services to tell us about this other coverage (phone numbers are printed on the back cover of this booklet).
- You can indicate this coverage on your enrollment form when you enroll in our plan. Health Net will then send a letter to you to get more detailed information about this other coverage.

We protect the privacy of your personal health information

We make sure that your health information is protected

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

For more information about how we protect your personal health information, please go to the portion "We must protect the privacy of your personal health information" in the "Your rights and responsibilities" section of this booklet.

How other insurance works with our plan

Which plan pays first when you have other insurance?

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

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

- If you have retiree coverage, Medicare pays first.

- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the size of the employer, and whether you have Medicare based on age, disability, or End-stage Renal Disease (ESRD):

    - If you're under 65 and disabled and you or your family member is still working, your plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.

    - If you're over 65 and you or your spouse is still working, the plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.

    - If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

- No-fault insurance (including automobile insurance)

- Liability (including automobile insurance)

- Black lung benefits
- Workers' compensation

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

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

IMPORTANT PHONE NUMBERS AND RESOURCES

Our plan contacts

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

How to contact our plan's Member Services

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

Member Services	
CALL	**1-800-539-4072** Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. Calls to this number are free. During the Medicare annual enrollment period (between October 15 and December 7) through February 14, our plan operates a toll-free call center for both current and prospective members that is staffed seven days a week from 8:00 a.m. to 8:00 p.m. Pacific time. During this time period, current and prospective members are able to speak with a Member Service representative. If you call outside these hours, you will receive a voice mail. When leaving a message, you should include your name, phone number and the time you called, and a representative will return your call no later than one business day after you leave a message. However, after February 14, 2013, your call will be handled by our automated phone system, Saturdays, Sundays, and holidays. When leaving a message, please include your name, phone number and the time that you called, and a representative will return your call no later than one business day after you leave a message Member Services also has free language interpreter services available for non-English speakers.

TTY/TDD	**1-800-929-9955** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. Calls to this number are free
FAX	**1-866-214-1992**
WRITE	Health Net Medicare Programs PO Box 10198 Van Nuys, California, 91410-0198
WEBSITE	www.healthnet.com/uc

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

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

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

Coverage Decisions for Medical Care	
CALL	**1-800-539-4072** Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. Calls to this number are free.
TTY/TDD	**1-800-929-9955** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	Elective Requests: **1-800-793-4473** Urgent Requests: **1-800-672-2135**
WRITE	Health Net Medical Management 21281 Burbank Blvd. Woodland Hills, CA 91367
WEBSITE	www.healthnet.com/uc

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

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

Appeals for Medical Care	
CALL	**1-800-539-4072** Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. Calls to this number are free.
TTY/TDD	**1-800-929-9955** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	Standard Appeals: **1-818-676-8179** Expedited Appeals: **1-866-587-0544**
WRITE	Health Net Seniority Plus (Employer HMO) Appeals and Grievance Department Post Office Box 10344 Van Nuys, California 91410-0344
WEBSITE	www.healthnet.com/uc

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

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

Complaints about Medical Care	
CALL	**1-800-539-4072** Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. Calls to this number are free.
TTY/TDD	**1-800-929-9955** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	**1-818-676-8179**
WRITE	Health Net Seniority Plus (Employer HMO) Appeals and Grievance Department Post Office Box 10344 Van Nuys, California 91410-0344
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

How to contact us when you are asking for a coverage decision about your prescription drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs. For more information on asking for coverage decisions about your prescription drugs, see the "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**" section of this booklet.

Coverage Decisions for Prescription Drugs	
CALL	**1-800-539-4072** Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. Calls to this number are free.

TTY/TDD	**1-800-929-9955** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	**1-818-676-8086**
WRITE	Health Net of California Attn: Pharmacy P.O. Box 9103 Van Nuys, CA 91409-9103
WEBSITE	www.healthnet.com/uc

How to contact us when you are making an appeal about your prescription drugs

An appeal is a formal way of asking us to review and change a coverage decision we have made. For more information on making an appeal about your Part D prescription drugs, see the "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**" section of this booklet.

Appeals for Prescription Drugs	
CALL	**1-800-539-4072** Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
TTY/TDD	**1-800-929-9955** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.

FAX	**1-800-977-1959**
WRITE	Health Net Seniority Plus (Employer HMO) Appeals and Grievance Department P.O. Box 10450 Van Nuys, CA 91410-0450
WEBSITE	www.healthnet.com/uc

How to contact us when you are making a complaint about your prescription drugs

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

Complaints about prescription drugs	
CALL	**1-800-539-4072** Calls to this number are free 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
TTY/TDD	**1-800-929-9955** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	**1-800-977-1959**

WRITE	Health Net Seniority Plus (Employer HMO) Appeals and Grievance Department P.O. Box 10450 Van Nuys, CA 91410-0450
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare go to www.medicare.gov/MedicareComplaintForm/home.aspx.

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

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see the "Asking us to pay our share of a bill you have received for covered medical services or drugs" section of this booklet.

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

Payment Requests	
CALL	**1-800-539-4072** Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
TTY/TDD	**1-800-929-9955** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	Medical Claims: Elective Requests: **1-800-793-4473** Urgent Requests: **1-800-672-2135** Pharmacy Claims: **1-818-676-8086**

WRITE	Medical Claims: Health Net of California P.O. Box 14703 Lexington, KY 40512 Pharmacy Claims: Health Net of California Attn: Pharmacy P.O. Box 9103 Van Nuys, CA 91409-9103
WEBSITE	www.healthnet.com/uc

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

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

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

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

WEBSITE http://www.medicare.gov

This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.

The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:

- **Medicare Eligibility Tool:** Provides Medicare eligibility status information.
- **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

You can also use the website to tell Medicare about any complaints you have about our plan:

- **Tell Medicare about your complaint:** You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

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

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

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

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

HICAP (California SHIP)	
CALL	**1-800-434-0222**
TTY	**1-800-735-2929** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	HICAP 1300 National Drive, Suite 200 Sacramento, CA 95834-1992
WEBSITE	www.cahealthadvocates.org/hicap

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

There is a Quality Improvement Organization for each state. For California, the Quality Improvement Organization is called Health Services Advisory Group.

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

You should contact Health Services Advisory Group in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.

- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

Health Services Advisory Group (California's Quality Improvement Organization)	
CALL	**1-866-800-8749**
TTY	**711 (National Relay Service)**
WRITE	Health Services Advisory Group 700 N. Brand Blvd., Suite 370 Glendale, CA 91203
WEBSITE	www.hsag.com

Social Security

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

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for a reconsideration.

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

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

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

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

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments). (Some people with QMB are also eligible for full Medicaid benefits (QMB+).)

- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. (Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).)

- **Qualified Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact the Department of Health Care Services.

Department of Health Care Services (California's Medicaid program)	
CALL	**1-800-541-5555 or 1-916-636-1980**
TTY	**711 (National Relay Service)**
WRITE	Department of Health Care Services PO Box 997417, MS 4607 Sacramento, CA 95899-7417
WEBSITE	www.medi-cal.ca.gov

Information about programs to help people pay for their Part D prescription drugs

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay Part D 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 get help paying for any Medicare drug plan's monthly premium, yearly deductible, and Part D prescription copayments. This Extra Help also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for Extra Help. Some people automatically qualify for Extra Help and don't need to apply. Medicare mails a letter to people who automatically qualify for Extra Help.

You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for getting Extra Help, call:

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your State Medicaid Office. See the "Medicaid" portion of this section for contact information.

If you believe you have qualified for Extra Help and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows 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.

- Call Member Services at the number printed on the back cover of this booklet and tell the representative that you think you qualify for extra help (Best Available Evidence). You may be required to provide one of the following types of documentation:
    - 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.
    - Supplemental Security Income (SSI) Notice of Award with an effective date of your actual Medicaid status.
- If you are institutionalized and believe you qualify for zero cost-sharing, call Member Services at the number printed on the back cover of this booklet and tell the representative that you believe you qualify for extra help. You may be required to provide one of the following types of documentation:
    - 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.
- If you are unable to provide the documentation described above and you believe that you may qualify for extra help, call Member Services at the number printed on the back cover of this booklet and a representative will assist you.
- When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. 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. 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 Services if you have questions (phone numbers are printed on the back cover of this booklet).

Medicare Coverage Gap Discount Program

The Medicare Coverage Gap Discount Program is available nationwide. Because our plan offers additional gap coverage during the Coverage Gap Stage, your out-of-pocket costs will sometimes be lower than the costs described here. Please go to the "There is no Coverage Gap for our plan" portion of the "What you pay for your prescription drugs" section of this booklet for more information about your coverage during the Coverage Gap Stage.

The Medicare Coverage Gap Discount Program provides manufacturer discounts on Part D brand name drugs to Part D enrollees who have reached the coverage gap threshold and are not already receiving "Extra Help." A discount on the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) is available for those Part D brand name drugs from manufacturers that have agreed to pay the discount. The plan pays an additional 2.5% and you pay the remaining 47.5% for your Part D brand drugs.

If you reach the coverage gap threshold, we will automatically apply the discount when your pharmacy bills you for your Part D brand name drug prescription. Your Explanation of Benefits (EOB) will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer counts toward your out-of-pocket costs as if you had paid this amount and moves you through the coverage gap.

How to contact the Railroad Retirement Board

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

Railroad Retirement Board	
CALL	**1-877-772-5772** Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.

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

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

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group, call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. (Phone numbers for Member Services are printed on the back cover of this booklet.)

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact **that group's benefits administrator.** The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

USING THE PLAN'S COVERAGE FOR YOUR MEDICAL SERVICES

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

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

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

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

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

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.

- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network generally bill us directly for care they give you. When you see a network provider, you usually pay only your share of the cost for their services.

- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in the "Medical Benefits Chart (what is covered and what you pay)" section of this booklet.

Basic rules for getting your medical care covered by the plan

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

We will generally cover your medical care as long as:

- **The care you receive is included in the plan's Medical Benefits Chart** (this chart is in the "Medical Benefits Chart (what is covered and what you pay)" section of this booklet).
- **The care you receive is considered medically necessary**. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a network PCP (for

more information about this, see the "You must choose a Primary Care Provider (PCP) to provide and oversee your medical care" portion of this section).

- In most situations, our plan or your Medical Group must give you approval in advance before you can use other providers in the plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral." For more information about this, see the "How to get care from specialists and other network providers," portion of this section.
- Referrals from your PCP are not required for emergency care or urgently needed care. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see the "What kinds of medical care can you get without getting approval in advance from your PCP?" portion of this section).

- **You must receive your care from a network provider** (for more information about this, see the "Use providers in the plan's network to get your medical care" portion in this section). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Here are three exceptions:*
  - The plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see the "How to get covered services when you have an emergency or an urgent need for care" portion of this section.
  - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. The plan or your Medical Group must give you approval in advance before you can use an out-of-network provider. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see the "How to get care from out-of-network providers" portion of this section.
  - Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. ***If possible, please 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***

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

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

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

When you become a member of our plan, you must 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. 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, and gynecologists who provide care for women. A nurse practitioner (NP),

a State licensed registered nurse with special training, providing a basic level of health care, can act as your PCP.

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

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

"Coordinating" your covered services includes checking or consulting with other plan providers about your care and how it is going. 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). For certain services, your PCP will need to get prior authorization (approval in advance). If the service you need requires prior authorization, your PCP will request the authorization from our plan or your Medical Group. 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.

As we explained above, you will usually see your PCP first for most of your routine health care needs. When your PCP thinks that you need specialized treatment, he or she will need to give you a referral (approval in advance) to see a plan specialist or certain other providers. There are only a few types of covered services you may get without getting approval from your PCP first, as we explain below. Please refer to the "How to get care from specialists and other network providers" and "What kinds of medical care can you get without getting approval in advance from your PCP?" portions in this section for more information.

How do you choose your PCP?

When you enroll in our plan, you will choose a contracting Medical Group from our network. You will also choose a PCP from this contracting Medical Group. The PCP you choose must be with a Medical Group within 30 miles or 30 minutes from where you live or work. Medical Groups (and their affiliated PCPs and hospitals) can be found in the Provider Directory or you may visit our website at www.healthnet.com/uc. To confirm the availability of a provider, or to ask about a specific PCP, please contact Member Services at the phone number printed on the back cover of this booklet.

Each Medical Group and PCP makes referrals to certain plan specialists and uses certain hospitals within their network. If there is a particular plan specialist or hospital that you want to use, check first to be sure that the specialists and hospitals are in the Medical Groups and PCP's

network. The name and office telephone number of your PCP is printed on your membership card.
If you do not choose a Medical Group or PCP or if you chose a Medical Group or PCP that is not available with this plan, we will automatically assign you to a Medical Group and PCP near your home.

For information on how to change your PCP, please see "Changing your PCP" below.

Changing your PCP

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

Your request will be effective on the first day of the month following the date our plan receives your request. To change your PCP, call Member Services or you may visit our website at www.healthnet.com/uc to make your request.

When you contact us, be sure to let us know 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 let you know how you can continue with the specialty care and other services you have been getting when you change your PCP. They will also 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 tell you when the change to your new PCP will take effect.

They will also send you a new membership card that shows the name and phone number of your new PCP.

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

You can get services such as those listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (x-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider.
- Flu shots and pneumonia vaccinations as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed care from in-network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, e.g., when you are temporarily outside of the plan's service area.

- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan's service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away. Phone numbers for Member Services are printed on the back cover of this booklet.) ***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***

How to get care from specialists and other network providers

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

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

In order for you to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist). It is very important to get a referral (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 , as explained in the "What kinds of medical care can you get without getting approval in advance from your PCP?" portion 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.

Each Medical Group and PCP makes referrals to certain plan specialists and uses certain hospitals within their network. This means that the Medical Group and PCP you choose may determine the specialists and hospitals you may use. If there are specific specialists or hospitals you want to use, find out if your Medical Group or PCP uses these specialists or hospitals. You may generally change your PCP at any time if you want to see a plan specialist or go to a hospital that your current PCP can't refer you to. Earlier in this section, under "Changing your PCP," we tell you how to change your PCP.

Some types of services will require getting approval in advance from our plan or your Medical Group (this is called getting "prior authorization"). Prior authorization is an approval process that happens before you get certain services. If the service you need requires prior authorization, your PCP or other network provider will request the authorization from our plan or your Medical Group. The request will be reviewed and a decision (organization determination) will be sent to you and your provider. Please refer to the "Medical Benefits Chart (what is covered and what you pay for)" section in this booklet for specific benefits that require prior authorization.

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

Sometimes a specialist, clinic, hospital or other network provider you are using might leave the plan. If this happens, and it is a provider you see on a regular basis, we will make a good faith effort to send you notification at least 30 calendar days prior to the provider's termination effective date. If you continue seeing the provider after the termination effective date, you may have to pay for these services yourself. If you decide to switch to another network provider, Member Services can assist you in finding and selecting a provider. Phone numbers are printed on the back cover of this booklet.

How to get care from out-of-network providers

If there is a certain type of service that you need, and that service is not available in our plan's network, you will need to get prior authorization (approval in advance) first. Your PCP will request prior authorization from our plan or your Medical Group.

It is very important to get approval in advance before you see an out-of-network provider or receive services outside of our network (with the exception of emergency and urgently needed care, as explained in the "How to get covered services when you have an emergency or urgent need for care" portion below). If you don't get approval in advance, you may have to pay for these services yourself.

For information on coverage of out-of-network emergency and urgently needed care, please see the "How to get covered services when you have an emergency or urgent need for care" portion below.

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

Getting care if you have a medical emergency

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

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

If you have a medical emergency:

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

What is covered if you have a medical emergency?

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

You may get covered emergency medical care outside the United States. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. You are not covered for prescriptions purchased outside the United States. For more information, see the "Medical Benefits Chart (what is covered and what you pay)" section in this Evidence of Coverage, or call Member Services at the phone number printed on the back cover of this booklet.

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

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

What if it wasn't a medical emergency?

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

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

- You go to a network provider to get the additional care.
- – ***or*** – the additional care you get is considered "urgently needed care" and you follow the rules for getting this urgent care (for more information about this, see the "Getting care when you have an urgent need for care" portion of this section below).

Getting care when you have an urgent need for care

What is "urgently needed care"?

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

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

In most situations, if you are in the plan's service area, we will cover urgently needed care only if you get this care from a network provider and follow the other rules described earlier in this section. However, if the circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, we will cover urgently needed care that you get from an out-of-network provider.

What to do when you need medical care immediately

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

If your situation is not so severe: Call your PCP or Medical Group or, if you cannot call them or you need medical care right away, go to the nearest medical center, urgent care center, or hospital.

If you are unsure of whether an emergency medical condition exists, you may call your Medical Group or PCP for help.

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

If you are not sure whether you have an emergency or require urgent care, please contact a clinician by calling Decision Power® toll free at 1-800-893-5597 (TTY/TDD: 1-800-276-3821) 24 hours a day, 7 days a week. This number is also on your membership card. As a Health Net Member, you have access to triage or screening services, 24 hours a day, 7 days a week.

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

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

Urgently needed care received outside of the United States may be considered an emergency under the Worldwide coverage benefit. For more information, see the "Medical Benefits Chart (what is covered and what you pay)" section in this Evidence of Coverage, or call Member Services at the phone number printed on the back cover of this booklet.

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

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

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, see the "**Asking us to pay our share of a bill you have received for covered medical services or drugs**" section in this booklet for information about what to do.

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

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

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

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

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

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

What is a "clinical research study"?

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

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

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

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

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

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

1. We can let you know whether the clinical research study is Medicare-approved.

2. We can tell you what services you will get from clinical research study providers instead of from our plan.

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

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

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

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.

- An operation or other medical procedure if it is part of the research study.

- Treatment of side effects and complications of the new care.

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

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

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see the "Asking us to pay our share of a bill you have received for covered medical services or drugs" section of this ***Evidence of Coverage*** for more information about submitting requests for payment.

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

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

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (http://www.medicare.gov). You can also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

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

What is a religious non-medical health care institution?

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

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

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to ***non-religious*** aspects of care.

- If you get services from this institution that are provided to you in your home, our plan will cover these services only if your condition would ordinarily meet the conditions for coverage of services given by home health agencies that are not religious non-medical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
    - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
    - – ***and*** – you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Once authorized, you are covered for unlimited inpatient days in a Medicare-certified religious non-medical health care institution. Prior authorization (approval in advance) is required to be covered, except in an emergency.

Rules for ownership of durable medical equipment

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

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

In Original Medicare, people who rent certain types of durable medical equipment own the equipment after paying co-payments for the item for 13 months.

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

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

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

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

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

Understanding your out-of-pocket costs for covered services

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

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

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

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

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

What is the most you will pay for Medicare Part A and Part B covered medical services?

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

As a member of our plan, the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2013 is $1500. The amounts you pay for the applicable deductibles, copayments, and coinsurance for in-network covered services count toward this maximum out-of-

pocket amount. (The amounts you pay for any plan premiums (if applicable to your plan) do not count toward your maximum out-of-pocket amount.) In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with a diamond (◈) in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of $1500, you will not have to pay any out-of-pocket costs for the rest of the year for covered Part A and Part B services. However, you must continue to pay your plan premium (if applicable) and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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

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

Here is how this protection works.

