Health Net®
Seniority Plus

A COMPLETE

explanation of your plan

Evidence of Coverage
Seniority Plus

PLAN 57G

UNIVERSITY OF CALIFORNIA

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HUMAN RESOURCES AND BENEFITS

300 LAKESIDE DRIVE, 5TH FLOOR
OAKLAND, CALIFORNIA 94612-3556

July 2005

ELIGIBILITY AND ENROLLMENT PROVISIONS AND PLAN ADMINISTRATION INFORMATION APPLICABLE TO RETIREES OF THE UNIVERSITY OF CALIFORNIA WHO ARE ENROLLED IN THE SENIORITY PLUS MEDICARE MANAGED CARE HMO PLAN (HEALTH NET SENIORITY PLUS)

The following supersedes the information contained in the Evidence of Coverage for Retirees enrolled in Seniority Plus. The University of California establishes its own medical plan eligibility criteria for Retirees based on the University of California Group Insurance Regulations and any corresponding Administrative Supplements. Portions of these regulations are summarized below.

If you reside in the Seniority Plus service area, and meet the University's and the Plan's eligibility criteria, you may enroll in the Plan.

ELIGIBILITY PROVISIONS

WHO IS ELIGIBLE

You may participate in the Plan if you are an eligible Retiree and enrolled in both the Hospital (Part A) and the Medical (Part B) parts of Medicare. The same applies to your Dependents. Dependents who are covered by the Health Net plan, but not by both parts of Medicare, may continue in that Plan until they cease to be eligible. Anyone enrolled in a non-University Medicare + Choice contract is not eligible for this Plan.

Eligible Retirees (including Survivor):

You may continue University medical plan coverage when you retire (Retiree) or start collecting disability or survivor benefits (Survivor) from the University of California retirement plan, or any defined benefit plan to which the University contributes, provided:

1. you meet the University's service credit requirements for Retiree medical eligibility;
2. the effective date of your Retiree status is within 120 calendar days of the date employment ends (or the date of the Employee/Retiree's death in the case of a Survivor); and
3. you elect to continue coverage at the time of retirement.

Eligible Dependents:

SPOUSE: Your legal spouse.

CHILDREN: Any of your natural or legally adopted children who are unmarried and under age 23.

The following children are also eligible:

(a) Any unmarried stepchildren under age 23, who reside with you, who are dependent upon you or your spouse for at least 50% of their support and who are your or your spouse's dependents for income tax purposes.

(b) Any unmarried grandchildren under age 23, who reside with you, who are dependent upon you or your spouse for at least 50% of their support and who are your or your spouse's dependents for income tax purposes.

(c) Any unmarried children under age 18 for whom you are the legal guardian, who reside with you, who are dependent upon you for at least 50% of their support and who are your dependents for income tax purposes.

Your signature on the enrollment form attests to these conditions in (a), (b) and (c) above. You will be asked to submit a copy annually of your Federal income tax return (IRS form 1040 or IRS equivalent showing the covered dependent and your signature) to the University to verify income tax dependency.

Any unmarried child, as defined above, (except for a child for whom you are the legal guardian), who is incapable of self-support due to a physical or mental handicap may continue to be covered past age 23 provided: the child is dependent on you for at least 50% of his/her support, is your Dependent for income tax purposes, the incapacity began before age 23, the child was enrolled in a medical plan before age 23 and coverage is continuous. Application must be made to Health Net at least 31 days prior to the child's 23rd birthday and is subject to approval by the Plan. Health Net may periodically request proof of continued disability. Your signature on the enrollment form attests to these conditions. You will be asked to submit a copy annually of your Federal income tax return (IRS form 1040 or IRS equivalent showing the covered Dependent and your signature) to the University to verify income tax dependency.

Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan. If enrollment is transferred from one plan to another, a new application for continued coverage is not required.

If the overage handicapped child is not your natural or legally adopted child, the child must reside with you in order for the coverage to be continued past age 23.

OTHER ELIGIBLE DEPENDENTS: You may enroll an adult dependent relative or same-sex domestic partner and their eligible children as set forth in the University of California Group Insurance Regulations. An adult dependent relative is no longer eligible for coverage effective January 1, 2005. Only an adult dependent relative who was enrolled as an eligible dependent as of December 31, 2003 may continue coverage in UC-sponsored plans. For information on who qualifies and on the requirements to enroll an adult dependent relative or same-sex domestic partner, contact the University of California's Customer Service Center. Eligible persons may be covered under only one of the following categories: as an Employee, as an Retiree, as a Survivor, or as a Dependent, but not under any combination of these. If an Employee and the Employee's spouse or same-sex domestic partner are both eligible, each may enroll separately or one may cover the other as a Dependent. If they enroll separately, neither may enroll the other as a Dependent. Eligible children may be enrolled under either parent's or same-sex 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.