- If your cost sharing is a copayment (a set amount of dollars, for example, $20.00), then you pay only that amount for any covered services from a network provider.
- If your cost sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends on which type of provider you see:
    - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by the plan's reimbursement rate (as determined in the contract between the provider and the plan).
    - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
    - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Remember, the plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)

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

Your medical benefits and costs as a member of the plan

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

- With the exception of Employer-Sponsored benefits (benefits beyond the basic Medicare-covered benefits), your Medicare-covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. See the "Using the plan's coverage for your medical services" section in this booklet, as it provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a "referral." See the "Using the plan's coverage for your medical services" section in this booklet, as it provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that may need approval in advance are marked in the Medical Benefits Chart with an asterisk (*).
- For all Medicare-covered preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition
- Sometimes, Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during the plan year, either Medicare or our plan will cover those services.

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

Medical Benefits Chart

Services that are covered for you	**What you must pay** when you get these services
INPATIENT CARE	
Inpatient hospital care*	
**Prior authorization (approval in advance) may be required to be covered, except in an emergency.* You are covered for unlimited days. Covered services include, but are not limited to: • Semiprivate room (or a private room if medically necessary) • Meals including special diets • Regular nursing services • Costs of special care units (such as intensive care or coronary care units) • Drugs and medications • Lab tests • X-rays and other radiology services • Necessary surgical and medical supplies • Use of appliances, such as wheelchairs • Operating and recovery room costs • Physical, occupational, and speech language therapy • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Original Medicare rate, then you can choose to obtain your transplant services locally or at a distant location offered by the plan. If our plan provides transplant services at a distant location (outside the service area) and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. Contact Member Services for details regarding the plan's policy for transplant travel coverage	You pay $250 per admission for the Medicare-covered services listed. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.

Services that are covered for you	**What you must pay** when you get these services
• Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used • Physician services **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient to the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.	

Services that are covered for you	**What you must pay** when you get these services
Inpatient hospital transgender surgery/services* (including hysterectomy, oophorectomy and mastectomy) **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* • 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.	You pay $250 for transgender services. 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.
Inpatient mental health care* **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* Includes mental health care services that require a hospital stay. You are covered for unlimited days. For more information about inpatient mental health care benefits, please see the "Additional Benefit Information" portion of this section.	You pay $250 per admission for Medicare-covered services in a network hospital.
Inpatient substance abuse care* **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* Residential care in a hospital or substance abuse facility. You are covered for unlimited days. For more information about inpatient substance abuse benefits, please see the "Additional Benefit Information" portion of this section.	You pay $250 per admission for Medicare-covered services in a network hospital.

Services that are covered for you	**What you must pay** when you get these services
Inpatient services covered during a non-covered inpatient stay*	
**Prior authorization (approval in advance) may be required to be covered, except in an emergency.* As described in this Medical Benefits Chart under "Skilled nursing facility (SNF) care," the plan covers up to 100 days per benefit period for SNF care. If you have exhausted your inpatient benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient stay. However, in some cases, we will cover certain services you receive while you are in the skilled nursing facility (SNF). Covered services include, but are not limited to: • Physician services • Diagnostic tests (like lab tests) • X-ray, radium, and isotope therapy including technician materials and services • Surgical dressings • Splints, casts and other devices used to reduce fractures and dislocations • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including 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	The listed services will continue to be covered at the cost-sharing amounts shown in the Medical Benefits Chart for the specific service. For Medicare-covered medical supplies including cast and splints, you pay the applicable cost-sharing amount where the specific service is provided. For example, if these medical supplies were used during a visit to an emergency room, then they would be included as part of the emergency room visit copayment.

Services that are covered for you	**What you must pay** when you get these services
Acute care detoxification* **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* You are covered for unlimited days. For more information, please see the "Additional Benefit Information" portion of this section.	You pay $250 per admission for Medicare-covered acute care detoxification services.

Services that are covered for you	**What you must pay** when you get these services

Skilled nursing facility (SNF) care*

**Prior authorization (approval in advance) may be required to be covered, except in an emergency.*

(For a definition of "skilled nursing facility care," see "Definitions of important words" in this booklet. Skilled nursing facilities are sometimes called "SNFs.")

You are covered for 100 days each benefit period. No prior hospital stay is required.

Covered services include, but are not limited to, the following:

- Semiprivate room (or a private room if medically necessary)
- Meals, including special diets
- Skilled nursing services
- Physical therapy, occupational therapy, and speech therapy
- Drugs administered to you as part of your plan of care (This includes substances that are naturally present in the body, such as blood clotting factors.)
- Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used
- Medical and surgical supplies ordinarily provided by SNFs
- Laboratory tests ordinarily provided by SNFs
- X-rays and other radiology services ordinarily provided by SNFs
- Use of appliances such as wheelchairs ordinarily provided by SNFs
- Physician/Practitioner services

Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment.

There is no copayment for Medicare-covered services in a Skilled Nursing Facility.

You pay all costs for each day after day 100 in the benefit period.

A benefit period begins the first day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Services that are covered for you	**What you must pay** when you get these services
Skilled nursing facility (SNF) care* cont. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care) • A SNF where your spouse is living at the time you leave the hospital	
Home health agency care* **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include but are not limited to: • Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week) • Physical therapy, occupational therapy, and speech therapy • Medical and social services • Medical equipment and supplies	There is no copayment for Medicare-covered home health visits.

Services that are covered for you	**What you must pay** when you get these services

Hospice care

You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out-of-network provider.

Covered services include:

- Drugs for symptom control and pain relief
- Short-term respite care
- Home care.

For hospice services and for services that are covered by Medicare Part A or B and are related to your terminal condition: Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.

For services that are covered by Medicare Part A or B and are not related to your terminal condition: If you need non-emergency, non-urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal condition, your cost for these services depends on whether you use a provider in our plan's network:

- If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services
- If you obtain the covered services from an out-of-network provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare)

For services that are covered by our plan but are not covered by Medicare Part A or B: our plan will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal condition. You pay your plan cost sharing amount for these services.

When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not the plan.

You pay $20 for a consultative visit before you select hospice.

Services that are covered for you	**What you must pay** when you get these services
Note: If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your non-hospice care through our network providers will lower your share of the costs for the services. **The following service may require prior authorization (approval in advance) to be covered, except in an emergency:* **Hospice Consultation Services** Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	

Services that are covered for you	**What you must pay** when you get these services
Outpatient Services	
Physician/practitioner services, including doctor office visits*	
**Prior authorization (approval in advance) may be required to be covered, except in an emergency.*	You pay $20 for each Medicare-covered primary care doctor office visit or medically-necessary surgery services furnished in a physician's office.
Covered services include: • Office visits, including medical and surgical care in a physician's office • Medically-necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location	You pay $20 for each Medicare-covered specialist visit or medically-necessary surgery services furnished in a specialist's office.
• Basic hearing and balance exams, performed by your PCP or specialist, if your doctor orders it to see if you need medical treatment • Physician visit to Member's home (at discretion of the physician in accordance with the rules and criteria established by the plan)	You pay $20 for each physician visit to your home.
• Consultation, diagnosis, and treatment by a specialist • Second opinion by another network provider prior to surgery • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician)	For medically-necessary surgery services furnished in a certified ambulatory surgical center, hospital outpatient department, or any other location, you pay the applicable cost-sharing amount for where the specific service is provided.

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

Services that are covered for you	**What you must pay** when you get these services
Chiropractic services*	
**Prior authorization (approval in advance) may be required to be covered, except in an emergency.* Covered services include: • Manual manipulation of the spine to correct subluxation (Medicare-covered) • Routine chiropractic care (non Medicare-covered) ◈ ◈The amounts you pay for these services do not count toward your maximum out-of-pocket amount. Refer to "Additional Benefit Information" portion later in this section for more information.	You pay $20 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation). You pay $20 per visit when using our Chiropractic Network (up to 20 visits per plan year). ◈
Podiatry services*	
**Prior authorization (approval in advance) may be required to be covered, except in an emergency.* Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs) • Routine foot care for members with certain medical conditions affecting the lower limbs • Routine foot care (non Medicare-covered). Care is limited to one visit per calendar month. Additional visits or referrals must be arranged and approved by your PCP.	You pay $20 for each Medicare-covered visit (medically necessary foot care). You pay $20 for each routine (non Medicare-covered) visit.

Services that are covered for you	**What you must pay** when you get these services
Outpatient mental health care*	
**Prior authorization (approval in advance) may be required to be covered, except in an emergency.* Covered services include: Mental health services provided by a state-licensed psychiatrist, 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. Refer to "Additional Benefit Information" later in this section for more information on outpatient mental health services, including the outpatient registration process.	You pay $20 for each Medicare-covered individual therapy visit. You pay $10 for each Medicare-covered group therapy visit.
Partial hospitalization services*	
**Prior authorization (approval in advance) may be required to be covered, except in an emergency.* "Partial hospitalization" is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center, that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. For more information, please see the "Additional Benefit Information" portion of this section.	There is no copayment for Medicare-covered partial hospitalization.

Services that are covered for you	**What you must pay** when you get these services
Outpatient substance abuse services*	
**Prior authorization (approval in advance) may be required to be covered, except in an emergency.* Covered services include: Substance Use Disorder services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional or program as allowed under applicable state laws. Refer to "Additional Benefit Information" later in this section for more information on outpatient substance abuse services, including the outpatient registration process.	You pay $20 for each Medicare-covered individual therapy visit. You pay $10 for each Medicare-covered group therapy visit.
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.

Services that are covered for you	**What you must pay** when you get these services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers* **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an "outpatient."	You pay $100 for Medicare-covered outpatient surgery in a hospital or non-hospital based ambulatory surgical center.
Outpatient transgender surgery /services* (including hysterectomy, oophorectomy and mastectomy) **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* • 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.	You pay $100 for outpatient transgender surgery in a hospital or non-hospital based ambulatory surgical center. 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.

Services that are covered for you	**What you must pay** when you get these services
Ambulance services*	
• Covered ambulance services include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health) or if authorized by the plan. **Non-emergency transportation by ambulance may require prior authorization (approval in advance).* • 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.

Services that are covered for you	**What you must pay** when you get these services
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. • 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. • Worldwide Coverage- Defined as urgent, emergent, and post-stabilization care received outside of the United States.	You pay $65 for each Medicare-covered emergency room visit. You do not pay this amount if you are immediately admitted to the hospital. There is no copayment for Worldwide Coverage. If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost sharing you would pay at a network hospital.
Urgently needed care Urgently needed care is care provided to treat a non-emergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. 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. Urgently needed care received outside of the United States may be considered an emergency under the Worldwide Coverage benefit. Please refer to Emergency Care listed earlier in this chart.	You pay $20 for each Medicare-covered urgently needed care visit. You do not pay this amount if you are directly admitted to the hospital.

Services that are covered for you	**What you must pay** when you get these services
Outpatient rehabilitation services*	
**Prior authorization (approval in advance) may be required to be covered, except in an emergency.* Covered services include: physical therapy, occupational therapy, speech language therapy. Outpatient rehabilitation therapy services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	You pay $20 for each Medicare-covered outpatient rehabilitation service visit.
Cardiac rehabilitation services*	
**Prior authorization (approval in advance) may be required to be covered, except in an emergency.* Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	You pay $20 for each Medicare-covered cardiac rehabilitation service visit.
Pulmonary rehabilitation services*	
**Prior authorization (approval in advance) may be required to be covered, except in an emergency.* Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating their chronic respiratory disease.	You pay $20 for each Medicare-covered pulmonary rehabilitation service visit.

Services that are covered for you	**What you must pay** when you get these services
Durable medical equipment and related supplies*	
**Prior authorization (approval in advance) may be required to be covered, except in an emergency.* (For a definition of "durable medical equipment," see the "Definitions of important words"section of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. .	There is no copayment for Medicare-covered durable medical equipment and related supplies.
Prosthetic devices and related supplies*	
**Prior authorization (approval in advance) may be required to be covered, except in an emergency.* Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" later in this section for more detail.	There is no copayment for Medicare-covered prosthetic devices and related supplies.

Services that are covered for you	**What you must pay** when you get these services
Diabetes self-management training, diabetic services and supplies* **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* For all people who have diabetes (insulin and non-insulin users). Covered services include: • Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors • For people with diabetes who have severe diabetic foot disease: One pair per year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting • Diabetes self-management training is covered under certain conditions	There is no copayment for Medicare-covered diabetes supplies. There is no copayment for Medicare-covered therapeutic shoes for people with diabetes who have severe diabetic foot disease. There is no copayment for Medicare-covered diabetes self-management training.

Services that are covered for you	**What you must pay** when you get these services
Outpatient diagnostic tests and therapeutic services and supplies* **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* Covered services include, but are not limited to: • X-rays • Complex diagnostic radiology (PET Scan, CT Scan, MRI) • Radiation (radium and isotope) therapy including technician materials and supplies • Surgical supplies, such as dressings • Splints, casts and other devices used to reduce fractures and dislocations • 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	There is no copayment for the Medicare-covered services listed. For Medicare-covered medical supplies including cast and splints, you pay the applicable cost-sharing amount where the specific service is provided. For example, if these medical supplies were used during a visit to an emergency room, then they would be included as part of the emergency room visit copayment.
Preventive Services For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment or coinsurance will apply for the care received for the existing medical condition.	
Abdominal aortic aneurysm screening* **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" preventive visit.	There is no copayment for each Medicare-covered abdominal aortic aneurysm screening.

Services that are covered for you	**What you must pay** when you get these services
HIV screening* **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy	There is no copayment for Medicare-covered HIV screening.
Bone mass measurements* **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no copayment for Medicare-covered bone mass measurements.

Services that are covered for you	**What you must pay** when you get these services
Colorectal cancer screening * **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* 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, the following is covered: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy.	There is no copayment for Medicare-covered colorectal screening.
Breast cancer screening (mammograms) Covered services include: • One baseline exam mammogram between the ages of 35 and 39 • One screening mammogram every 12 months for women age 40 and older • Clinical breast exams once every 24 months	There is no copayment for Medicare-covered breast cancer screening (mammograms).

Services that are covered for you	**What you must pay** when you get these services
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months	There is no copayment for Medicare-covered cervical and vaginal cancer screening.
Prostate cancer screening exam * **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* For men age 50 and older, covered services include the following - once every 12 months: • Digital rectal exam • Prostate Specific Antigen (PSA) test	There is no copayment for Medicare-covered prostate cancer screening exams.

Services that are covered for you	**What you must pay** when you get these services
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine • Flu shots, once a year in the fall or winter **The following immunizations may require prior authorization (approval in advance):* • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B • Other vaccines if you are at risk and they meet Medicare Part B coverage rules Other immunizations: • Immunizations for foreign travel/occupational purposes. We also cover some vaccines under our Part D prescription drug benefit.	There is no copayment for the Medicare-covered pneumonia vaccine. There is no copayment for the Medicare-covered flu vaccine. There is no copayment for the Medicare-covered Hepatitis B vaccine. There is no copayment for other Medicare-covered vaccines if you are at risk and they meet Medicare Part B coverage rules. You pay 20% coinsurance for immunizations for foreign travel/occupational purposes.
Cardiovascular disease testing* **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* Blood tests for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no copayment for Medicare-covered cardiovascular disease testing.

Services that are covered for you	**What you must pay** when you get these services
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)* **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* We cover 1 visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well.	There is no copayment for Medicare-covered cardiovascular disease risk reduction visits.
Depression screening* **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* We cover 1 screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.	There is no copayment for Medicare-covered depression screening.
Obesity screening and therapy to promote sustained weight loss* **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no copayment for Medicare-covered obesity screening and therapy to promote sustained weight loss.

Services that are covered for you	**What you must pay** when you get these services
Screening and counseling to reduce alcohol misuse* **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no copayment for Medicare-covered screening and counseling to reduce alcohol misuse.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs* **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20 to 30 minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no copayment for Medicare-covered screening for STIs and counseling to prevent STIs.

Services that are covered for you	**What you must pay** when you get these services
Diabetes screening* **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no copayment for Medicare-covered diabetes screening. There is no copayment for fasting plasma glucose tests for persons at risk of diabetes.
Medical nutrition therapy* **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a transplant when referred by your doctor. We cover 3 hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew their referral yearly if your treatment is needed into the next plan year.	There is no copayment for each Medicare-covered medical nutrition therapy visit.

Services that are covered for you	**What you must pay** when you get these services
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use)*	
**Prior authorization (approval in advance) may be required to be covered, except in an emergency.* If you use tobacco, but do not have signs or symptoms of tobacco-related disease: We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco: We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable inpatient or outpatient cost sharing. Each counseling attempt includes up to four face-to-face visits. *The following service does not require prior authorization (approval in advance):* Our plan also covers additional on-line and telephonic smoking cessation counseling.◈ Refer to "Decision Power®: Health in Balance" under "Additional Benefit Information" later in this chart for more information on these benefits.	If you haven't been diagnosed with an illness caused or complicated by tobacco use: There is no copayment for each Medicare-covered smoking and tobacco use cessation counseling session. If you have been diagnosed with an illness caused or complicated by tobacco use, or you take a medicine that is affected by tobacco: You pay the applicable cost sharing for Medicare-covered smoking cessation counseling sessions where services are received. For example, if your counseling session is received as part of an outpatient mental health visit, you pay the applicable outpatient mental health cost sharing. There is no copayment for additional non-Medicare covered smoking cessation counseling sessions.

Services that are covered for you	**What you must pay** when you get these services
"Welcome to Medicare" preventive visit The plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This exam is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visit after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.

Services that are covered for you	**What you must pay** when you get these services
Other Services	
Services to treat kidney disease and conditions*	
**Prior authorization (approval in advance) may be required to be covered, except in an emergency.*	There is no copayment for Medicare-covered renal dialysis (kidney) services.
Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in the "Using the plan's coverage for your medical services" section of this booklet • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care) • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments) • Home dialysis equipment and supplies • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)	There is no copayment for Medicare-covered kidney disease education services.
Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B Drugs, please go to the "Prescription drugs" section below.	
Physical exam*	
**Prior authorization (approval in advance) may be required to be covered, except in an emergency.*	There is no copayment for each routine physical exam.
Routine annual physical exam, limited to one exam each year	

Services that are covered for you	**What you must pay** when you get these services
Prescription drugs	
Prescription drugs that are covered under Original Medicare (these Part B drugs are covered for everyone with Medicare). **Your Provider must get prior authorization from our plan for certain Prescription Drugs. Contact Member Services for details.* **Part B drugs*** "Drugs" includes substances that are naturally present in the body, such as blood clotting factors. • Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services • Drugs you take using durable medical equipment (such as nebulizers) that are authorized by Health Net • Clotting factors you give yourself by injection if you have hemophilia • Immunosuppressive drugs if you were enrolled in Medicare Part A at the time of the organ transplant • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug • Antigens • Certain oral anti-cancer drugs and anti-nausea drugs • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa) • Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home **Outpatient prescription drugs**◈ The "Using the plan's coverage for your prescription drugs" section of this booklet explains the prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your prescription drugs through our plan is listed in the "What you pay for your prescription drugs" section of this booklet.	You pay the applicable tier copayment or coinsurance for Medicare-covered Part B Drugs. There is no copayment for smoking cessation drugs.

Services that are covered for you	**What you must pay** when you get these services
Injection services*	
**Prior authorization (approval in advance) may be required to be covered, except in an emergency.*	There is a $20 copayment for injections or injectable substances obtained at a physician's office. You pay $20 for hormonal therapy treatment related to Gender Identity Disorder (GID). Injections or injectable substances obtained through a retail pharmacy are subject to the applicable Injectable or Specialty coinsurance.
Dental services*	
**Prior authorization (approval in advance) may be required to be covered, except in an emergency.* In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) are not covered by Original Medicare. Medicare-covered dental services include the following: • Otherwise non-covered procedures or services, such as tooth removal, when performed by a dentist incident to and as an integral part of an otherwise Medicare-covered procedure • Extractions of teeth to prepare jaw for radiation treatment of neoplastic disease • Dental exams prior to kidney transplantation	There is no copayment for Medicare-covered dental services. You pay 100% for routine dental services.

Services that are covered for you	**What you must pay** when you get these services
Hearing services*	
**Prior authorization (approval in advance) may be required to be covered, except in an emergency.* • Diagnostic hearing and balance evaluations performed by your PCP or provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider • Routine (non-Medicare-covered) hearing tests, once per year • Hearing aids that adequately meet the member's medical needs	You pay $20 for each Medicare-covered hearing test. You pay $20 for each routine hearing test. There is no copayment for 2 hearing aid devices (analog or digital) every 36 months with a benefit maximum of $2,000. No benefits will be provided for hearing aid charges which exceeds specifications prescribed for the correction of hearing loss. Hearing screening provided as part of a periodic health evaluation are covered at no charge.

Services that are covered for you	**What you must pay** when you get these services
Vision care* **Prior authorization (approval in advance) may be required to be covered, except in an emergency.* Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. • For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year • One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant. • Routine (non-Medicare covered) vision exams for refraction, once per year • Routine (non Medicare-covered) eyewear◈	You pay $20 for each Medicare-covered eye exam (diagnosis and treatment of diseases and injuries of the eye). There is no copayment for Medicare-covered glaucoma screening. Vision screening, provided as part of a periodic health evaluation, are covered at no charge. There is no copayment for Medicare-covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery). You pay $20 for each routine eye exam. For covered services under routine Vision care◈, please refer to "Additional Benefit Information" portion of this section.
Fitness facility membership/fitness classes (the Silver&Fit® program) This program, designed specifically for Medicare beneficiaries, incorporates exercise and health education to help you become physically fit.	There is no copayment for health club/fitness benefits at contracted facilities. Refer to "Additional Benefit Information" portion later in this section for more information.

Services that are covered for you	**What you must pay** when you get these services
Health and wellness education programs◈	
Provided by trained clinicians via telephone based coaching (available 24 hours a day, 7 days a week) to promote the adoption of healthy behaviors, help members build skills to enhance self care capabilities and provide support and education on treatment choices in order to make sound health care decisions with the overall goal to improve members' health. Clinicians also send educational materials and direct members to educational modules on Health Net's web site.	There is no copayment for health and wellness education programs. Refer to "Decision Power®: Health in Balance" under "Additional Benefit Information" later in this chart for more information on these benefits.

What types of benefits are not covered by the plan?

Benefits we do *not* cover (exclusions)

This section tells you what kinds of benefits are "excluded." Excluded means that the plan doesn't cover these benefits.

The list below describes some services and items that aren't covered under any conditions and some that are excluded only under specific conditions.

If you get benefits that are excluded, you must pay for them yourself. We won't pay for the excluded medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to the "Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)" portion of the "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**" section in this booklet.)

In addition to any exclusions or limitations described in the Medical Benefits Chart, or anywhere else in this Evidence of Coverage, **the following items and services aren't covered under Original Medicare or by our plan:**

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services. As noted in this section, we provide all Covered Services according to Medicare guidelines.

- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study or by our plan. (See the "How are your medical services covered when you are in a 'clinical research study'" portion in the "Using the plan's coverage for your medical services" section in this booklet for more information on clinical research studies.) Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by your immediate relatives or members of your household.
- Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care such as cleanings, filling, or dentures. However, non-routine dental care received at a hospital required to treat illness or injury may be covered as inpatient or outpatient care.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.

- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.

- Radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.

- Reversal of sterilization procedures and non-prescription contraceptive supplies.

- Acupuncture.

- Naturopath services (uses natural or alternative treatments).

- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.

- Prenatal, maternity or post-partum care for a non-Health Net Seniority Plus (Employer HMO) Member acting as a surrogate.

- Services related to educational and professional purposes are not covered, including ancillary services such as: Vocational rehabilitation; Employment counseling, training or educational therapy for learning disabilities; Investigations required for employment; Education for obtaining or maintaining employment, or for professional certification; Education for personal or professional growth, development or training; or Academic education during residential treatment.

- Services that do not meet national standards for professional medical or mental health practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy, sleep therapy, biofeedback, hypnotherapy and crystal healing therapy are not covered.

- Services that you get without a referral from your PCP or Medical Group, when a referral from your PCP or Medical Group is required for getting that service.

- Stem cell harvesting and storage not associated with an approved transplant.

- The following types of treatment are only covered when provided in connection with covered treatment for a Mental Disorder or Chemical Dependency:

    1. Treatment for co-dependency.

    2. Treatment for psychological stress.

    3. Treatment of marital or family dysfunction.

- Treatment of delirium, dementia, amnesic disorders (as defined in the DSM-IV) and mental retardation are covered for Medically Necessary medical services but covered for accompanying behavioral and/or psychological symptoms only if amenable to psychotherapeutic or psychiatric treatment.

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

- Treatment or consultations provided by telephone are not covered.

The plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

Mental Disorders and Substance Abuse Exclusions and Limitations

See the exclusions and limitations as listed under "Mental Health Care and Substance Abuse Benefits" later in this section.

Vision Care Exclusions and Limitations

See the exclusions and limitations as listed under "Vision Care" later in this section.

Chiropractic Services Exclusions and Limitations

See the exclusions and limitations as listed under "Chiropractic Services" later in this section.

Health and Fitness – SILVER&FIT® Exclusions and Limitations

See the exclusions and limitations as listed under "Health and Fitness – SILVER&FIT®" later in this section.

Prescription Drug Exclusions and Limitations

See the exclusions and limitations as listed in the "Using the plan's coverage for your prescription drugs" section later in this Evidence of Coverage.

Additional Benefit Information

Mental Health Care and Substance Abuse Benefits

Important Information: Please Read!

If you are a member of one of the following medical groups the information below describing how to obtain mental health services through MHN Services does not apply:

PAMF-Camino Site
Palo Alto Medical Foundation
Sutter Independent Physicians
Sutter Medical Group (Sacramento/Placer Division)
Sutter Medical Group (Yolo Division)

If you are a member of one of these medical groups, you **must** obtain a referral from your primary care physician and use network hospitals and specialists associated with your Medical Group for all mental health services, except in an emergency or for urgent care when outside the Service Area. Mental health services should not be obtained from MHN Services as discussed below (or throughout this Evidence of Coverage), but only through your medical group. Please refer to the Medical Benefits Chart under "Inpatient Mental Health Care," "Outpatient Mental Health Care" and "Outpatient Substance Abuse," for information on your mental health benefits and copayments. If you have any questions about this or any other Seniority Plus (Employer HMO) benefit, please contact our Member Services Department by calling **1-800-539-4072** (TDD/TTY **1-800-929-9955**) 8:00 a.m. to 8:00 p.m., seven days a week.

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

Getting Services from MHN-Contracted Providers

Seniority Plus (Employer HMO) members have the freedom to choose any Medicare eligible contracted provider who provides mental health and substance abuse services to them as a Medicare patient.

Inpatient and Alternate Levels of Care (Partial Hospitalization, Intensive Outpatient)

MHN Services must authorize these services and supplies to be covered. To get authorization for these services, you must call MHN at **1-800-646-5610** (or TDD/TTY: **1-800-327-0801** for the hearing and speech impaired), 24 hours a day, seven days a week.

MHN Services will refer you to a nearby Medicare eligible 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 Services for review. When authorized by MHN Services, the proposed services will be covered by this Plan. If MHN Services does not approve the treatment plan, no further services or supplies will be covered for that condition. However, MHN Services may direct you to community resources where alternative forms of assistance are

available.

For up-to-date provider information, please contact MHN Services at **1-800-646-5610** (or TDD/TTY: **1-800-327-0801** for the hearing and speech impaired), 24 hours a day, seven days a week. You may also contact Health Net's Member Services Department at the telephone number printed on the back cover of this booklet, or visit our website at www.healthnet.com/uc.

Outpatient Registration Process
For outpatient office-based mental health services, you or your provider should contact MHN to register your care. You or your provider will receive a reference number, can verify eligibility, and discuss your benefits and any applicable copayments. Registering your outpatient care can help ensure smooth claims payment as your case will be in our system, but services still will be reimbursed if registration does not take place as registration is voluntary.

Medical necessity review may take place in the form of discussion with your provider about your treatment plan sometime during your course of treatment. MHN is available to answer any questions regarding your care 24 hours a day, 7 days a week. To contact MHN, call **1-800-646-5610** (or TDD/TTY: **1-800-327-0801** for the hearing and speech impaired), 24 hours a day, seven days a week.

What Mental Health and Substance Abuse Services are Covered?

The following services are covered under your plan. Please refer to the Medical Benefits Chart 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 Substance Abuse may be covered with unlimited visits, subject to Medical Necessity review as determined by MHN Services. Medication management care is also covered when appropriate. Refer to "Outpatient Mental Health Care" and "Outpatient Substance Abuse Services" in the Medical Benefits Chart for your cost-sharing information.

Second Opinion
MHN Services may, as a condition of coverage, require that you 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.
- 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 Services at **1-800-646-5610** (or TDD/TTY **1-800-327-0801** for the hearing and speech impaired) 24 hours a day, seven days a week. MHN Services will review the request, and if a second opinion is considered Medically Necessary, MHN Services 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 Services will ensure that the provider selected for the second opinion is appropriately licensed and has expertise in the specific clinical area in question.

If you face an imminent and serious threat to health, including, but not limited to, the potential loss of life, limb or other major bodily function, or lack of timeliness would be detrimental to the ability to regain maximum function, the second opinion will be rendered in a timely fashion appropriate to the nature of the condition not to exceed 72 hours of MHN Services receipt of the request, whenever possible. For a complete copy of this policy, contact MHN Services at **1-800-646-5610** (TDD/TTY **1-800-327-0801**), 24 hours a day, seven days a week.

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

Inpatient treatment of a Mental Disorder or Substance Abuse is covered as shown above in the Medical Benefit Chart in this section.

Covered inpatient services and supplies include:

- Accommodations in a room of two or more beds, including special treatment units, such as intensive care units and psychiatric care units, unless a private room is determined to be Medically Necessary.
- Supplies and ancillary services normally provided by the facility, including professional services, laboratory services, drugs and medications dispensed for use during the confinement, psychological testing and individual, family or group therapy or counseling.
- Intensive outpatient care program, which is a treatment program that is utilized when a patient's condition requires structure, monitoring, and medical/psychological intervention at least three (3) hours per day, three (3) times per week.
- Partial hospitalization/day treatment program, which is a treatment program that may be free-standing or Hospital-based and provides services at least four (4) hours per day and at least four (4) days per week.

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

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

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

MHN has a licensed clinician available 24 hours a day, seven days a week to address all requests for immediate admission to a facility if the patient poses a danger to self or others or is gravely disabled. MHN Services can be contacted 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.

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

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 Services, subject to applicable copayments and any other exclusions and limitations of this Plan.

Your non-Contracted Mental Health Professional must be willing to accept MHN Services' standard mental health provider contract terms and conditions.

If you would like more information on how to request continued care, or request a copy of our continuity of care policy, please call MHN Services 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.

Mental Disorders and Substance Abuse Exclusions and Limitations
Mental health care as a condition of parole, probation or court-ordered testing for Mental Disorders is limited to Medically Necessary services and subject to this Plan's visit limits described earlier in this section.

Services and supplies for treating Mental Disorders and Substance Abuse are covered only as specified in the Medical Benefits Chart under "Inpatient Mental Health Care," "Outpatient Mental Health Care" and "Outpatient Substance Abuse Services."

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

- Court-ordered testing and treatment, except when Medically Necessary and within the allowable visits under the plan contract.
- Private Hospital rooms and/or private duty nursing, unless determined to be a Medically Necessary Service and Authorization from MHN Services is obtained.
- Ancillary services such as:
  - Vocational rehabilitation and other rehabilitation services.
  - Behavioral training.
  - Speech or occupational therapy.
  - Sleep therapy and employment counseling.
  - Training or educational therapy or services.
  - Other education services.
  - Nutrition services.
- Treatment by providers other than those within licensing categories recognized by Medicare or MHN Services as providing medically necessary services in accordance with applicable medical community standards.

- Services in excess of those with respect to which Authorization by MHN Services is obtained when authorization is required.
- 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 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 Services 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 Services 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.
- Services received before the Member's effective date or services received during an Inpatient stay that began before the Member's effective date. Additionally, services received after the Member's coverage ended are not covered, except for services received during an Inpatient stay that began before the Member's termination date.
- 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 Services.
- Electro-Convulsive Therapy (ECT) except as authorized by MHN Services according to MHN Services 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.

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

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

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

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

You can also contact MHN Services 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, to check the status of your claim. We will be able to provide a status within 72 hours of receipt of your claim. If a reimbursement is due to you, a check will be mailed no later than 60 days of receipt of your claim.

When You Receive Emergency/Urgent Services from a Non-Contracting MHN Services Provider/Facility

You may be hospitalized at a non-MHN Services facility due to an immediate medical emergency. You may be transferred to an MHN Services facility as soon as your medical condition is stable enough for such a move. If MHN Services arranges a transfer, MHN Services will be financially responsible for the cost of the transportation to an MHN Services facility. When receiving Emergency Care from a non-MHN Services provider, you should request that the provider bill MHN Services directly for services. If the provider bills you directly, MHN Services will reimburse you charges paid for emergency services and out-of-area urgent care services less any applicable copayments. In order to receive reimbursement, you should submit an itemized bill and completed claim form to MHN Services. A claim form can be obtained online at www.mhn.com or by contacting MHN's Claims Line for assistance at the toll-free number **1-800-444-4281** (National Relay Service: 711, available for the hearing and speech impaired) Monday through Friday from 8:00 a.m. to 7:00 p.m., Central time.

Completed claim forms should be submitted to:

MHN Services 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 Services 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. Calls to these numbers are free. Or visit MHN Services' web site at www.mhn.com for a list of MHN Services Contracted Mental Health Professionals in your area.

Vision Care

Refractive Eye Examination
Eye examinations to determine the need for correction of vision are covered and must be provided through your contracting Physician Group.

Eyewear
You are covered for one (1) pair of Eyeglasses or Contact Lenses after each cataract surgery with insertion of an intraocular lens.

We also cover Eyewear beyond what Medicare covers as described below:

You can obtain an annual eye exam with your basic medical benefit through your Health Net Seniority Plus (Employer HMO) contracting Physician Group. Please refer to the "Vision Care" portion of the Medical Benefit Chart in this section for your cost-sharing amounts. We also offer coverage for your eyewear. The Health Net Vision Plan is offered by Health Net Seniority Plus (Employer HMO) which is serviced by EyeMed Vision Care, LLC.

How To Use The Plan

- Make arrangements for your routine annual eye exam through your contracting Physician Group or PCP. For Referral to a Specialist (ophthalmologist or optometrist), please contact your PCP directly. Vision care provided by someone other than a Health Net Seniority Plus (Employer HMO) 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. to 8:00 p.m. and Sunday, 8:00 a.m. to 5:00 p.m., Pacific Time. TTY/TDD services are available Monday through Friday during the hours of 5:00 a.m. to 2:00 p.m., Pacific Time, at 1-866-308-5375 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 5:00 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 pay nothing.

Eyewear Schedule:

Cost Sharing:

Frames (one pair of frames during a 24-month period*)

Frames (*Any available frame at provider location*)	Health Net Vision pays the first $100.You pay 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	You pay $65. Health Net Vision pays the remaining balance.
Premium Progressive Lenses	You pay $65 plus 80% of the retail charge, minus the $120 plan allowance.

Eyeglass Lens Options (one pair every 24 months*)

Tint – Solid or Gradient	Health Net Vision pays in full.

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. You pay 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 the "Eyewear Schedule" at one visit. If you do not use the full allowed amount during the initial purchase, the remaining balance will not carry over.)	Health Net Vision pays the first $100. You pay 100% of the remaining balance, if applicable.
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 or the provider attests to the specified level of visual improvement
- **High Ametropia** exceeding –10D or +10D in spherical equivalent in either eye
- **Anisometropia** of 3D in spherical equivalent or more
- **Vision Improvement** for patients whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses

Contact lenses applied to meet the approved criteria related to eye conditions as established by the EyeMed Quality Assurance Committee. These eye conditions prevent the member from achieving a specified level of visual acuity through the wearing of conventional spectacle lenses. The contact lenses may be any modality (e.g., soft conventional, soft disposable, gas permeable, etc.) depending on the eye condition and the recommendation of the provider.

EyeMed will deny the coverage if the prescription does not fall within the defined guidelines. Alternatively, you can use the standard contact lens benefit as described in the plan.

Vision Care Exclusions and Limitations

The following items and services are also limited or excluded under the Vision Care benefits:

- Eye exams are not covered. For covered eye exams please refer to the Medical Benefits

Chart earlier in this section.

- 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.
- 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 Medical Benefits Chart earlier in this section.
- 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.
- Prescription drugs or over-the-counter drugs are not covered. For covered Prescription drugs or over-the-counter drugs, please refer to the Medical Benefits Chart earlier in this section.
- Vision aids (other than Eyeglasses or Contact Lenses) are not covered.
- Cost Sharing amounts are a one-time use benefit; no remaining balances.
- Out-of-Network vision care services not covered.
- Lost or broken materials are not covered, except in the next Benefit Frequency when materials would next become available.
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan.
- Two pair of glasses in lieu of bifocals.
- Services or materials provided by any other group benefit plan providing vision care.
- Services rendered after your coverage ends, except when materials that were ordered before coverage ended are delivered and the services rendered to you are within 31 days from the date of such order.
- Services provided as a result of any Workers' Compensation law, or similar legislation, or required by any governmental agency or program whether federal, state, or subdivisions thereof.
- Discounts or promotional offers do not apply for benefits provided by other benefit plans. If a discount or promotional offer is accepted, plan benefits do not apply for the benefit period. Allowances are one-time use benefits; no remaining balance.

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.

Chiropractic Services

American Specialty Health Plans of California, Inc. (ASH Plans) will provide access to covered Chiropractic Services for you. You may access any ASH Plans Contracted Chiropractor without a physician referral, including without a Referral from your Primary Care Physician ("PCP"). All covered Chiropractic Services must be Medically Necessary and may require verification of Medical Necessity through an authorization process by ASH Plans, except as listed below. The ASH Plans Contracted Chiropractor you select will provide the initial examination and will contact ASH Plans for any required verification of medical necessity of the treatment plan he/she develops for you. For a list of ASH Plans Contracted Chiropractors, please call ASH Plans at **1-800-678-9133** (TDD/TTY **1-877-710-2746**), Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays, Pacific Time.

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

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

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

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

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

Chiropractic Covered Services:

- You are required to pay a copayment for each office visit to an ASH Plans Contracted Chiropractor, as described below. A maximum number of visits per plan year will apply to each Member**.** All Chiropractic Services except for the initial evaluation may require verification of Medical Necessity.
- A new patient exam or an established patient exam for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of Chiropractic Services. A new patient is one who has not received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years.
- Established patient exams to assess the need to initiate, continue, extend, or change a Course of Treatment. The established patient exam may require verification of Medical Necessity.
- Adjunctive modalities and procedures such as rehabilitative exercise, traction, ultrasound, electrical muscle stimulation, and other therapies are covered only when provided during the same Course of Treatment and in support of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.
- Follow-up office visits may include manipulation of the spine, joints and/or musculoskeletal soft tissue, a re-evaluation, and/or other services, in various combinations.
- X-rays and clinical laboratory tests are payable in full when provided by or referred by ASH Plans Contracted Chiropractor and verified by ASH Plans as being Medically Necessary. Radiological consultations are a covered benefit when verified by ASH Plans as being Medically Necessary Services and when provided by a licensed chiropractic radiologist, medical radiologist, radiology group, or hospital that has contracted with ASH Plans to provide those services.
- Chiropractic Supports and Appliances ◄ are covered up to a maximum of $50 per year when verified by ASH Plans as being Medically Necessary for the treatment of either Musculoskeletal Disorders or Related Pain Syndromes or both.
- Urgent Services ▲.
- Emergency Services ▼.