The University and/or the Plan reserve the right to periodically request documentation to verify eligibility of Dependents. Such documentation could include a marriage certificate, birth certificate(s), adoption records, or other official documentation.

ENROLLMENT PROVISIONS

Retirees and their enrolled Dependents who become eligible for Medicare Hospital insurance (Part A) as primary coverage must enroll in and remain in both Hospital (Part A) and Medical (Part B) portions of Medicare. This includes those who are entitled to Medicare benefits through their own or their spouse's non-University employment. Beginning January 1, 2005, Retirees or their Family Member(s) who become eligible for premium free Medicare Part A and do not enroll in Part B, will permanently lose their UC-sponsored medical coverage. Retirees and their Family Members who were eligible for premium free Medicare Part A, but declined to enroll in Part B of Medicare before January 1, 2005, were assessed a monthly offset fee by the University to cover increased costs. The offset fee may increase annually, but will stop when the Retiree or Family Member becomes covered under Part B. Retirees or Family Members who are not eligible for premium free Part A will not be assessed an offset fee nor lose their UC-sponsored medical coverage. Documentation attesting to their ineligibility for Medicare Part A will be required. Forms for this purpose may be obtained from the University of California's Customer Service Center at 1-800-888-8267. (Retirees/Dependents who are not entitled to Social Security and Medicare Part A will not be required to enroll in Part B.)

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

To enroll yourself and any eligible Dependents, you must complete a University of California Medicare Declaration form and Seniority Plus' own enrollment form. This notifies the University that you are covered by the Hospital (Part A) and Medical (Part B) parts of Medicare. Medicare Declaration forms and Seniority Plus' enrollment forms are available through the University of California Customer Service Center and completed forms should be returned to University of California, Human Resources and Benefits, Health & Welfare Administration-AH Unit, Post Office Box 24570, Oakland, CA 94623-9909.

Any individual enrolled in a University-sponsored Medicare+Choice Managed Care Contract must assign his/her Medicare benefit to that plan or lose UC-sponsored medical coverage.

The Medicare Secondary Payer (MSP) Law affects the order in which claims are paid by Medicare and an employer group health plan. UC Retirees hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to MSP. For Employees or their spouses who are age 65 or older and eligible for a group health plan due to employment, Medicare becomes the secondary payer and the employer plan becomes the primary payer.

Upon receipt by the University of confirmation of Medicare enrollment, the Retiree/Dependent will be changed from the Health Net non-Medicare plan to Health Net's Seniority Plus for Medicare enrollees. Retirees and their Dependents are required to transfer to the plan for Medicare enrollees.

You may also enroll yourself and any eligible Dependents during your Period of Initial Eligibility (PIE) which begins on:

a) the date you have an involuntary loss of other group medical coverage; or

b) the date you move out of a University health maintenance organization (HMO) plan's service area on either a permanent basis, or for more than two months on a temporary basis.

If you are an Retiree enrolled as a spouse on a University medical plan and become eligible for both parts of Medicare in your own right, you may enroll yourself on the earlier of:

a) the date both parts of Medicare are in effect; or

b) the effective date of retirement.

In addition, you and your eligible Dependents may enroll during a group open enrollment period established by the University.

To enroll your newly eligible Dependents, contact the University of California Customer Service Center to obtain an enrollment form and return it during the Dependent's PIE.

You may enroll Dependents during a newly eligible Dependent's PIE. The PIE starts the day the Dependent becomes eligible for benefits. For a new spouse, eligibility begins on the date of marriage. Survivor may not add new spouses to their coverage.

For a newborn child, eligibility begins on the child's date of birth.

For newly adopted children, eligibility begins on the earlier of:

a) the date the Retiree or Retiree's spouse has the legal right to control the child's health care; or

b) the date the child is placed in the Retiree's physical custody.

If not enrolled during the PIE beginning on the date, there is a second PIE beginning on the date that the adoption becomes final.

You may also enroll your eligible Dependent during a PIE which begins on the date he or she has an involuntary loss of other group medical coverage.

A PIE ends 31 days after it begins (or on the preceding business day for the University of California Customer Service Center if the 31st day is on a weekend or a holiday).

If your Dependent fails to enroll during the PIE or open enrollment period, you may enroll your dependent at any other time upon completion of a 90 consecutive calendar day waiting period. The 90 day waiting period starts on the date the enrollment form is received by the University of California Customer Service Center and ends 90 consecutive calendar days later.