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

ASH Group Contracted Chiropractor and you would submit a claim to ASH Group for reimbursement.

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

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

Second Opinion

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

X-ray and Laboratory Tests

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

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

Chiropractic Services Exclusions and Limitations

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

- Services rendered in excess of visit limits or benefit maximums.

- Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order.
- Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; and all support appliances or durable medical equipment **except those specifically noted as covered above under "Chiropractic Covered Services."**
- Education programs, non-medical lifestyle or self-help, or any self-help physical exercise training or any related diagnostic testing.
- Hypnotherapy, behavior training, sleep therapy and weight programs.
- Services or treatments delivered by a Non- Contracted Provider, except for (a) Emergency Services; (b) Urgent Services; (c) services that are provided pursuant to a continuity of care plan approved by ASH Plans; or (d) services that are provided upon referral by ASH Plans in situations where such services are not available and accessible to a Member from a Contracted Chiropractor within the Service Area.
- Adjunctive physiotherapy modalities and procedures unless provided during the same Course of Treatment and in conjunction with chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.
- Services, exams, (other than an initial examination to determine the appropriateness of Chiropractic Services), and/or treatments for conditions other than Musculo-skeletal or Related Disorders or Pain Syndromes.
- Services provided by a chiropractor practicing outside California, except for Emergency Chiropractic Services or Urgent Services.
- Any service or supply that is not permitted by state law with respect to the provider's scope of practice.
- Thermography; magnets used for diagnostic or therapeutic use; nerve conduction studies (e.g., EEG, EMG, SEMG, SSEP, and NCV); or electrocardiogram (EKG) studies.
- Transportation costs, including local ambulance charges.
- Dietary and nutritional supplements, including vitamins, minerals, herbs, herbals and herbal products, injectable supplements and injection services, or other similar products.
- Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, therapeutic radiology, and any diagnostic radiology other than covered plain film studies.
- Services or treatments for pre-employment physicals or vocational rehabilitation.
- Any services or treatments for conditions caused by or arising out of the course of employment or covered under workers' compensation or similar laws.

- Auxiliary aids and services, including, but not limited to, interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids.

- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services under anesthesia, or other related services.

- Thermography, magnets used for diagnostic or therapeutic use, ion cord devices, manipulation or adjustments of the joints, physical therapy services, iridology, hormone replacement products, acupuncture point or trigger-point injections (including injectable substances), laser/laser biostim, colorpuncture, NAET diagnosis and/or treatment, and direct moxibustion. Any service or supply that is not permitted by state law with respect to the provider's scope of practice.

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, Pacific Time.

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

American Specialty Health Plans
P.O. Box 509002
San Diego, CA 92150-9002

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

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

When receiving Emergency Care or Urgent Care from a non-Contracted Provider, you 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, you 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, Pacific Time.

Completed claim forms should be submitted to:

American Specialty Health Plans
P.O. Box 509002

San Diego, CA 92150-9002

QUESTIONS?

For up-to-date provider information, 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, Pacific Time. Or visit ASH Plans' website at www.ashcompanies.com for a list of ASH Plans Contracted Chiropractors in your area.

Grievance Procedures

If you have a complaint about the Chiropractic program or services you received, call Member Services at 1-800-539-4072 (TDD/TTY **1-800-929-9955**) 8:00 a.m. to 8:00 p.m., seven days a week. See the "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**," section of this booklet for more information.

Medicare Appeals Procedure

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

Health and Fitness – SILVER&FIT®

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

Prior to proceeding in any exercise or weight management program, 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.

How do I enroll?

You will receive a list of fitness facilities in your area with your temporary ID card in your pre-enrollment packet. Simply choose a fitness facility from the list enclosed with your enrollment packet. For more information on fitness facilities, visit www.SilverandFit.com or call Silver&Fit customer service at **1-877- 427-4788** or TTY/TDD phone **1-877-710-2746**, Monday – Friday, 5 a.m. – 6 p.m. (Pacific Time). Once you have chosen a fitness facility, take your temporary ID card along with your health plan ID card to the fitness facility of your choice. You may be required by the fitness facility you chose to sign a membership agreement. The membership agreement that you may be required to sign at the fitness facility is for a no-cost "standard fitness facility membership," which includes the covered services available through the program,

described below. If you choose to access fitness facility services otherwise available at the facility for an additional fee, then the agreement may reflect costs associated with those non-program related services.

If you choose to enroll in the Silver&Fit Home Fitness program, you can enroll online at SilverandFit.com or by calling Silver&Fit customer service at **1-877- 427-4788** or TTY/TDD phone **1-877-710-2746**, Monday – Friday, 5 a.m. – 6 p.m. (Pacific Time). **If you are already enrolled in the Silver&Fit benefit and choose to remain enrolled, you do not need to take any action (there is no need to re-enroll).**

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

Fitness Clubs

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

- Fitness orientation and equipment demonstration for all new program members
- Cardiovascular equipment
- Free weights or resistance training equipment
- Exercise classes
- Where available, amenities such as saunas, steam rooms, pools, and whirlpools

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

Exercise Centers

The Silver&Fit standard exercise center membership 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, Pilates, yoga studios, or others.

Explanation of covered services (i.e., what is the "Silver&Fit Home Fitness Program?")

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

- Walking Kit
- Strength Exercise Kit
- Yoga Kit
- Tai Chi Kit
- Pilates Kit

- Aqua Aerobics Kit
- Stress Management Kit
- Dance Kit

Services offered through the "Customer Service Hotline"

You 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:

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

Silver&Fit Web Site

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

- Utilize the fitness facility locator and enrollment change features in the event you wish to change fitness facilities
- Access fitness literature to help you make better health decisions
- Choose from dozens of health trackers to track your progress
- Access the Silver&Fit member newsletter, *The Silver Slate*®

Exclusions and limitations

The following services are not offered:

- Services or supplies provided by any person, company other than a Silver&Fit participating fitness facility
- All education materials other than those produced for Silver&Fit by American Specialty Health Incorporated
- Telecommunications devices, telephone handset amplifiers, television recorders, and telephones compatible with hearing aids
- Education program services for individuals other than the member

- Prescription drugs, over-the-counter products, dietary supplements, herbal supplements, vitamins, minerals, weight control products, meal-replacement beverages or powders, or any other types of food or food product, whether or not it is recommended, prescribed, or supplied by a health care provider, fitness facility, or program
- All listening devices, including, but not limited to, audiotape and CD players
- Services for members with serious medical conditions for which Silver&Fit services are not appropriate

Silver&Fit and *The Silver Slate* are federally registered trademarks of American Specialty Health Incorporated, and are used with permission in this Evidence of Coverage.

Decision Power®: Health in Balance

Information, resources and support for every person, every stage of health

With Health Net, you get more than health care coverage. You get Decision Power.

Decision Power brings together under one roof the information, resources and personal support that fit you, your health and your life. Whether you're focused on staying fit, dealing with back pain or facing a serious diagnosis, we're here to help you work with your doctor and make informed decisions. Here's how it works:

→ Staying healthy is just as important as getting well.

Making the most of your health is what Decision Power is all about. We're focused on your whole health, not just one concern or disease. So we work with you to identify potential health risks, and help prevent minor concerns from becoming big problems. And we're here should you face serious medical concerns.

→ Your health, your time, your choice.

Whether you …

- have a question
- want help with a specific health goal
- need treatment but need decision support to understand all your options
- are living with illness

…**you choose how and when** to use the information, resources and support available. You can use Decision Power online or by calling a clinician on our nurse 24 line. Try multiple resources at once, or one at a time. 24 hours a day, seven days a week, Decision Power is here for you.

Log on to www.healthnet.com/uc:

- **Try a step-by-step plan** that combines online coaching and self-help tools with phone support so making lasting, healthy changes is easier.
  - Tobacco use
  - Weight Management (Adult and Pediatric)
  - Nutrition
  - Stress Reduction
  - High Cholesterol
  - High Blood Pressure (Hypertension)
- **Track your health progress** and build a complete medical snapshot to have whenever you need it. You can set up your Personal Health Record to capture claims data. You can also enter immunization and test records/results. Plus, you'll automatically receive next steps and alerts about things to discuss with your doctor.
- **Find support for mental health concerns** — tools and programs to assess depression, alcohol use and other emotional health concerns.
- **Keep track of prescriptions** in our **medication center** where you'll also find the most up-to-date information about potentially harmful drug interactions, prescription drugs and over-the-counter medications and supplements.
- **Know the numbers** with our handy tools including health trackers (cholesterol, diet, and fitness), hospital comparison report and treatment cost estimator.
- **Be informed** — Decision Power delivers trusted, easy to understand materials right to your fingertips. Beyond our in-depth article library, you'll find:
  - Condition and topic specific videos to support and educate you in your healthcare decisions and choices
  - Access to information resources, such as Healthwise® Knowledgebase, an online health encyclopedia; calendars; tracking tools; and interactive modules

Talk to a Clinician 24 hours a day:

With Decision Power, you get the convenience of a single point of contact for any and every health question, goal or situation. The clinician you talk to – a trained professional such as a nurse – will present choices, explain options and support you based on your individual values, family needs, situation and preferences.

- **1:1 consultations** with a trained clinician. All of our 24 hour clinicians have experience and know-how to help you with your primary concern while exploring and addressing the range of issues that may be related to and complicated by it.
- **Answers** to health questions 24 hours a day. However always call 9-1-1 or go straight to the emergency room in a life-threatening situation.
- **Techniques** for talking to your doctor and evaluating treatment options.

- **Pointers** for setting achievable health goals on topics such as weight management, tobacco cessation, stress reduction, cholesterol management, blood pressure control and more.
- **Guidance**/support for living with an ongoing illness such as asthma, diabetes, heart disease and depression, among others.
- **Specialized support** for end-stage diseases, severe trauma — expert nurse case managers work one-on-one with patients and families, facilitating any and all services that may be helpful — home care, hospice, skilled nursing, behavioral health, and more.

→**Doctor-patient connection.** Doctors know medicine. You know your body. With Decision Power, it's easy to learn what questions to ask, how to explain your preferences and to get the support you need from your doctor. The more you know, the easier it is to navigate complicated health choices and make the ones that are right for you.

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

Try it today! Log on to www.healthnet.com/uc or call us toll-free at 1-800-893-5597 (TTY/TDD: 1-800-276-3821).

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

Decision Power is part of Health Net's Medicare Advantage benefit plans. But it is not affiliated with Health Net's provider network. Decision Power services, including Health Coaches, are additional resources that Health Net makes available to enrollees of Health Net of California, Inc. and Health Net Life Insurance Company.

USING THE PLAN'S COVERAGE FOR YOUR PRESCRIPTION DRUGS

?

Did you know there are programs to help people pay for their Part D drugs?

The "Extra Help" program helps people with limited resources pay for their Part D drugs. These include "Extra Help" Programs. See the "Important phone numbers and resources" section of this booklet for more information.

Are you currently getting help to pay for your Part D drugs?

If you are in a program that helps pay for your Part D drugs, **some information in this *Evidence of Coverage* may not apply to you.** We send you an insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider or the "LIS Rider"), that tells you about your Part D drug coverage. If you don't have this insert, please call Member Services and ask for the LIS Rider. Phone numbers for Member Services are printed on the back cover of this booklet.

Introduction

This section describes your coverage for Part D drugs

This section explains rules for using your coverage for drugs. The next section in this booklet, "**What you pay for your prescription drugs**," tells what you pay for drugs.

In addition to your coverage for Part D drugs, our plan covers some drugs not covered by Part D. These drugs are included on our Drug List. The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage.

- The plan covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. The "**Medical Benefits Chart (what is covered and what you pay)**" section in this booklet tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay.

- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. The "**Medical Benefits Chart (what is covered and what you pay)**" section of this booklet tells about the benefits and costs for Part B drugs.

The two examples of drugs described above are covered by the plan's medical benefits. The rest of your prescription drugs are covered under the plan's prescription drug benefits.

Basic rules for the plan's drug coverage

The plan will generally cover your drugs as long as you follow these basic rules:

- You must use a network pharmacy to fill your prescription. (See the "Fill your prescription at a network pharmacy or through the plan's mail-order services" portion of this section.)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See the "Your drugs need to be on the plan's drug list" portion of this section.)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See the "Your drugs need to be on the plan's 'Drug List'" portion of this section for more information about a medically accepted indication.)

Fill your prescription at a network pharmacy or through the plan's mail-order services

To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies. (See the "When can you use a pharmacy that is not in the plan's network?" portion of this section for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the prescription drugs that are covered on the plan's Drug List.

Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (www.healthnet.com/uc), or call Member Services (phone numbers are printed on the back cover of this booklet). Choose whatever is easiest for you.

You may go to any of our network pharmacies. If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get

help from Member Services (phone numbers are on the back cover of this booklet) or use the *Pharmacy Directory*. You can also find information on our website at www.healthnet.com/uc.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special extraordinary handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Member Services (phone numbers are printed on the back cover of this booklet).

Using the plan's mail-order services

For certain kinds of drugs, you can use the plan's network mail-order services. Generally, the drugs available through mail order are maintenance drugs that you take on a regular basis, for a chronic or long-term medical condition. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

Our plan's mail-order service requires you to order ***at least* a 30-day supply of the drug and *no more than* a 90-day supply**.

To get order forms and information about filling your prescriptions by mail, visit our website (www.healthnet.com/uc), or call Member Services at the number listed on the back cover of this booklet for assistance.

Usually a mail-order pharmacy order will get to you in no more than 14 days. If your mail order is delayed, call Member Services at the number printed on the back cover of this booklet for assistance.

UC Walk-Up Service through UC Medical Center Pharmacies

Health Net and the UC Medical Center Pharmacies have partnered to offer UC members 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 mail-order services, you can obtain up to a 90-day supply at UC-designated Medical Center Pharmacies for the same cost-sharing that you would pay for a 90-day supply from a preferred mail-order pharmacy.

How can you get a long-term supply of drugs?

The plan offers two ways to get a long-term supply of "mail-order" drugs on our plan's Drug List.

1. **Some retail pharmacies** in our network allow you to get a long-term supply of maintenance drugs. Some of these retail pharmacies may agree to accept a lower cost-sharing amount for a long-term supply of maintenance drugs. Other retail pharmacies may not agree to accept the lower cost-sharing amounts for a long-term supply of maintenance drugs. In this case you will be responsible for the difference in price. Your *Pharmacy Directory* tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).

2. For certain kinds of drugs, you can use the plan's preferred **mail-order services.** The drugs available through our plan's mail-order service are marked as "**mail-order" drugs** in our Drug List. Our plan's mail-order service requires you to order *at least* a 30-day supply of the drug and *no more than* a 90-day supply. See the "Using the plan's mail-order services" portion of this section for more information about using our mail-order services. When you get a long-term supply of drugs through the plan's preferred mail-order service, your cost sharing may be lower.

3. Health Net and the **UC Medical Center Pharmacies** have partnered to offer UC members 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 mail-order services, you can obtain up to a 90-day supply at UC-designated Medical Center Pharmacies for the same cost-sharing that you would pay for a 90-day supply from a preferred mail-order pharmacy.

When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an ***out-of-network*** pharmacy *only* when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an ***out-of-network*** pharmacy:

- If you are unable to obtain a covered drug in a timely manner within our service area

because there are no network pharmacies within a reasonable driving distance that provide service 24-hours a day, seven days a week.
- 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, or other covered drugs that are administered in your doctor's office.
- If you need a prescription filled that is related to care for a medical emergency or urgently needed care.
- If you are evacuated or otherwise displaced from your home because of a federal disaster or other public health emergency declaration.

In these situations, **please check first with Member Services** to see if there is a network pharmacy nearby. (Phone numbers for Member Services are printed on the back cover of this booklet.)

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. See the "How to ask us to pay you back or to pay a bill you have received" portion of the "Asking us to pay our share of a bill you have received for covered medical services or drugs" section of this booklet, which explains how to ask the plan to pay you back.

Your drugs need to be on the plan's "Drug List"

The "Drug List" tells which drugs are covered

The plan has a ***List of Covered Drugs (Formulary)***. In this ***Evidence of Coverage*****, we call it the "Drug List" for short.**

The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this section and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or treatment of your medical condition and meet accepted standards of medical practice for which it is being prescribed.)
- -- or -- supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

The Drug List includes both brand name and generic drugs

A generic drug is a prescription drug that has the same active ingredients as the brand name drug. Generally, it works just as well as the brand name drug, and usually it costs less. There are generic drug substitutes available for many brand name drugs.

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see the "What types of drugs are *not* covered by the plan?" portion later in this section).

- In other cases, we have decided not to include a particular drug on the Drug List.

There are different "cost-sharing tiers" for drugs on the Drug List

Every drug on the plan's Drug List is in one of the cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug. To find out what type of drugs are covered under each drug tier and your cost-sharing for each tier, refer to the "What you pay for your prescription drugs" section later in this *Evidence of Coverage.*

- Tier 1 includes preferred generic drugs.

- Tier 2 includes preferred brand drugs. Drugs on this tier are not eligible for exceptions for payment at a lower tier.

- Tier 3 includes non-preferred brand drugs.

- Tier 4 (Injectable Drugs) includes injectable drugs that do not meet the Centers for Medicare & Medicaid Services (CMS) minimum cost threshold required to be placed on Specialty Tier (Tier 5).

- Tier 5 (Specialty Tier) includes high cost drugs. Specialty Tier (Tier 5) drugs are not eligible for exceptions for payment at a lower tier.

How can you find out if a specific drug is on the Drug List?

You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail.

2. Visit the plan's website (www.healthnet.com/uc). The Drug List on the website is always the most current.

3. Call Member Services to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. (Phone numbers for Member Services are printed on the back cover of this booklet.)

There are restrictions on coverage for some drugs

Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work medically just as well as a higher-cost drug, the plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to ask us to make an exception. We may or may not agree to waive the restriction for you. (See the "What is an exception?" portion of the "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**" section of this booklet for information about asking for exceptions.)

What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The information below tells you more about the types of restrictions we use for certain drugs.

Restricting brand name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand name drug and usually costs less. **When a generic version of a brand name drug is available, our network pharmacies will usually provide you the generic version.**

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This is called **"prior authorization."** Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by the plan.

Trying a different drug first

This requirement encourages you to try less costly but just as effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called **"step therapy**."

Quantity limits

For certain drugs, we limit the amount of the drug that you can have. For example, the plan might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Do any of these restrictions apply to your drugs?

The plan's Drug List includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List. For the most up-to-date information, call Member Services (phone numbers are printed on the back cover of this booklet) or check our website (www.healthnet.com/uc).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to ask us to make an exception. We may or may not agree to waive the restriction for you. (See the "What is an exception?" portion of the "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**" section of this booklet for information about asking for exceptions.)

What if one of your drugs is not covered in the way you'd like it to be covered?

There are things you can do if your drug is not covered in the way you'd like it to be covered

Suppose there is a prescription drug you are currently taking, or one that you and your provider think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

- **What if the drug you want to take is not covered by the plan?** For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand name version you want to take is not covered.

- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** As explained in the "There are restrictions on coverage for some drugs" portion of this section, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you. For example, you might want us to cover a certain drug for you without having to try other drugs first. Or you may want us to cover more of a drug (number of pills, etc.) than we normally will cover.

- **What if the Part D drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be?** The plan puts each covered drug into one of the different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

There are things you can do if your drug is not covered in the way that you'd like it to be covered. Your options depend on what type of problem you have:

- If your drug is not on the Drug List or if your drug is restricted, see the "What can you do if your drug is not on the Drug List or if the drug is restricted in some way?" portion of this section to learn what you can do.

- If your Part D drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, see the "What can you do if your Part D drug is in a cost-sharing tier you think is too high?" portion of this section to learn what you can do.

What can you do if your Part D drug is not on the Drug List or if the drug is restricted in some way?

If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the Part D drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.

- You can change to another drug.

- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, the plan can offer a temporary supply of a Part D drug to you when your Part D drug is not on the Drug List or when it is restricted in some way. Doing this gives you time to talk with your provider about the change in coverage and figure out what to do.

To be eligible for a temporary supply of a Part D drug, you must meet the two requirements below:

1. The change to your Part D drug coverage must be one of the following types of changes:

- The Part D drug you have been taking is **no longer on the plan's Drug List**.

- -- or -- the Part D drug you have been taking is **now restricted in some way** (the "There are restrictions on coverage for some drugs" portion of this section tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who were in the plan last year and aren't in a long-term care facility:**

  We will cover a temporary supply of your Part D drug **one time only during the first 90 days after the implementation of a new formulary at the beginning of each year (January 1)**. This temporary supply will be for a maximum of 30 days, or less if your prescription is written for fewer days (in which case we will allow multiple fills to provide up to a total of a 30-day supply of your prescription). The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and aren't in a long-term care facility:**

  We will cover a temporary supply of your Part D drug **one time only during the first 90 days of your membership** in the plan. This temporary supply will be for a maximum of 30 days, or less if your prescription is written for fewer days (in which case we will allow multiple fills to provide up to a total of a 30-day supply of your prescription). The prescription must be filled at a network pharmacy.

- **For those members who are new to the plan and reside in a long-term care facility:**

  We will cover a temporary supply of your Part D drug **during the first 90 days of your membership** in the plan. The first supply will be for a maximum of 34 days, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a supply right away:**

  We will cover one 34-day supply of your Part D drug, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

- **For those who are current members of the plan and are moving from a long-term care facility or a hospital stay to home and need a transition supply right away:**

  We will cover one 30-day supply of your Part D drug, or less if your prescription is written for fewer days (in which case we will allow multiple fills to provide up to a total of a 30-day supply of your prescription).

- **For those who are current members of the plan and are moving from home or a hospital stay to a long-term care facility and need a transition supply right away:**

  We will cover one 34-day supply of your Part D drug, or less if your prescription is written for fewer days (in which case we will allow multiple fills to provide up to a total of a 34-day supply of your prescription).

To ask for a temporary supply of your Part D drug, call Member Services (phone numbers are printed on the back cover of this booklet).

During the time when you are getting a temporary supply of a Part D drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch

to a different Part D drug covered by the plan or ask the plan to make an exception for you and cover your current Part D drug. The sections below tell you more about these options.

You can change to another drug

Start by talking with your provider. Perhaps there is a different Part D drug covered by the plan that might work just as well for you. You can call Member Services to ask for a list of covered Part D drugs that treat the same medical condition. This list can help your provider to find a covered drug that might work for you. (Phone numbers for Member Services are printed on the back cover of this booklet.)

You can ask for an exception

You and your provider can ask the plan to make an exception for you and cover the Part D drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask the plan to cover a Part D drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the Part D drug without restrictions.

If you and your provider want to ask for an exception, the "Step-by-step: How to ask for a coverage decision, including an exception" portion of the "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**" section of this booklet tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

What can you do if your Part D drug is in a cost-sharing tier you think is too high?

If your Part D drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another Part D drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different Part D drug in a lower cost-sharing tier that might work just as well for you.

You can call Member Services to ask for a list of covered Part D drugs that treat the same medical condition. This list can help your provider find a covered Part D drug that might work for you.(Phone numbers for Member Services are printed on the back cover of this booklet.)

You can ask for an exception

For Part D drugs in tiers 3 (Non-preferred brand name) and 4 (Injectable Drugs), you and your provider can ask the plan to make an exception in the cost-sharing tier for the Part D drug so that you pay less for the it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception see the "Step-by-step: How to ask for a coverage decision, including an exception" portion of the "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**" section of this booklet, as it tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Drugs in some of our cost-sharing tiers are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in Tiers 2 (Preferred brand drugs), Tier 5 (Specialty Tier), or non-Part D drugs on the Drug List.

What if your coverage changes for one of your drugs?

The Drug List can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make many kinds of changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List**. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier**.
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see the "What if one of your drugs is not covered in the way you'd like it to be covered" portion in this section).
- **Replace a brand name drug with a generic drug**.

In almost all cases, we must get approval from Medicare for changes we make to the Part D drugs on the plan's Drug List.

What happens if coverage changes for a Part D drug you are taking?

How will you find out if your Part D drug's coverage has been changed?

If there is a negative change to coverage ***for a Part D drug you are taking***, the plan will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time**.

Once in a while, a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons. If this happens, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away. Your provider will also know about this change, and can work with you to find another drug for your condition.

Do changes to your Part D drug coverage affect you right away?

If any of the following types of changes affect a Part D drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

- If we move your Part D drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the Part D drug.
- If we remove your Part D drug from the Drug List, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happens for a Part D drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a Part D **brand name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your Part D brand name drug at a network pharmacy.
    - During this 60-day period, you should be working with your provider to switch to the generic or to a different Part D drug that we cover.
    - Or you and your provider can ask the plan to make an exception and continue to cover the Part D brand name drug for you. For information on how to ask for an exception, see the "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**" section of this booklet.
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
    - Your provider will also know about this change, and can work with you to find another drug for your condition.

What types of drugs are *not* covered by the plan?

Types of drugs we do not cover

This portion of the section tells you what kinds of prescription drugs are "excluded."

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed below. The only exception is if the requested Part D drug is found upon appeal to

be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints" section of this booklet.)

Here are three general rules about drugs that our plan will not cover:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan will not cover a drug purchased outside the United States and its territories.
- Our plan usually will not cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
    - Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, the following categories of drugs are not covered or are restricted by our plan:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins, mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs when used for the treatment of sexual or erectile dysfunction are limited to four doses per month. Drugs when used for the treatment of sexual or erectile dysfunction are limited to eight doses per month for Members who received eight doses per month prior to being Medicare-eligible and enrolling in this plan.

We offer additional coverage of some prescription drugs not normally covered in a Medicare Prescription Drug Plan (enhanced drug coverage). Refer to the Drug List (*Formulary)* to determine which drugs are covered under our enhanced drug coverage and for any applicable restrictions. The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in the "What you pay for prescription drugs" section of this booklet.)

In addition, if you are **receiving Extra Help from Medicare** to pay for your Part D prescriptions, the Extra Help program will not pay for the drugs not normally covered. (Please refer to the plan's Drug List or call Member Services for more information. Phone numbers for Member Services are printed on the back cover of this booklet.) However, if you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in the "Important phone numbers and resources" section of this booklet.)

Show your plan membership card when you fill a prescription

Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill the plan for *our* share of your covered prescription drug cost. You will need to pay the pharmacy *your* share of the cost when you pick up your prescription.

What if you don't have your membership card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call the plan to get the necessary information.

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. (You can then **ask us to reimburse you** for our share. See, the "How to ask us to pay you back or to pay a bill you have received" portion of the "Asking us to pay our share of a bill you have received for covered medical services or drugs" section of this booklet for information about how to ask the plan for reimbursement.)

Drug coverage in special situations

What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. The "What you pay for your prescription drugs" section of this booklet gives more information about drug coverage and what you pay.

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage. The "Ending your membership in the plan" section of this booklet, tells when you can leave our plan and join a different Medicare plan.

What if you're a resident in a long-term care facility?

Usually, a long-term care facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your *Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Services (phone numbers are printed on the back cover of this booklet.

What if you're a resident in a long-term care facility and become a new member of the plan?

If you need a Part D drug that is not on our Drug List or is restricted in some way, the plan will cover a **temporary supply** of your Part D drug during the first 90 days of your membership. The first supply will be for a maximum of 34 days, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and need a Part D drug that is not on our Drug List or if the plan has any restriction on the drug's coverage, we will cover one 34-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a Part D drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different Part D drug covered by the plan that might work just as well for you. Or you and your provider can ask the plan to make an exception for you and cover the Part D drug in the way you would like it to be covered. If you and your provider want to ask for an exception, see the "Step-by-step: How to ask for a coverage decision, including an exception" portion of the "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**" section of this booklet as it tells what to do.

Special note about "creditable coverage":

Each year your employer or retiree group should send you a notice that tells if your prescription drug coverage for the next plan year is "creditable" and the choices you have for drug coverage.

If the coverage from the group plan is **"creditable,"** it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep these notices about creditable coverage, because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from your employer or retiree plan's benefits administrator or the employer or union.

Programs on drug safety and managing medications

Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors.
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition.
- Drugs that may not be safe or appropriate because of your age or gender.
- Certain combinations of drugs that could harm you if taken at the same time.
- Prescriptions written for drugs that have ingredients you are allergic to.
- Possible errors in the amount (dosage) of a drug you are taking.

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Programs to help members manage their medications

We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

These programs are voluntary and free to members. A team of pharmacists and doctors developed the programs for us. The programs can help make sure that our members are using the drugs that work best to treat their medical conditions and help us identify possible medication errors.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Member Services (phone numbers are printed on the back cover of this booklet).

WHAT YOU PAY FOR YOUR PRESCRIPTION DRUGS

?

Did you know there are programs to help people pay for their Part D drugs?

The "Extra Help" program helps people with limited resources pay for their Part D drugs. For more information, see the "Information about programs to help people pay for their Part D prescription drugs" portion of the "Important phone numbers and resources" section of this booklet.

Are you currently getting help to pay for your Part D drugs?

If you are in a program that helps pay for your Part D drugs, **some information in this *Evidence of Coverage* may not apply to you.** We send you a separate insert, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider") that tells you about your Part D drug coverage. If you don't have this insert, please call Member Services and ask for the LIS Rider. Phone numbers for Member Services are printed on the back cover of this booklet.

Introduction

Use this section together with other materials that explain your drug coverage

This section focuses on what you pay for your prescription drugs. To keep things simple, we use "drug" in this section to mean a prescription drug. As explained in the "Using the plan's coverage for your prescription drugs" section of this *Evidence of Coverage*, not all drugs are Part D drugs – some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law. Some non-Part D drugs may be covered by our plan.

To understand the payment information we give you in this section, you need to know the basics of what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Here are materials that explain these basics:

- **The plan's *List of Covered Drugs (Formulary).*** To keep things simple, we call this the "Drug List."
    - This Drug List tells which drugs are covered for you.
    - It also tells which of the different "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
    - If you need a copy of the Drug List, call Member Services (phone numbers are printed on the back cover of this booklet). You can also find the Drug List on our

website at www.healthnet.com/uc. The Drug List on the website is always the most current.

- **The "Using the plan's coverage for your prescription drugs" section of this *Evidence of Coverage.*** This section gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. This section also tells which types of prescription drugs are not covered by our plan.

- **The plan's *Pharmacy Directory.*** In most situations you must use a network pharmacy to get your covered drugs (see the "Using the plan's coverage for your prescription drugs" section of this *Evidence of Coverage* for the details). The *Pharmacy Directory* has a list of pharmacies in the plan's network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month's supply).

What you pay for a Part D drug depends on which "drug payment stage" you are in when you get the Part D drug

What are the drug payment stages for our members?

There are different "drug payment stages" for your Part D prescription drug coverage. How much you pay for a Part D drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium (if applicable) regardless of the drug payment stage.

Stage 1 *Yearly Deductible Stage*	Stage 2 *Initial Coverage Stage*	Stage 3 *Coverage Gap Stage*	Stage 4 *Catastrophic Coverage Stage*
Because there is no deductible for the plan, this payment stage does not apply to you.	During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** You stay in this stage until your total drug costs reach the limit for the Initial Coverage Stage.	When you are in the Coverage Gap Stage (after your total Part D drug costs reach $2,970), you pay the lesser of your copayment or coinsurance, or 47.5% of the cost for covered Part D brand name drugs plus a portion of the dispensing fee. You continue to pay your copayment or coinsurance for covered Part D generic drugs. For all other covered non-Part D drugs you continue to pay your copayment or coinsurance. You stay in this stage until your total "out-of-pocket costs" (your payments) reach the limit for the Coverage Gap stage.	Most people do not reach the Catastrophic Coverage Stage. If you do reach this stage, **we will pay most of the cost** of your drugs for the rest of the calendar year (through December 31, 2013). Please note: After your out-of-pocket costs (your payments) reach $2,000, you pay no copayments or coinsurance for all covered drugs (excluding Part B drugs and products) for the remainder of the year. Please see the "Out-of-pocket maximum for outpatient prescription drugs" portion of this section for more information.

We send you reports that explain payments for your Part D drugs and which payment stage you are in

We send you a monthly report called the "Explanation of Benefits" (the "EOB")

Our plan keeps track of the costs of your Part D prescription drugs and the payments you have made when you get your Part D prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your "**out-of-pocket**" cost.
- We keep track of your Part D "**total drug costs**." This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the *Explanation of Benefits* (it is sometimes called the "EOB") when you have had one or more Part D prescriptions filled through the plan during the previous month. It includes:

- **Information for that month**. This report gives the payment details about the Part D prescriptions you have filled during the previous month. It shows the total Part D drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year.** This is called "year-to-date" information. It shows you the total Part D drug costs and total Part D payments for your drugs since the year began.

Help us keep our information about your Part D drug payments up to date

To keep track of your Part D drug costs and the payments you make for Part D drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for Part D prescription drugs when we will not automatically get the information we need to keep track of your Part D out-of-pocket costs. To help us keep track of your Part D out-of-pocket costs, you may give us copies of receipts for Part D drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to the "How to ask us to pay you back or to pay a bill you have received" portion of the "Asking us to pay our share of a bill you have received for covered medical services or drugs" section of this *Evidence of Coverage*.) Here are some types of situations when you may want to give us copies of your Part D drug receipts to be sure we have a complete record of what you have spent for your Part D drugs:
    - When you purchase a covered Part D drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.

- When you pay a copayment for Part D drugs that are provided under a drug manufacturer patient assistance program.
- Any time you have purchased covered Part D drugs at out-of-network pharmacies or other times you have paid the full price for a covered Part D drug under special circumstances.

- **Send us information about the payments for Part D drugs others have made for you.** Payments made by certain other individuals and organizations for Part D drugs also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive an *Explanation of Benefits (EOB)* in the mail, please look it over to be sure the information is complete and correct. If you think a Part D drug is missing from the report, or you have any questions, please call us at Member Services (phone numbers are printed on the back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

There is no deductible for our plan

You do not pay a deductible for your Part D drugs

There is no deductible for our plan. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See the "During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share" portion of this section for information about your coverage in the Initial Coverage Stage.

During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share

What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, the plan pays its share of the cost of your covered prescription drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

The plan's cost-sharing tiers

Every drug on the plan's Drug List is in one of the cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug:

- **Cost-Sharing Tier 1** is the lowest tier and includes preferred generic drugs.
- **Cost-Sharing Tier 2** includes preferred brand drugs. Drugs on this tier are not eligible for exceptions for payment at a lower tier.
- **Cost-Sharing Tier 3** includes non-preferred brand drugs.
- **Cost-Sharing Tier 4** (Injectable Drugs) includes injectable drugs that do not meet the Centers for Medicare & Medicaid Services (CMS) minimum cost threshold required to be placed on the Specialty Tier (Tier 5).
- **Cost-Sharing Tier 5** (Specialty Tier) includes high cost drugs. Specialty Tier (Tier 5) drugs are not eligible for exceptions for payment at a lower tier.

To find out which cost-sharing tier your drug is in, look it up in the plan's *Drug List*.

Your pharmacy choices

How much you pay for a drug depends on where you get the drug from:

- A retail pharmacy that is in our plan's network
- A pharmacy that is not in the plan's network
- The plan's mail-order pharmacy
- UC Walk-Up Service

For more information about these pharmacy choices and filling your prescriptions, see the "Using the plan's coverage for your prescription drugs" section in this booklet and the plan's *Pharmacy Directory*.

A table that shows your costs for a one-month (30-day) supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends on which cost-sharing tier your drug is in. Please note:

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay either the full price of the drug or the copayment amount, whichever is lower.

We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see the "When can you use a pharmacy that is not in the plan's network?" portion of the "Using the

plan's coverage for your Part D prescription drugs" section of this booklet for information about when we will cover a prescription filled at an out-of-network pharmacy.

Your share of the cost when you get a one-month (30-day) supply (or less) of a covered prescription drug from:

	Network pharmacy (up to a 30-day supply)	**The plan's mail-order service (Preferred Pharmacy)** (up to a 30-day supply)	**The plan's mail-order service (Non-preferred Pharmacy)** (up to a 30-day supply)	**Network long-term care pharmacy** (up to a 34-day supply)	**Out-of-network pharmacy** (coverage is limited to certain situations; see the "Using the plan's coverage for your prescription drugs" section for details.) (up to a 30-day supply)
Cost-Sharing Tier 1 (Preferred generic drugs.)	**$5**	**$5**	**$5**	**$5**	**$5**
Cost-Sharing Tier 2 (Preferred brand drugs. Drugs on this tier are not eligible for exceptions for payment at a lower tier)	**$25**	**$25**	**$25**	**$25**	**$25**
Cost-Sharing Tier 3 (Non-preferred brand drugs.)	**$40**	**$40**	**$40**	**$40**	**$40**

	Network pharmacy (up to a 30-day supply)	**The plan's mail-order service** **(Preferred Pharmacy)** (up to a 30-day supply)	**The plan's mail-order service** **(Non-preferred Pharmacy)** (up to a 30-day supply)	**Network long-term care pharmacy** (up to a 34-day supply)	**Out-of-network pharmacy** (coverage is limited to certain situations; see the "Using the plan's coverage for your prescription drugs" section for details.) (up to a 30-day supply)
Cost-Sharing Tier 4 Injectable Drugs (Includes injectable drugs that do not meet the Centers for Medicare & Medicaid Services (CMS) minimum cost threshold required to be placed on the Specialty Tier (Tier 5).)	25%	25%	25%	25%	25%
Cost-Sharing Tier 5 Specialty Tier (High cost drugs. Specialty Tier (Tier 5) drugs are not eligible for exceptions for payment at a lower tier.)	25%	25%	25%	25%	25%

	Network pharmacy (up to a 30-day supply)	**The plan's mail-order service (Preferred Pharmacy)** (up to a 30-day supply)	**The plan's mail-order service (Non-preferred Pharmacy)** (up to a 30-day supply)	**Network long-term care pharmacy** (up to a 34-day supply)	**Out-of-network pharmacy** (coverage is limited to certain situations; see the "Using the plan's coverage for your prescription drugs" section for details.) (up to a 30-day supply)
Erectile Dysfunction Drugs*	50%	N/A	N/A	N/A	N/A

*Drugs when used for the treatment of sexual or erectile dysfunction are limited to four doses per month. Drugs when used for the treatment of sexual or erectile dysfunction are limited to eight doses per month for Members who received eight doses per month prior to being Medicare-eligible and enrolling in this plan.