An Retiree who currently has two or more covered Dependents may add a newly eligible Dependent after the PIE. Retroactive coverage for such enrollment is limited to the later of:

a) a maximum of 60 days prior to the date your Dependent's enrollment form is received by the University of California Customer Service Center; or
b) the date the Dependent became eligible.

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

Effective Date Provisions

COVERAGE FOR RETIREES ENROLLING IN CONJUNCTION WITH RETIREMENT:

Coverage for Retirees and their Dependents is effective on the first of the month following the first full calendar month of retirement income, provided the continuation form is submitted to the University of California Customer Service Center.

COVERAGE FOR RETIREES OR DEPENDENTS BECOMING ELIGIBLE FOR MEDICARE:

Coverage will be transferred from the Health Net plan for non-Medicare enrollees to the Seniority Plus plan for Medicare enrollees effective on the date determined by the carrier, based on processing the Seniority Plus enrollment form through the Health Care Financing Administration (HCFA).

OTHER SITUATIONS:

Coverage for Retirees and their Dependents enrolling during a PIE is effective on the first day of the PIE provided the enrollment form is received by the University of California Customer Service Center during the PIE. There is one exception to this rule: coverage for a newly adopted child enrolling during the second PIE is effective on the date the adoption becomes final.

For dependents who complete a 90 day waiting period, coverage is effective on the 91st consecutive calendar day after the date the enrollment form is received by the University of California Customer Service Center.

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

In order to change from individual to two-party coverage and from two-party to family coverage, you will need to obtain a change form from the University of California Customer Service Center, complete and return it.

FRAUD

Coverage for an Retiree or covered Dependent may be terminated for fraud or deception in the use of the services of the Plan, or for knowingly permitting such fraud or deception by another**.** Deception includes but is not limited to intentionally enrolling an ineligible individual. Such termination shall be effective upon the mailing of written notice by the Plan to the Retiree and the University. A Dependent who commits fraud or deception will be permanently deenrolled while any other Dependent and the Retiree will be deenrolled for 18 months. If an Retiree commits fraud or deception, the Retiree and any Dependents will be deenrolled for 18 months.

COBRA

OPTIONAL CONTINUATION OF COVERAGE

Under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA), as amended, enrolled persons who would lose coverage under the Seniority Plus medical plan due to certain "Qualifying Events" are entitled to elect, without having to submit evidence of good health, continued coverage at their own expense. Continued coverage shall be the same as for active eligible Employees and their eligible Dependents under the University group plan. If coverage is modified for active eligible Employees and their Dependents, it shall be modified in the same manner for persons with continued coverage (Qualified Beneficiaries) and an appropriate adjustment in premiums may be made.

Right to Continue Benefits - A right under this part is subject to the rest of these provisions:

You have the right to continue benefits under the plan for yourself and any enrolled dependents if your coverage would have ended for either of the following Qualifying Events:

(1) because your employment ended for a reason other than gross misconduct; or
(2) because your work hours were reduced (including approved leave without pay or layoff).

Each of your eligible Dependents has the right to continue benefits under the plan under the following circumstances:

In the case of your eligible Dependent spouse, your spouse may continue coverage for himself or herself and any enrolled Dependent children if your spouse's coverage would have ended because of any of the following Qualifying Events:

(1) because your employment ended for a reason other than gross misconduct; or
(2) because your work hours were reduced (including approved leave without pay or layoff); or
(3) at your death; or
(4) because you became entitled to Medicare benefits; or
(5) when your spouse ceased to be an eligible Dependent as a result of a divorce, legal separation, or annulment.

If coverage ends under (5) immediately above, please see "Notice" below.

In case of your eligible Dependent child, your child may continue coverage for himself or herself if your child's coverage would have ended because of any of the following Qualifying Events:

(1) because your employment ended for a reason other than gross misconduct; or
(2) because your work hours were reduced (including approved leave without pay or layoff); or
(3) at your death; or
(4) because you became entitled to Medicare benefits; or
(5) because of your divorce, legal separation, or annulment; or
(6) when your eligible Dependent child ceased to be an Eligible Dependent under the rules of the plan.

If coverage for an eligible Dependent ends due to an event shown (5) or (6) immediately above, please see "Notice" below.

For the qualifying event (1) or (2), if you become entitled to Medicare due to age within 18 months before the qualifying event, your eligible Dependent spouse or your eligible Dependent child may continue COBRA coverage for up to 36 months counted from the date you became entitled to Medicare.