A table that shows your costs for a long-term (90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see the "Using the plan's coverage for your prescription drugs" section in this booklet.)

The table below shows what you pay when you get a long-term (90-day supply) of a drug.

- Please note: If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

Your share of the cost when you get a long-term (90-day) supply of a covered prescription drug from:

	Network pharmacy (a 90-day supply)	**UC Walk-Up service through UC Medical Center Pharmacies** (a 90-day supply)	**The plan's mail-order service (Preferred Pharmacy)** (a 90-day supply)	**The plan's mail-order service (Non-preferred Pharmacy)** (a 90-day supply)
Cost-Sharing Tier 1 (Preferred generic drugs.)	**$15**	**$10**	**$10**	**$15**
Cost-Sharing Tier 2 (Preferred brand drugs. Drugs on this tier are not eligible for exceptions for payment at a lower tier.)	**$75**	**$50**	**$50**	**$75**
Cost-Sharing Tier 3 (Non-preferred brand drugs.)	**$120**	**$80**	**$80**	**$120**

	Network pharmacy (a 90-day supply)	**UC Walk-Up service through UC Medical Center Pharmacies** (a 90-day supply)	**The plan's mail-order service (Preferred Pharmacy)** (a 90-day supply)	**The plan's mail-order service (Non-preferred Pharmacy)** (a 90-day supply)
Cost-Sharing Tier 4 Injectable Drugs (Includes injectable drugs that do not meet the Centers for Medicare & Medicaid Services (CMS) minimum cost threshold required to be placed on the Specialty Tier (Tier 5).)	**25%**	**25%**	**25%**	**25%**
Cost-Sharing Tier 5 Specialty Tier (High cost drugs. Specialty Tier (Tier 5) drugs are not eligible for exceptions for payment at a lower tier.)	**25%**	**25%**	**25%**	**25%**

You stay in the Initial Coverage Stage until your total out-of-pocket Part D drug costs for the year reach $4,750

You stay in the Initial Coverage Stage until your total out-of-pocket Part D drug costs reach $4,750. Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. (See the "How Medicare calculates your out-of-pocket costs for prescription drugs" portion of this section for information about how Medicare counts your out-of-pocket costs.)

When you reach an out-of-pocket limit of $4,750, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

We offer additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. **Payments made for these drugs will not count towards your initial coverage limit or total out-of-pocket costs**.

The *Explanation of Benefits* (EOB) that we send to you will help you keep track of how much you and the plan have spent for your Part D drugs during the year. Many people do not reach the $4,750 limit in a year.

We will let you know if you reach this $4,750 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

Please note: After your out-of-pocket costs (your payments) reach $2,000, you pay no copayments or coinsurance for all covered drugs (excluding Part B drugs and products) for the remainder of the year. Please see the "Out-of-pocket maximum for outpatient prescription drugs" portion of this section for more information.

How Medicare calculates your out-of-pocket costs for prescription drugs

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When you reach an out-of-pocket limit of $4,750, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

*These payments **are** **included** in your out-of-pocket costs*

*When you add up your out-of-pocket costs, **you can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in "Using the plan's coverage for your prescription drugs" section of this booklet):*

- The amount you pay for Part D drugs when you are in any of the following drug payment stages:
  - The Deductible Stage (if your plan has a deductible).
  - The Initial Coverage Stage.
- Any payments you made for Part D drugs during this plan year as a member of a different Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations.** This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand name drugs is included. But the amount the plan pays for your generic drugs is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of $4,750 in out-of-pocket costs within the plan year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

*These payments are **not** **included** in your out-of-pocket costs*

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- The amount you pay for your monthly premium (if applicable).
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage.
- Prescription drugs covered by Part A or Part B.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments made by the plan for your generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veteran's Administration.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Member Services to let us know (phone numbers are printed on the back cover of this booklet).

How can you keep track of your out-of-pocket total?

- **We will help you**. The *Explanation of Benefits* (EOB) report we send to you includes the current amount of your out-of-pocket costs (The "We send you reports that explain payments for your Part D drugs and which payment stage you are in" portion of this section tells about this report). When you reach a total of $4,750 in out-of-pocket costs for the year, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.

Make sure we have the information we need. The "Help us keep our information about your drug payments up to date" portion of this section tells what you can do to help make sure that our records of what you have spent are complete and up to date.

There is no coverage gap for our plan

You do not have a coverage gap for your Part D drugs.

There is no coverage gap for our plan. You pay your copayment or coinsurance for covered Part D generic drugs.

Medicare Coverage Gap Discount Program

When you are in the Coverage Gap Stage (after your total Part D drug costs reach $2,970), you pay the lesser of your copayment or coinsurance, or 47.5% of the cost for covered Part D brand name drugs plus a portion of the dispensing fee. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the Coverage Gap Stage.

You continue paying the lesser of your copayment or coinsurance or the discounted price for covered Part D brand name drugs until your yearly out-of-pocket payments reach a maximum amount that Medicare has set. In 2013, that amount is $4,750. Once your yearly out-of-pocket payments for Part D drugs reach $4,750, you move on to the Catastrophic Coverage Stage. See the "During the Catastrophic Coverage Stage, the plan pays most of the cost for your Part D drugs" portion below for information about your coverage in the Catastrophic Coverage Stage.

For all other covered non-Part D drugs you continue to pay your copayment or coinsurance.

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When you reach an out-of-pocket limit of $4,750, you leave the Coverage Gap Stage and move on to the Catastrophic Coverage Stage.

Please note: After your out-of-pocket costs (your payments) reach $2,000, you pay no copayments or coinsurance for all covered drugs (excluding Part B drugs and products) for the remainder of the year. Please see the "Out-of-pocket maximum for outpatient prescription drugs" portion of this section for more information.

Out-of-Pocket maximum for outpatient prescription drugs

There is a yearly out-of-pocket maximum of $2,000 for covered outpatient prescription drugs. Once your out-of-pocket costs for covered outpatient prescription drugs (excluding Part B drugs and products) reach $2,000 in the calendar year, you will not pay any more copayment/coinsurance for covered outpatient prescription drugs for the rest of the year. All expenses that apply to the $2,000 out-of-pocket maximum will automatically be calculated by Health Net.

During the Catastrophic Coverage Stage, the plan pays most of the cost for your Part D drugs

Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your Part D out-of-pocket costs have reached the $4,750 limit for the plan year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the plan year.

During this stage, the plan will pay most of the cost for your Part D drugs.

- **Your share** of the cost for a covered Part D drug will be either coinsurance or a copayment, whichever is the *larger* amount:
    - –*either* – coinsurance of 5% of the cost of the drug
    - –*or* – $2.65 copayment for a generic drug or a drug that is treated like a generic. Or a $6.60 copayment for all other drugs.
- **Our plan pays the rest** of the cost.
- **For all other covered** drugs you pay the applicable copayment or coinsurance as stated in the Initial Coverage Stage

Please note: After your out-of-pocket costs (your payments) reach $2,000, you pay no copayments or coinsurance for all covered drugs (excluding Part B drugs and products) for the remainder of the year. Please see the "Out-of-pocket maximum for outpatient prescription drugs" portion of this section for more information.

What you pay for vaccinations covered by Part D depends on how and where you get them

Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot

Our plan provides coverage of a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Medical Benefits Chart in the "Medical Benefits Chart (what is covered and what you pay)" section earlier in this booklet. There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of **the Part D vaccine medication itself**. The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the Part D vaccination shot**. (This is sometimes called the "administration" of the vaccine.)

What do you pay for a vaccination?

What you pay for a vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
    - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to the "Medical Benefits Chart (what is covered and what you pay)" section of this booklet.
    - Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary).*
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccination shot.**

What you pay at the time you get the Part D vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your Part D vaccination shot, you will have to pay the entire cost for both the Part D vaccine medication and for getting the Part D vaccination shot. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the Part D vaccine medication or the Part D vaccination shot, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccination shot.

Situation 1: You buy the Part D vaccine at the pharmacy and you get your vaccination shot at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your copayment or coinsurance for the Part D vaccine itself.
- Our plan will pay for the cost of giving you the Part D vaccination shot.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the Part D vaccination, you will pay for the entire cost of the Part D vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in the "Asking us to pay our share of a bill you have received for covered medical services or drugs" section of this booklet.

- You will be reimbursed the amount you paid less your normal copayment or coinsurance for the Part D vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

Situation 3: You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the Part D vaccination shot.

- You will have to pay the pharmacy the amount of your copayment or coinsurance for the Part D vaccine itself.
- When your doctor gives you the Part D vaccination shot, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in the "Asking us to pay our share of a bill you have received for covered medical services or drugs" section of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the Part D vaccine less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

You may want to call us at Member Services before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Member Services whenever you are planning to get a vaccination. (Phone numbers for Member Services are printed on the back cover of this booklet.)

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

Do you have to pay the Part D "late enrollment penalty"?

What is the Part D "late enrollment penalty"?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, the late enrollment penalty rules do not apply to you. You will not pay a late enrollment penalty, even if you go without "creditable" prescription drug coverage.

You may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage or you experienced a continuous period of 63 days or more when you didn't have creditable prescription drug coverage. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

The penalty is added to your monthly premium. When you first enroll in our plan, we let you know the amount of the penalty.

Your late enrollment penalty is considered part of your plan premium. If you do not pay the part of your premium that is the late enrollment penalty you could be disenrolled for failure to pay your plan premium. Please contact your employer/union benefits administrator for more information about the premium payment for this plan.

How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For our example, if you go 14 months without coverage, the penalty will be 14%.

- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2012, the average premium amount was $31.08. This amount may change for 2013.

- To get your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $31.08, which equals $4.35 which rounds to $4.40. This amount would be added **to the monthly premium for someone with a late enrollment penalty**.

There are three important things to note about this monthly late enrollment penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.

- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.

- Third, if you are under 65 and currently receiving Medicare benefits, the late enrollment penalty will reset when you turn 65. After age 65, your late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for Medicare.

In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the late enrollment penalty.

You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "**creditable drug coverage**." Please note:
    - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
        - Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean the prescription drug coverage was creditable coverage. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
    - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
    - For additional information about creditable coverage, please look in your *Medicare & You* 2013 Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.
- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

What can you do if you disagree about your late enrollment penalty?

If you disagree about your late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the letter you receive stating you have to pay a late enrollment penalty. Call Member Services to find out more about how to do this (phone numbers are printed on the back cover of this booklet).

Important: Do not stop paying your late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

Do you have to pay an extra Part D amount because of your income?

Who pays an extra Part D amount because of income?

Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, you must pay an extra amount directly to the government for your Medicare Part D coverage.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. The extra amount must be paid separately and cannot be paid with your monthly plan premium.

How much is the extra Part D amount?

If your modified adjusted gross income (MAGI) as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium.

The chart below shows the extra amount based on your income.

If you filed an individual tax return and your income in 2011 was:	If you were married but filed a separate tax return and your income in 2011 was:	If you filed a joint tax return and your income in 2011 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)
Equal to or less	Equal to or less	Equal to or less	$0

If you filed an individual tax return and your income in 2011 was:	If you were married but filed a separate tax return and your income in 2011 was:	If you filed a joint tax return and your income in 2011 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)
than $85,000	than $85,000	than $170,000	
Greater than $85,000 and less than or equal to $107,000		Greater than $170,000 and less than or equal to $214,000	$11.60
Greater than $107,000 and less than or equal to $160,000		Greater than $214,000 and less than or equal to $320,000	$29.90
Greater than $160,000 and less than or equal to $214,000	Greater than $85,000 and less than or equal to $129,000	Greater than $320,000 and less than or equal to $428,000	$48.30
Greater than $214,000	Greater than $129,000	Greater than $428,000	$66.60

What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact Social Security at 1-800-772-1213 (TTY 1-800-325-0778).

What happens if you do not pay the extra Part D amount?

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you will be disenrolled from the plan and lose prescription drug coverage.

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

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

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

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

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

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

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

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

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

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

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

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

3. If you are retroactively enrolled in our plan.

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

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

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

4. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, 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. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to the "When can you use a pharmacy that is not in the plan's network" portion of the "Using the plan's coverage for your prescription drugs" section of this booklet to learn more.)

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

5. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

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

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

How and where to send us your request for payment

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

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

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

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

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

For Prescription Drugs, mail your request for payment together with any bills or receipts to us at this address:

Health Net of California
Attn: Pharmacy
P.O. Box 9103
Van Nuys, CA 91409-9103

You must submit your claim to us within one year (for medical claims) and 3 years (for drug claims) of the date you received the service or item or drug.

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

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

We check to see whether we should cover the service or drug and how much we owe

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

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (The "Using the plan's coverage for your medical services" section of this booklet explains the rules you need to follow for getting your medical services covered. The "Using the plan's coverage for your prescription drugs" section of this booklet explains the rules you need to follow for getting your prescription drugs covered.)

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

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

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

For the details on how to make this appeal, see the "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**" section of this booklet. The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading the "A guide to 'the basics' of coverage decisions and appeals" portion in this section. This is an introductory that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read the "A guide to 'the basics' of coverage decisions and appeals" portion, you can go to the section in "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)** that tells what to do for your situation:

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

Other situations in which you should save your receipts and send copies to the plan

In some cases, you should send copies of your receipts to us to help us track your Part D out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your Part D drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your Part D out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here are two situations when you should send us copies of receipts to let us know about payments you have made for your drugs:

1. When you buy a Part D drug for a price that is lower than our price

Sometimes you can buy your drug **at a network pharmacy** for a price that is lower than the plan's price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your Part D out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

2. When you get a Part D drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any Part D drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your Part D out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your Part D out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore, you cannot make an appeal if you disagree with our decision.

YOUR RIGHTS AND RESPONSIBILITIES

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

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

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

Our plan has people and translation services available to answer questions from non-English speaking members. This information is available for free in other languages. Please contact our Member Services at 1-800-539-4072 (TTY/TDD 1-800-929-9955). Hours of operation 8:00 a.m. to 8:00 p.m., 7 days a week. We can also give you information in audio, large print or other alternate formats if you need it. If you are eligible for Medicare because of disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

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

We must treat you with fairness and respect at all times

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

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

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

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

As a member of our plan, you have the right to choose a primary care provider (PCP) in the plan's network to provide and arrange for your covered services (the "Using the plan's coverage for your medical services" section of this booklet explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are printed on the

back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers ***within a reasonable amount of time***. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

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

We must protect the privacy of your personal health information

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

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.

- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.

- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.

- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.

    - For example, we are required to release health information to government agencies that are checking on quality of care.

- Because you are a member of our Medicare plan, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your healthcare provider to decide whether the changes should be made.

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

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

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

As a member of our plan, you have the right to get several kinds of information from us. This includes information about Health Net, its services, its providers and member rights and responsibilities. (As explained above in the "We must provide information in a way that works for you (in languages other than English, in audio, in large print, or other alternate formats, etc.)" portion above, you have the right to get information from us in a way that works for you. This includes getting the information in large print or other alternate formats.

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

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare Advantage health plans.

- **Information about our network providers including our network pharmacies.**

  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.

  - For a list of the providers in the plan's network, see the Provider Directory.

  - For a list of the pharmacies in the plan's network, see the *Pharmacy Directory.*

- For more detailed information about our providers or pharmacies, you can visit our website at www.healthnet.com/uc or call Member Services (phone numbers are printed on the back cover of this booklet).

- **Information about your coverage and rules you must follow in using your coverage.**

  - In the "Using the plan's coverage for your medical services and Medical Benefits Chart (what is covered and what you pay)"and "Using the plan's coverage for your prescription drugs" sections of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.

  - To get the details on your prescription drug coverage, see the "Using the plan's coverage for your prescription drugs" and the "What you pay for your prescription drugs" sections of this booklet plus the plan's *List of Covered Drugs (Formulary).* These sections, together with the *List of Covered Drugs (Formulary)*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.

  - If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).

- **Information about why something is not covered and what you can do about it.**

  - If a medical service or drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.

  - If you are not happy or if you disagree with a decision we make about what medical care or drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see the "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**" section of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (The "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**" section also tells about how to make a complaint about quality of care, waiting times, and other concerns.)

  - If you want to ask our plan to pay our share of a bill you have received for medical care or a prescription drug, see the "Asking us to pay our share of a bill you have received for covered medical services or drugs" section of this booklet.

We must support your right to make decisions about your care

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

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

- **The right to say "no.**" You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. The "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**" section of this booklet tells how to ask the plan for a coverage decision.

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

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

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself, and to name an alternative person as backup.

- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself, such as for life support treatment.

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

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

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, from the California Medical Association by calling 1-800-882-1262 (National Relay Service 711) or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Member Services to ask for the forms (phone numbers are printed on the back cover of this booklet).

- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. It must be notarized or witnessed by two qualified individuals. You should consider having a lawyer help you prepare it.

- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

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

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

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

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

Physician Orders for Life Sustaining Treatment (POLST)

You may also consider completing a POLST form if you are terminally ill or in frail health. This form must be signed by your physician and allows you to give specific end-of-life treatment instructions, such as for pain management, resuscitation, feeding procedures and other medical interventions. It has the force of a physician's medical order and remains with you wherever you receive care. It is in addition to, and does not replace, an advance directive.

What if your instructions are not followed?

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

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

The telephone number is 1-800-368-1019 or 1-415-437-8310 (National Relay Service: 711).

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

If you have any problems or concerns about your covered services or care, the "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**" section of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**" section of this booklet, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

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

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

If you have any questions or concerns about the rights and responsibilities or if you have suggestions to improve our member rights policy share your thoughts with us by contacting Member Services.

Evaluation of new technologies

New technologies include procedures, drugs, biological product, or devices that have recently been developed for the treatment of specific diseases or conditions, or are new applications of existing procedures, drugs, biological products, and devices. New technologies are considered investigational if there is no conclusive medical and scientific evidence in published peer-reviewed medical literature that the drug, biological product, device, or procedure has a

beneficial effect on health outcomes, there is no clearance from a federal, governmental regulatory body, or other governmental agency (e.g., U.S. Food and Drug Administration (FDA)) for final and unrestricted market approval for use in the treatment of a specified condition, and not generally accepted by the medical community.

Health Net, Inc. assesses technology through an established process for recognizing and evaluating advances in new technologies and new applications of existing technologies which should be included in applicable benefit plans and to ensure members have access to safe and effective care. Health Net, Inc. may rely upon published evaluations and clinical recommendations of recognized experts (e.g., national medical associations, independent medical panels, technology assessment organizations, and practicing physicians). Such experts base their evaluations and findings on the scientific quality of the supporting evidence and rationale for the new technologies or new applications. Health Net, Inc.'s Medical Advisory Council has the responsibility for assessing new technology and new applications and for medical policy decisions. Medicare's National and Local Coverage Determinations, when applicable, are also followed.

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

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

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

Is it about something else?

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

- You can **call Member Services** (phone numbers are printed on the back cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, see the "Important phone numbers and resources" section of this booklet.
- Or, **you can call Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

How to get more information about your rights

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

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

- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, see the "Important phone numbers and resources" section of this booklet.

- You can contact **Medicare**.

    - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." The publication is available at: http://www.medicare.gov/Publications/Pubs/pdf/11534.pdf.

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

You have some responsibilities as a member of the plan

What are your responsibilities?

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

- ***Get familiar with your covered services and the rules you must follow to get these covered services.*** *Use this* Evidence of Coverage *booklet to learn what is covered for you and the rules you need to follow to get your covered services.*

    - The "Using the plan's coverage for your medical services" and "Medical Benefits Chart (what is covered and what you pay)" sections give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.

    - The "Using the plan's coverage for your prescription drugs" and "What you pay for your prescription drugs" sections give the details about your coverage for prescription drugs.

- ***If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.*** *Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).*

    - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "**coordination of benefits**" because it involves

coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We'll help you with it. (For more information about coordination of benefits, go to the "How other insurance works with our plan" portion of the "Getting started as a member" section of this booklet.)

- ***Tell your doctor and other health care providers that you are enrolled in our plan.*** *Show your plan membership card whenever you get your medical care or prescription drugs.*

- ***Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.***

  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health, and work with them to develop mutually agreed upon goals. Follow the treatment plans and instructions that you and your doctors agree upon.

  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.

  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

- ***Be considerate.*** *We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.*

- ***Pay what you owe.*** *As a plan member, you are responsible for these payments:*

  - You must pay your plan premiums to continue being a member of our plan. Please contact your employer/union benefits administrator for information about your plan premium.

  - In order to be eligible for our plan, you must have Medicare Part A and Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.

  - For most of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). The "Medical Benefits Chart (what is covered and what you pay)" section of this booklet tells what you must pay for your medical services. The "What you pay for your

prescription drugs" section of this booklet tells what you must pay for your prescription drugs.

- If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
    - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see the "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**" section of this booklet for information about how to make an appeal.
- If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
- If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a member of the plan.

- ***Tell us if you move.*** *If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).*
    - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (The "Getting started as a member" section tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
    - **If you move *within* our service area, we still need to know** so we can keep your membership record up to date and know how to contact you.
- ***Call Member Services for help if you have questions or concerns.*** *We also welcome any suggestions you may have for improving our plan.*
    - Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.
    - For more information on how to reach us, including our mailing address, please see the "Important phone numbers and resources" section of this booklet.

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

BACKGROUND

Introduction

What to do if you have a problem or concern

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

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

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

Which one do you use? That depends on the type of problem you are having. The guide in "To deal with your problem, which process should you use?" portion will help you identify the right process to use.

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

What about the legal terms?

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

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

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

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

Where to get more information and personalized assistance

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

Get help from an independent government organization

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

The services of SHIP counselors are free. You will find phone numbers in the "Important phone numbers and resources" section of this booklet.

You can also get help and information from Medicare

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

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

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

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

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

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

Is your problem or concern about your benefits or coverage?

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

Yes. My problem is about benefits or coverage.	**No.** My problem is not about benefits or coverage.
Go on to the next portion of this section **"A guide to 'the basics' of coverage decisions and making appeals."**	Skip ahead to **the portion** at the end of this section: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

COVERAGE DECISIONS AND APPEALS

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

Asking for coverage decisions and making appeals: the big picture

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

Asking for coverage decisions

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

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

Making an appeal

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

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision.

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

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

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

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

- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see the "You can get help from government organizations that are not connected with us" portion of this section).

- For Part D prescription drugs, your doctor or other prescriber can request a coverage determination or a Level 1 or 2 appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.

- For medical care, a doctor can make a request for you. Your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.

- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
    - There may be someone who is already legally authorized to act as your representative under State law.
    - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or on our website at http://www.healthnet.com/uc.) The form gives that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Which portion of this section gives the details for your situation?

There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one separately. Please refer to the following portions of this section for more information:

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

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

Program (the "Important phone numbers and resources" section of this booklet has the phone numbers for this program).

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

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

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

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

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

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

2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.

3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.

4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.

5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

    - NOTE: **If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services**, you need to read a separate portion of this section because special rules apply to these types of care. Here's what to read in those situations:

        - The "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon" portion of the "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**"section of this booklet.

- The "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" portion of the "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**" section of the booklet tells about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.

- For *all other* situations that involve being told that medical care you have been getting will be stopped, use this portion ("Your medical care: How to ask for a coverage decision or make an appeal") of this section as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	**This is what you can do:**
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next portion of this section, "**Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)"**.
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an **appeal**. (This means you are asking us to reconsider.) Skip ahead to the "**Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)"** portion of this section.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to the **"What if you are asking us to pay you for our share of a bill you have received for medical care?"** portion of this section.

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

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

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

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

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, see the "Important phone numbers and resources" section of this booklet, and look for the portion called, "How to contact us when you are asking for a coverage decision about your medical care."

Generally we use the standard deadlines for giving you our decision

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

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

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

- **A fast coverage decision means we will answer within 72 hours.**
    - **However, we can take up to 14 more calendar days** if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
    - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see the "How to make a complaint about quality of care, waiting times, customer service, or other concerns" portion of this section.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
    - You can get a fast coverage decision only if you are asking for coverage for medical care *you have not yet received*. You cannot get a fast coverage decision if your request is about payment for medical care you have already received.
    - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*
- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.
    - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
    - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
    - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see the "How to make a complaint about quality of care, waiting times, customer service, or other concerns" portion of this section.)

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

*Deadlines for a **"fast"** coverage decision*

- Generally, for a fast coverage decision, we will give you our answer **within 72 hours**.
    - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. If we take extra days, it is called "an extended time period."
    - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see the "How to make a complaint about quality of care, waiting times, customer service, or other concerns" portion of this section.).
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested,** we will send you a detailed written explanation as to why we said no.

*Deadlines for a **"standard"** coverage decision*

- Generally, for a standard coverage decision, we will give you our answer **within 14 days of receiving your request.**
    - We can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
    - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see the "How to make a complaint about quality of care, waiting times, customer service, or other concerns" portion of this section.)
    - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. The "Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)" portion below tells how to make an appeal.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our coverage decision, we will provide the coverage by the end of that extended period.

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

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

- If we say no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.

- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see the "Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)" portion below.

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

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

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

What to do

- **To start an appeal you, your doctor or your representative, must contact our plan.** For details on how to reach us for any purpose related to your appeal, see the "Important phone numbers and resources" section of this booklet.

- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a signed request.**

    - If you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the

"Appointment of Representative" form. It is also available on Medicare's website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or on our website at www.healthnet.com/uc.) While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form within 44 days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be sent to the Independent Review Organization for dismissal.

- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in the "Important phone numbers and resources" section of this booklet.

- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

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

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

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

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

- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)

- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

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

- When our plan is reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.

- We will gather more information if we need it. We may contact you or your doctor to get more information.

*Deadlines for a **"fast" appeal***

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.

    - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days.** If we decide to take extra days to make the decision, we will tell you in writing.

    - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.

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

*Deadlines for a **"standard" appeal***

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.

    - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days.**

    - If you believe we should *not* take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see the

"How to make a complaint about quality of care, waiting times, customer service, or other concerns" portion of this section.)

- If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.

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

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

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

Step-by-step: How to make a Level 2 Appeal

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

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

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- We will send the information about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**.

- You have a right to give the Independent Review Organization additional information to support your appeal.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

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

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.

- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

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

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.

- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**.

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

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

- **If the review organization says yes to part or all of what you requested,** we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization.

- **If this organization says no to part or all of your appeal**, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")

    - The written notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too

low, you cannot make another appeal, which means that the decision at Level 2 is final.

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

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

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

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

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see the "Asking for coverage decisions and making appeals: the big picture" portion of this section). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see the "Medical Benefits Chart (what is covered and what you pay)" section of this booklet). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in the "Using the plan's coverage for your medical services" section of this booklet).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. (When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)

- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

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

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

To make this appeal, follow the process for appeals that we describe in the "Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)" part of this section. Go to this part for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)

- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

Your prescription drugs: How to ask for a coverage decision or make an appeal

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

This section tells you what to do if you have problems getting a drug or you want us to pay you back for a drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan's *List of Covered Drugs (Formulary).* To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See the "Your drugs need to be on the plan's 'Drug List'" portion of the "Using the plan's coverage for your prescription drugs" section of this booklet for more information about a medically accepted indication.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.

- For details about what we mean by Part D drugs, the *List of Covered Drugs*, (*Formulary*) rules and restrictions on coverage, and cost information, see the "Using our plan's coverage for your prescription drugs" and "What you pay for your prescription drugs" sections of this booklet.

Coverage decisions and appeals

As discussed in the "A guide to 'the basics' of coverage decisions and appeals" portion of this section, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms	An initial coverage decision about your Part D drugs is called a **"coverage determination."**

Here are examples of coverage decisions you ask us to make about your drugs:

- You ask us to make an exception, including:
    - Asking us to cover a drug that is not on the plan's *List of Covered Drugs (Formulary)*
    - Asking us to waive a restriction on the plan's coverage for a drug (such as limits on the amount of the drug you can get)
    - Asking to pay a lower cost-sharing amount for a covered Part D drug on Tier 3 (Non-preferred brand drugs) or Tier 4 (Injectable Drugs)
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan's *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you.)
    - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use this chart below to help you determine which part has information for your situation:

Which of these situations are you in?			
Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you have already received and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.) Start with **the "What is an exception?"** portion of this section.	You can ask us for a coverage decision. Skip ahead to **the "Step-by-step: How to ask for a coverage decision, including an exception"** portion of this section.	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to **the "Step-by-step: How to ask for a coverage decision, including an exception"** portion of this section	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **the "Step-by-step: How to make a Level 1 Appeal for a Part D drug (how to ask for a review of a coverage decision made by our plan)** portion of this section.

What is an exception?

If a Part D drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a drug for you that is not on our *List of Covered Drugs (Formulary).*** (We call it the "Drug List" for short.)

Legal Terms	Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a **"formulary exception."**

   - If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in Tier 3 (Non-preferred brand drug).

   - If we agree to make an exception and cover a Part D drug, you cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the Part D drug.

2. **Removing a restriction on our coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to the "Using your plan's coverage for your prescription drugs" section of this booklet).

Legal Terms	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a **"formulary exception."**

   - The extra rules and restrictions on coverage for certain drugs include:

     - *Being required to use the generic version* of a drug instead of the brand name drug.

     - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")

     - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called "step therapy.")

     - *Quantity limits*. For some drugs, there are restrictions on the amount of the drug you can have.

   - If we agree to make an exception and waive a restriction on a Part D drug for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. **Changing coverage of a drug to a lower cost-sharing tier (this type of exception only applies to Part D drugs).** Every drug on our Drug List is in one of the cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms	Asking to pay a lower preferred price for a covered non-preferred Part D drug is sometimes called asking

for a **"tiering exception."**

- If your Part D drug is in Tier 3 (Non-preferred brand drugs) or Tier 4 (Injectable Drugs) you can ask us to cover it at the cost-sharing amount that applies to drugs in Tier 2 (Preferred brand drugs). This would lower your share of the cost for the drug.

- You cannot ask us to change the cost-sharing tier for any drug in Tier 2 (Preferred brand drugs), Tier 5 (Specialty Tier), or non-Part D drugs.

Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. The "Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)" portion of this section tells how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Step-by-step: How to ask for a coverage decision, including an exception

Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a "fast coverage decision." You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other

prescriber) can do this. For the details, go to the "Important phone numbers and resources" section of this booklet and look for the portion called, "How to contact us when you are asking for a coverage decision about your prescription drugs." Or if you are asking us to pay you back for a drug, go to the portion called, "Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received."

- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. The "A guide to 'the basics' of coverage decisions and appeals" portion of this section tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.

- **If you want to ask us to pay you back for a drug,** start by reading the "Asking us to pay our share of a bill you have received for covered medical services or drugs" section of this booklet. The "Asking us to pay our share of a bill you have received for covered medical services or drugs" section of this booklet describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.

- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See the "What is an exception?" and "Important things to know about asking for exceptions" portions of this section for more information about exception requests.

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

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

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours.

- **To get a fast coverage decision, you must meet two requirements:**

  - You can get a fast coverage decision only if you are asking for a *drug you have not yet received*. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)

  - You can get a fast coverage decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*

- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**

- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.

    - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).

    - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.

    - The letter will also tell how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see the "How to make a complaint about quality of care, waiting times, customer service, or other concerns" portion of this section.)

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

*Deadlines for a **"fast"** coverage decision*

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.

    - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.

    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.

- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.

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

*Deadlines for a **"standard"** coverage decision about a drug you have not yet received*

- If we are using the standard deadlines, we must give you our answer **within 72 hours.**
    - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
    - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Deadlines for a "standard" coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
    - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested,** we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

- If we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

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

Legal Terms	An appeal to the plan about a drug coverage decision is called a plan **"redetermination."**

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

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
  - For details on how to reach us by phone, fax, or mail for any purpose related to your appeal, see the "Important phone numbers and resources" section of this booklet, and look for the portion called, "How to contact us when you are making an appeal about your prescription drugs."
- **If you are asking for a standard appeal, make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in "**Important phone numbers and resources" section of this booklet**,** ("How to contact our plan when you are making an appeal about your prescription drugs").
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information in your appeal and add more information.**

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

If your health requires it, ask for a "fast appeal"

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

- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in the "Step-by-step: How to ask for a coverage decision, including an exception" portion of this section.

Step 2: Our plan considers your appeal for a Part D drug and we give you our answer.

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

*Deadlines for a **"fast" appeal***

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
  - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

*Deadlines for a **"standard" appeal***

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for a "fast" appeal.
    - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested –**
    - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
    - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Step 3: If we say no to your appeal for a Part D drug, you decide if you want to continue with the appeals process and make *another* appeal.

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Step-by-step: How to make a Level 2 Appeal for a Part D drug

If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

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

Step 1: To make a Level 2 Appeal for a Part D drug, you must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.

- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." **You have the right to ask us for a copy of your case file**.

- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization does a review of your appeal for a Part D drug and gives you an answer.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

*Deadlines for **"fast" appeal** at Level 2*

- If your health requires it, ask the Independent Review Organization for a "fast appeal."

- If the review organization agrees to give you a "fast appeal," the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.

- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

*Deadlines for **"standard" appeal** at Level 2*

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.

- **If the Independent Review Organization says yes to part or all of what you requested –**

- If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.

- If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to s**end payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal for a Part D drug?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).

- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.

- The Level 3 Appeal is handled by an administrative law judge. The "Taking your appeal to Level 3 and beyond" portion in this section tells more about Levels 3, 4, and 5 of the appeals process.

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

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

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

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

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

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

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

Legal Terms	The written notice from Medicare tells you how you can **"request an immediate review."** Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (The "Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date" portion tells you how you can request an immediate review.)

2. **You must sign the written notice to show that you received it and understand your rights.**
    - You or someone who is acting on your behalf must sign the notice. (The "A guide to 'the basics' of coverage decisions and appeals" portion of this section tells how you can give written permission to someone else to act as your representative.)
    - Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does *not* mean** you are agreeing on a discharge date.

3. **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
    - If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
    - To look at a copy of this notice in advance, you can call Member Services (phone numbers are printed on the back cover of this booklet) or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

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

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

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see the "You can get help from government organizations that are not connected with us" portion of this section).

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

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

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

What is the Quality Improvement Organization?

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

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in the "You can get help from government organizations that are not connected with us" portion in the "Important phone numbers and resources" section of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
    - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
    - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see the "What if you miss the deadline for making your Level 1 Appeal?" portion of this section.

Ask for a "fast review":

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

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

<u>Step 2:</u> The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.

- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

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

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

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**

- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See the "Medical Benefits Chart (what is covered and what you pay)" section of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, **our coverage for your inpatient hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.

- If the review organization says *no* to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

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

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

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

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

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

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

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

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

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

Step 3: Within 14 calendar days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

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

If the review organization says no:

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

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- The "Taking your appeal to Level 3 and beyond" portion in this section tells more about Levels 3, 4, and 5 of the appeals process.

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

You can appeal to us instead

As explained above in the "Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date" portion, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date). If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

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

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

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

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

- For details on how to contact our plan, see the "Important phone numbers and resources" section of this booklet, and look for the portion called, "How to contact our plan when you are making an appeal about your medical care."
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast" review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.

- If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If we say *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

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

Step-by-Step: How to make a Level 2 Alternate Appeal

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

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

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. The "How to make a complaint about quality of care, waiting times, customer service, or other concerns" portion of this section tells how to make a complaint.).

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.

- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says *no* to your appeal,** it means they agree with us that your planned hospital discharge date was medically appropriate.

    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.

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

How to ask us to keep covering certain medical services if you think your coverage is ending too soon

This section is about three services only:
Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is about the following types of care *only*:

- **Home health care services** you are getting.

- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see the "Definitions of important words" section in this booklet.)

- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see the "Definitions of important words" section in this booklet.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see the "Medical Benefits Chart (what is covered and what you pay)" section in this booklet.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, *we will stop paying our share of the cost for your care.*

If you think we are ending the coverage of your care too soon, **you can appeal our decision**. This section tells you how to ask for an appeal.

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

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice.
   - The written notice tells you the date when we will stop covering the care for you.
   - The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms	In telling you what you can do, the written notice is telling how you can request a **"fast-track appeal."** Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (The "Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time" portion below tells how you can request a fast-track appeal.)

Legal Terms	The written notice is called the "**Notice of Medicare Non-Coverage."** To get a sample copy, call Member Services (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227, 24 hours a

day, 7 days a week. TTY users should call 1-877-486-2048.). Or get a copy online at http://www.cms.hhs.gov/BNI/

2. **You must sign the written notice to show that you received it.**
    - You or someone who is acting on your behalf must sign the notice. (The "A guide to 'the basics' of coverage decisions and appeals" portion of this section tells how you can give written permission to someone else to act as your representative.)
    - Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with the plan that it's time to stop getting the care.

Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. The "How to make a complaint about quality of care, waiting times, customer service, or other concerns" portion of this section tells you how to file a complaint.)
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see the "You can get help from government organizations that are not connected with us" portion of this section).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in the "Important phone numbers and resources," section of this booklet.)

What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal *no later than noon of the day after you receive the written notice telling you when we will stop covering your care*.

- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see the "What if you miss the deadline for making your Level 1 Appeal?" portion of this section.

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.

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

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

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

What happens if the reviewers say yes to your appeal?

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

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

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

- This first appeal you make is "Level 1" of the appeals process. If reviewers say *no* to your Level 1 Appeal – <u>and</u> you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal <u>and</u> you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another

look at the decision they made on your first appeal. If we turn down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

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

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

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

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

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

Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.

- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it.

- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- The "Taking your appeal to Level 3 and beyond" portion of this section tells more about Levels 3, 4, and 5 of the appeals process.

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

You can appeal to us instead

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

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

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

Here are the steps for a Level 1 Alternate Appeal:

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

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

- For details on how to contact us, see the "Important phone numbers and resources" section of this booklet, and look for the portion called, "How to contact our plan when you are making an appeal about your medical care."
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast" review of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan's coverage for services you were receiving.

- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a "fast review," we are allowed to decide whether to agree to your request and give you a "fast review." But in this situation, the rules require us to give you a fast response if you ask for it.)

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say no to your fast appeal,** then your coverage will end on the date we have told you and we will not pay after this date. We will stop paying our share of the costs of this care.

- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end, then **you will have to pay the full cost** of this care yourself.

Step 4: If we say *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

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

Step-by-Step: How to make a Level 2 Alternate Appeal

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

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

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. The "How to make a complaint about quality of care, waiting times, customer service, or other concerns" portion of this section tells how to make a complaint.)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

- **If this organization says *yes* to your appeal,** then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.

    - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.

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

Taking your appeal to Level 3 and beyond

Levels of Appeal 3, 4, and 5 for Medical Service Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal	**A judge who works for the Federal government** will review your appeal and give you an answer. This judge is called an "Administrative Law Judge."

- **If the Administrative Law Judge says yes to your appeal, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the judge's decision.
    - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge says no to your appeal, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal	The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over -** We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
    - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals Council's decision.
    - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Medicare Appeals Council denies the review request, the appeals process *may* or *may not* be over**.
    - If you decide to accept this decision that turns down your appeal, the appeals process is over.
    - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the **Federal District Court** will review your appeal.