If a second Qualifying Event occurs to a Qualified Beneficiary who already has continuation coverage because your employment has ended or work hours were reduced, that Qualified Beneficiary's coverage may be continued up to a maximum of 36 months from the date of the first Qualifying Event.

Notice - If your coverage for an eligible Dependent ends due to your divorce, legal separation, or annulment, or if your eligible Dependent ceased to be an eligible Dependent under the rules of the plan, you or your eligible Dependent must give written notice of the event to the Employer at the University of California Customer Service Center within sixty (60) days of the event or eligibility to elect continuation coverage will be lost.

Continuation - Once aware of a Qualifying Event, the Employer will give a written election notice of the right to continue the coverage to you (or to the Qualified Beneficiary in the event of your death). Such notice will state the amount of the premium required for the continued coverage. If a person wants to continue the coverage, the Election Notice must be completed and returned to the address below, along with the first month's premium within sixty (60) days of the later of:

(1) the date of the Qualifying Event; or

(2) the date the Qualified Beneficiary received notice informing the person of the right tocontinue.

Health Net
P.O. Box 9103
Van Nuys, CA 91409-9103

Benefits of the continuation plan are identical to this group medical plan and cost is explained below under "Cost of Continuation Coverage".

The continued coverage period runs concurrently with any other University continuation provision (e.g., during leave without pay) except continuation under the Family and Medical Leave Act (FMLA). Coverage will be continued from the date it would have ended until the first of these events occurs:

With respect to yourself and any Qualified Beneficiaries, the day 18 months from the earlier of the date:

(a) your employment ends for a reason other than gross misconduct, or
(b) your work hours are reduced. But, coverage may continue for all Qualified Beneficiaries for up to 11 additional months while the Qualified Beneficiary is determined to be disabled under Title II or XVI of the United States Social Security Act if:

(i) the disability was determined to exist at the time, or during the first sixty (60) days, of the 18 months of COBRA coverage, and
(ii) the person gives Health Net written notice of the disability within sixty (60) days after the determination of disability is made and within 18 months after the date employment ended or work hours were reduced.

Health Net must be notified if there is a final determination under the United States Social Security Act that the person is no longer disabled. The notice must be provided within thirty (30) days after the final determination. The coverage will end on the first of the month that starts more than thirty (30) days after the determination.

(2) With respect to your Qualified Beneficiaries (other than yourself), the day 36 months from the earliest of the date:

(a) of your death; or
(b) of your entitlement to Medicare benefits; or
(c) of your divorce, annulment, or legal separation from your spouse; or
(d) your dependent child ceases to be an Eligible Dependent under the rules of the Plan.

The 36 months will be counted from the date of the earliest Qualifying Event.

With respect to any Qualified Beneficiary:

(3) If the person fails to make any premium payment required for the continued coverage, the end of the period for which the person has made the required payments.

(4) The day the person becomes covered (after the day the person made the election for continuation of coverage) under any other group health plan, on an insured or uninsured basis. This item (4) by itself will not prevent coverage from being continued until the end of any period for which pre-existing conditions are excluded or benefits for them are limited under the other health plan.

(5) The day the person becomes entitled to Medicare Benefits.

(6) The day the employer no longer provides group health coverage to any of its employees.

California Continuation Coverage - Employees entitled to COBRA continuation coverage due to employment termination on or after January 1, 1996 are entitled to extend medical coverage for themselves and their spouses after their initial 18-month COBRA period ends, provided the employee was at least age 60 on the date employment ended, had worked for the University for at least five continuous years immediately prior to termination, and was eligible for and elected COBRA continuation medical plan coverage in connection with the termination of employment. The former spouse of the above former employee is entitled to California Continuation Coverage, provided the former spouse continued coverage under COBRA as a Qualified Beneficiary. This continuation does not apply to children of a former employee. The continuation will end on the earlier of:

(1) the date the individual turns 65;

(2) the date the University no longer maintains the group plan, including any replacement plan;

(3) the date the individual is covered by a group medical plan not maintained by the University;

(4) the date the individual becomes entitled to Medicare;

(5) with respect to the spouse or former spouse only, the date five years from the date COBRA ends for the spouse or former spouse.

If the employee's coverage terminates, the spouse may continue coverage until one of the terminating events applies to the spouse. Health Net will notify eligible COBRA Qualified Beneficiaries before the end of the maximum 18 month COBRA continuation period. If an eligible individual wishes to continue the coverage, they must apply, in writing, to the medical carrier no later than 30 days before the end of the COBRA continuation period.