- This is the last step of the administrative appeals process.

Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal	**A judge who works for the Federal government** will review your appeal and give you an answer. This judge is called an

"Administrative Law Judge."

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.

- **If the answer is no, the appeals process *may* or *may not* be over**.

  - If you decide to accept this decision that turns down your appeal, the appeals process is over.

  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal The **Medicare Appeals Council** will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize or provide the drug coverage** that was approved by the Medicare Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.

- **If the answer is no, the appeals process *may* or *may not* be over**.

  - If you decide to accept this decision that turns down your appeal, the appeals process is over.

  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

MAKING COMPLAINTS

How to make a complaint about quality of care, waiting times, customer service, or other concerns

?

If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to the "A guide to 'the basics' of coverage decisions and appeals" portion of this section.

What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only.* This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint"

Quality of your medical care

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

Disrespect, poor customer service, or other negative behaviors

- Has someone been rude or disrespectful to you?
- Are you unhappy with how our Member Services has treated you?
- Do you feel you are being encouraged to leave the plan?

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at the plan?
  - Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.

Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

Information you get from us

- Do you believe we have not given you a notice that we are required to give?
- Do you think written information we have given you is hard to understand?

The next page has more examples of possible reasons for making a complaint

Possible complaints
(continued)

These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in the earlier portions of this section. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked us for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a “fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint.
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

The formal name for "making a complaint" is "filing a grievance"

Legal Terms

- What this section calls a **"complaint"** is also called a **"grievance."**
- Another term for **"making a complaint"** is **"filing a grievance."**
- Another way to say "**using the process for complaints"** is "**using the process for filing a grievance."**

Step-by-step: Making a complaint

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

- **Usually, calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. 1-800-539-4072. Calls to this number are free. Hours of Operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. TTY/TDD: 1-800-929-9955.

- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.

- If you ask for a written response, file a written complaint (grievance), or if your complaint is related to quality of care, we will respond to you in writing. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaint. We call this the Grievance Procedure.** To make a complaint, or if you have questions about this procedure, please call Member Services at the phone number above. Or, you may mail or fax us a written request to the address or fax number listed under Appeals for Medical Care or Complaints about Medical Care and Appeals for Prescription Drugs or Complaints about Prescription Drugs in the "Important phone numbers and resources" section of this booklet.
    - You need to file your complaint within 60 calendar days after the event. (We can give you more time for Part D prescription drug complaints if you have a good reason for missing the deadline.) You can submit your Grievance, formally, in writing or via fax at the address or fax number listed under Appeals for Medical Care or Complaints about Medical Care, and Appeals for Prescription Drugs or Complaints about Prescription Drugs, in the "Important phone numbers and resources" section of this booklet.

- We must notify you of our decision about your complaint (grievance) as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.
- In certain cases, you have the right to ask for a fast review of your complaint. This is called the Expedited Grievance Procedure. You are entitled to a fast review of your complaint if you disagree with our decision in the following situations:
  - We deny your request for a fast review of a request for medical care or Part D drugs.
  - We deny your request for a fast review of an appeal of denied services or Part D drugs.
  - We decide additional time is needed to review your request for medical care.
  - We decide additional time is needed to review your appeal of denied medical care.

  You may submit this type of complaint by phone by calling Member Services at the number on the back cover of this booklet. You may also submit the complaint to us in writing or by fax at the address or fax number listed under Appeals for Medical Care or Complaints about Medical Care, and Appeals for Prescription Drugs or Complaints about Prescription Drugs, in the "Important phone numbers and resources" section of this booklet. Once we receive the expedited grievance (complaint), a Clinical Practitioner will review the case to determine the reasons for the denial of your request for a fast review or if the case extension was appropriate. We will notify you of the decision of the fast case orally and in writing within 24 hours of receiving your complaint.

- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.

- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast" complaint.** If you have a "fast" complaint, it means we will give you **an answer within 24 hours**.

Legal Terms	What this section calls a **"fast complaint"** is also called an **"expedited grievance."**

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.

- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to us).

    - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients.

    - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in the "Important phone numbers and resources" section of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.

- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users can call 1-877-486-2048.

Appeals Procedures for your Employer-Sponsored Benefits

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

This portion of this section 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 arranging for someone to provide it. There are 4 possible steps for requesting care or payment of Employer-Sponsored Benefits.

STEP 1: The Initial Decision

The starting point is when we make an Initial Decision about your care or about paying for care you have already received. When we make an Initial Decision, we are giving our interpretation of how the benefits and services that are covered for Members of Seniority Plus 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** (TDD/TTY **1-800-929-9955**) 8:00 a.m. to 8:00 p.m., seven days a week or by sending information to:

Health Net
Appeals & Grievance Department
P.O. Box 10344
Van Nuys, CA 91410-0344

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.

- 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** (TDD/TTY **1-800-929-9955**) 8:00 a.m. to 8:00 p.m., seven days a week to request the independent review or by sending the request to:

Health Net
Appeals & Grievance Department
P.O. Box 10344
Van Nuys, CA 91410-0344

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

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

STEP 4: Binding Arbitration

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

ENDING YOUR MEMBERSHIP IN THE PLAN

Introduction

This section focuses on ending your membership in our plan

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

- You might leave our plan because you have decided that you *want* to leave.
    - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. The "When can you end your membership in our plan?" portion of this section tells you *when* you can end your membership in the plan.
    - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. The "How do you end your membership in our plan?" portion of this section tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. The "We must end your membership in the plan in certain situations" portion of this section tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care through our plan until your membership ends.

When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period and during the annual Medicare Advantage Disenrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

You can end your membership during the Annual Enrollment Period

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

- Please contact your employer's or union's benefits administrator for information regarding other plan options and/or questions about your employer's or union's open enrollment season.

- From October 15 through December 7, during the Annual Coordinated Election Period (AEP), anyone with Medicare may switch from one way of getting Medicare to another for the following year. Your change will take effect on January 1.
- There may be other limited times during which you may make changes. For more information about these times and the options available to you, please refer to the "Medicare & You" handbook you receive each fall. You may also call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.or visit www.medicare.gov to learn more about your options.

You can end your membership during the annual Medicare Advantage Disenrollment Period, but your choices are more limited

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

- **When is the annual Medicare Advantage Disenrollment Period?** This happens every year from January 1 to February 14.
- **What type of plan can you switch to during the annual Medicare Advantage Disenrollment Period?** During this time, you can cancel your Medicare Advantage plan enrollment and switch to Original Medicare. If you choose to switch to Original Medicare, during this period you have until February 14 to join a separate Medicare prescription drug plan to add drug coverage.
- **When will your membership end?** Your membership will end on the first day of the month after we get your request to switch to Original Medicare. If you also choose to enroll in a Medicare prescription drug plan, your membership in the drug plan will begin the first day of the month after the drug plan gets your enrollment request.

In certain situations, you can end your membership during a Special Enrollment Period

In certain situations, members of our plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (http://www.medicare.gov):
    - Usually, when you have moved.
    - If you have Medi-Cal (Medicaid).

- If you are eligible for Extra Help with paying for your Medicare prescriptions.
- If we violate our contract with you.
- If you are getting care in an institution, such as a nursing home or long-term care hospital.
- If you enroll in the Program of All-inclusive Care for the Elderly (PACE).

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.

- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
  - Another Medicare Advantage health plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
  - Original Medicare *with* a separate Medicare prescription drug plan.
  - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.
    - **If you receive Extra Help from Medicare to pay for your prescription drugs:** If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

  Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See the "Do you have to pay the Part D "late enrollment penalty"?" portion in the "What you pay for your prescription drugs" section of this booklet for more information about the late enrollment penalty.

- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

Where can you get more information about when you can end your membership?

If you have any questions or would like more information on when you can end your membership:

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

- You can find the information in the ***Medicare & You 2013*** Handbook.
    - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
    - You can also download a copy from the Medicare website (http://www.medicare.gov). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

How do you end your membership in our plan?

Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see the "When can you end your membership in our plan?" portion of this section for information about the enrollment periods). However, if you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, ask to be disenrolled from our plan.

There are two ways you can ask to be disenrolled:

- You can make a request in writing to us. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet).
- --*or*--You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See the "Do you have to pay the Part D "late enrollment penalty"?" portion of the "What you pay for your prescription drugs" section of this booklet for more information about the late enrollment penalty.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
• Another Medicare health	• Enroll in the new Medicare health plan.

If you would like to switch from our plan to:	This is what you should do:
plan.	You will automatically be disenrolled from our plan when your new plan's coverage begins.
• Original Medicare *with* a separate Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from our plan when your new plan's coverage begins.
• Original Medicare *without* a separate Medicare prescription drug plan. • **Note:** If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See the "Do you have to pay the Part D "late enrollment penalty"?" portion in the "What you pay for your prescription drugs" section of this booklet for more information about the late enrollment penalty.	• **Send us a written request to disenroll** Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). • You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048. • You will be disenrolled from our plan when your coverage in Original Medicare begins.

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

Until your membership ends, you are still a member of our plan

If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See the "When can you end your membership in our plan?" portion of this section for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.

- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

We must end your membership in the plan in certain situations

When must we end your membership in the plan?

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

- If you do not stay continuously enrolled in Medicare Part A and Part B.

- If you move out of our service area

- If you are away from our service area for more than six months.

    - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. (Phone numbers for Member Services are printed on the back cover of this booklet.)

- If you become incarcerated (go to prison).

- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.

- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)

- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)

- If you let someone else use your membership card to get medical care. (We cannot make you leave our plan for this reason unless we get permission from Medicare first.)

    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

- If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our plan and you will lose prescription drug coverage.

When Coverage Ends

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

Involuntarily ending your membership due to termination of the Group Policy

All Group Members

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

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

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

- The Group will provide Health Net with timely notice of termination of the Group Service Agreement or the ineligibility of a Member to participate in the Group sponsored plan. Such notice must be prospective, not retroactive.

- The Group must provide a prospective notice to its Members alerting them of the termination event and of other insurance options that may be available to them through their employer or union.

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

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

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

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

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

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

- The Member establishes primary residency outside the continental United States.

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

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

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

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

Individual Members - Termination for Cause

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

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

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

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

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

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

Coverage Options Following Termination

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

COBRA Continuation Coverage

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

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

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

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

What should you do if this happens?

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

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

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in the "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**" section of this booklet for information about how to make a complaint.

LEGAL NOTICES

Notice about governing law

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

Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, 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.

Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, our plan, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any State laws.

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

When you are injured

If you are ever injured through the actions of another person, or yourself (responsible party), Health Net will provide benefits for all covered services that you receive through this Plan. However, if you receive money or are entitled to receive money because of your injuries, whether through a settlement, judgment or any other payment associated with your injuries, Health Net or the medical providers retain the right to recover the value of any services provided to you through this Plan.

As used throughout this provision, the term responsible party means any party actually or potentially responsible for making any payment to a Member due to a Member's injury, illness or condition. The term responsible party includes the liability insurer of such party or any insurance coverage.

Some examples of how you could be injured through the actions of a responsible party are:

- You are in a car accident;
- You slip and fall in a store.

Health Net's rights of recovery apply to any and all recoveries made by you or on your behalf from the following sources, including but not limited to:

- Payments made by a third party or any insurance company on behalf of a third party;
- Uninsured or underinsured motorist coverage;
- Personal injury protection, no fault or any other first party coverage;
- Workers Compensation or Disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' insurance coverage, umbrella coverage;
- Medical expenses incurred as a result of medical malpractice; and
- Any other payments from any other source received as compensation for the responsible party's actions.

By accepting benefits under this Plan, you acknowledge that Health Net has a first priority right of subrogation and reimbursement that attaches when this Plan has paid for health care benefits for expenses incurred due to the actions of a responsible party and you or your representative recovers or is entitled to recover any amounts from a responsible party.

By accepting benefits under this Plan, you also grant Health Net an assignment of your right to recover medical expenses from any coverage available to the extent of the full cost of all covered services provided by the Plan and you specifically direct such carriers to directly reimburse the Plan on your behalf.

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

Steps you must take

If you are injured because of a responsible party, you must cooperate with Health Net and/or the medical providers' efforts to recover its expenses, including:

- Telling Health Net and the medical providers the name and address of the responsible party, if you know it, the name and address of your lawyer, if you are using a lawyer, the name and address of any insurance company involved with your injuries and describing how the injuries were caused.
- Completing any paperwork that Health Net or the medical providers may reasonably require to assist in enforcing the lien.
- Promptly responding to inquiries from Health Net about the status of the case and any settlement discussions.
- Notifying Health Net immediately upon you or your lawyer receiving any money from the responsible parties, any insurance companies, or any other source.
- Pay the health care lien from any recovery, settlement or judgment, or other source of compensation and all reimbursement due Health Net for the full cost of benefits paid under the Plan that are associated with injuries through a responsible party regardless of whether specifically identified as recovery for medical expenses and regardless of whether you are made whole or fully compensated for your loss;
- Do nothing to prejudice Health Net's rights as set forth above. This includes, but is not limited to, refraining from any attempts to reduce or exclude from settlement or recovery the full cost of all benefits paid by the plan; and

Hold any money that you or your lawyer receive from the responsible parties, or from any other source, in trust, and reimbursing Health Net and the medical providers for the amount of the lien as soon as you are paid.

Membership card

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

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

Independent contractors

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

Health care plan fraud

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

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

Circumstances beyond Health Net's control

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

Notice of privacy practices

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

*Nonpublic personal financial information includes personally identifiable financial information that you provided to us to obtain insurance or we obtained in providing benefits to you. Examples include Social Security numbers, account balances and payment history. We do not disclose any nonpublic personal information about you to anyone, except as permitted by law.

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

We are required by federal and state laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. 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, to be reimbursed by another insurer that may be responsible for payment or for premium billing.
- **Health Care Operations.** We use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or customer service.
- **Treatment.** We may use and disclose your protected health information to assist your health care providers (doctors, pharmacies, hospitals, and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.
- **Plan Sponsor.** If you are enrolled through a group health plan, we may provide non-identifiable summaries of claims and expenses for enrollees in your group health plan to the plan sponsor, which is usually the employer.

If the plan sponsor provides plan administration services, we may also provide access to identifiable health information to support its performance of such services which may include but are not limited to claims audits or customer services functions. Health Net will only share health information upon a certification from the plan sponsor representing there are restrictions in place to ensure that only plan sponsor employees with a legitimate need to know will have access to health information in order to provide plan administration functions.

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

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: **1-800-522-0088**
Fax: **1-818-676-8314**
Email: **Privacy@healthnet.com**

Binding Arbitration

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

Sometimes disputes or disagreements may arise between you (including your enrolled Family Members, heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of this Evidence of Coverage or regarding other matters relating to or arising out of your Health Net membership. Typically such disputes are handled and resolved through the Health Net Grievance, Appeal and Independent Medical Review process described above. However, in the event that a dispute is not resolved in that process, Health Net uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, health care providers, or their agents or employees, are also involved. In addition, disputes with Health Net involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

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

This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

Health Net's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is $200,000 or less, the parties shall, within 30 days of submission of the demand for Arbitration to Health Net, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $200,000. In the event that the total amount of damages is over $200,000, the parties shall, within 30 days of submission of the demand for Arbitration to Health Net, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

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

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

Health Net of California
Attention: Litigation Administrator
PO Box 4504
Woodland Hills, CA 91365-4505

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

DEFINITIONS OF IMPORTANT WORDS

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – A set time each fall when members can change their health or drugs plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. The "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**" section in this booklet explains appeals, including the process involved in making an appeal.

Balance Billing – A situation in which a provider (such as a doctor or hospital) bills a patient more than the plan's cost-sharing amount for services. As a member of our plan you only have to pay the plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" you. See the "Our plan does not allow providers to 'balance bill' you" portion of the "Medical Benefits Chart (what is covered and what you pay)" section of this booklet for more information about balance billing.

Benefit Period – The way that both our plan and Original Medicare measures your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

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 Stage – The stage 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 $4,750 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. See the "Important phone numbers and resources" section of this booklet as it explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services or prescription drugs after you pay any deductibles (if applicable to your plan). Coinsurance is usually a percentage (for example, 20%).

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

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

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. (This is in addition to any applicable plan monthly premium.) Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of the different cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision 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. Coverage determinations are called "coverage decisions" in this booklet. The "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" section of this booklet explains how to ask us for a coverage decision.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our plan.

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

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

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

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

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

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

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

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

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to 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 Tier 3 (Non-preferred brand drugs) or Tier 4 (Injectable Drugs) 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).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

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, a "generic drug" works the same as a brand name drug and usually costs less. Generic drugs are manufactured and sold by other drug companies and are generally not available until after the patent on the brand name drug has expired.

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

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

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

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

Initial Coverage Stage – This is the stage after you have met your deductible (if applicable to your plan) and before your total drug expenses have reached *the initial coverage limit* as described in the "What you pay for your prescription drugs " section in this booklet, including amounts you've paid and what our plan has paid on your behalf.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, if you're eligible for Part B when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected 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. For example, if you receive Extra Help from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive Extra Help, you do not pay a penalty, even if you go without "creditable" prescription drug coverage.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand name and generic drugs.

Low Income Subsidy (LIS) – See "Extra Help."

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

Medicaid (or Medical Assistance) – A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See the "Important phone numbers and resources" section in this booklet for information about how to contact Medicaid in your state.

Medical Group - A group of Physicians, who are organized as a legal entity, that has an agreement in effect with our plan to provide medical care to our members.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See the "Your drugs need to be on the plan's 'Drug List'" portion of the "Using the plan's coverage for your prescription drugs" section of this booklet for more information about a medically accepted indication.

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

Medicare – The Federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with

permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a PACE plan or a Medicare Advantage Plan.

Medicare Advantage Disenrollment Period – A set time each year when members in a Medicare Advantage plan can cancel their plan enrollment and switch to Original Medicare. The Medicare Advantage Disenrollment Period is from January 1 until February 14, 2013

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

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

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

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

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

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See 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 makes a decision about whether items or services are covered or how much you have to pay for covered items or services. The Medicare Advantage organization's network provider or facility has also made an organization determination when it provides you with an item or service, or refers you to an out-of-network provider for an item or service. Organization determinations are called "coverage decisions" in this booklet. The "**What to do if you have a problem or complaint (coverage decisions, appeals, complaints)**" section in this booklet explains how to ask us for a coverage decision.

Original Medicare ("Traditional Medicare" or "Fee-for-service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care provider payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network 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.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in the "Using the plan's coverage for your medical services" section.

Out-of-Pocket Costs – See the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's "out-of-pocket" cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

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

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

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

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

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

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our Formulary. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Medical Benefits Chart in the "Medical Benefits Chart (what is covered and what you pay)" section of this booklet. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See the "Important phone numbers and resources" section of this booklet for information about how to contact the QIO for your state.

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 – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. The plan may disenroll you if you move out of the plan's service area.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Enrollment Period – A set time when members can change their health or drugs plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

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

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.

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

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

Health Net Seniority Plus (Employer HMO)

Member Services

CALL	**1-800-539-4072** Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. Member Services also has free language interpreter services available for non-English speakers.
TTY/TDD	**1-800-929-9955** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	**1-866-214-1992**
WRITE	Health Net Medicare Programs PO Box 10198 Van Nuys, California, 91410-0198
WEBSITE	www.healthnet.com/uc

*The Health Insurance Counseling and Advocacy Program (*California SHIP)

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

HICAP (California SHIP)	
CALL	**1-800-434-0222**
TTY	**1-800-735-2929** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	HICAP 1300 National Drive, Suite 200 Sacramento, CA 95834-1992
WEBSITE	www.cahealthadvocates.org/hicap