Cost of Continuation Coverage - The cost of the coverage will; include any portion previously paid by the Employer and shall not be more than 102% of the applicable group rate during the period of basic COBRA coverage; or not more than 150% anytime during the 11-month disability extension period (i.e., during the 19th through the 29th months); or not more than 213% during the extension period allowed by California Continuation Coverage.

For information on Open Enrollment actions for which a Qualified Beneficiary may be eligible and/or any applicable plan modifications and premium adjustment, contact University of California Human Resources and Benefits 1-800-888-8267 extension 7-0651 during the month of November.

Please note: When your continuation of coverage ends, you may be able to convert your coverage to an individual Conversion Plan if you wish.

Plan Administration

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

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

SPONSORSHIP AND ADMINISTRATION OF THE PLAN:

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

University of California
Human Resources and Benefits
300 Lakeside Drive, 5th Floor
Oakland, CA 94612-3557
1-800-888-8267 extension 70651

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

Health Net Seniority Plus
P.O. Box 10198
Van Nuys, CA 91410-09108
1-800-275-4737

GROUP CONTRACT NUMBER:

The Group Contract number for this Plan is 5047MW

TYPE OF PLAN:

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

PLAN YEAR:

The Plan year is January 1 through December 31.

CONTINUATION OF THE PLAN:

The University of California intends to continue the Plan of benefits described in this booklet but reserves the right to terminate or amend it at any time**.** The plan is not a vested plan. The right to terminate or amend applies to all employees, Retirees and plan beneficiaries. The amendment or termination shall be carried out by the President or his or her delegates. The University of California will also determine the terms of the Plan, such as benefits, premiums and what portion of the premiums the University will pay. The portion of the premium the University pays is subject to state appropriation which may change or be discontinued in the future.

FINANCIAL ARRANGEMENTS:

The benefits under this Plan are paid by Health Net under a Group Service Agreement. The cost of the premiums is currently paid entirely by the University of California.

AGENT FOR SERVICE OF LEGAL PROCESS:

Legal process may be served on Health Net at the following address:

Health Net
P.O. Box 9103
Van Nuys, CA 91409-9103

YOUR RIGHTS UNDER THE PLAN:

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

Examine, without charge, at the Plan Administrator's office, or instead of or in addition to, at other locations that may be specified by the Plan Administrator, all Plan documents, including the Group Service Agreement.

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

CLAIMS UNDER THE PLAN:

To file a claim or to appeal a denied claim, under this Plan, refer to the enclosed booklet.

NONDISCRIMINATION STATEMENT:

By authority of The Regents, University of California Human Resources and Benefits, located in Oakland, administers all benefit plans in accordance with applicable plan documents and regulations, custodial agreements, University of California Group Insurance Regulations, group insurance contracts, and state and federal laws. No person is authorized to provide benefits information not contained in these source documents, and information not contained in these source documents cannot be relied upon as having been authorized by The Regents. Source

documents are available for inspection upon request (1-800-888-8267). What is written here does not constitute a guarantee of plan coverage or benefits-particular rules and eligibility requirements must be met before benefits can be received. The University of California intends to continue the benefits described here indefinitely; however, the benefits of all employees, Retirees, and plan beneficiaries are subject to change or termination at the time of contract renewal or at any other time by the University or other governing authorities. The University also reserves the right to determine new premiums, employer contributions and monthly costs at any time. Health and welfare benefits are not accrued or vested benefit entitlements. If you belong to an exclusively represented bargaining unit, some of your benefits may differ from the ones described here. Contact your Human Resources Office for more information. In conformance with applicable law and University policy, the University is an affirmative action/equal opportunity employer.

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

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

Health Net of California, Inc. (Health Net) Member Services:

For help or information, please call Member Services Monday Through Friday, 7:30 a.m. to 12:00 p.m. and 1:00 p.m. to 5:00 p.m. Calls to these numbers are free:

1-800-275-4737

TTY: 1-800-929-9955 (This number is for people who have difficulties with hearing or speech. You need special telephone equipment to use this number.)

Welcome to Health Net Seniority Plus!

We are pleased that you've chosen Seniority Plus.

Seniority Plus is an HMO for people with Medicare

Now that you are enrolled in Seniority Plus, your getting your care through Health Net. Seniority Plus, an HMO, is offered by Health Net. (Seniority Plus is not a "Medigap" or supplemental Medicare insurance policy.) Your Member Contract for Seniority Plus consists of this Evidence of Coverage, your election form and any current or future amendments. It explains your rights, benefits, and responsibilities as a Member of Seniority Plus. It also explains our responsibilities to you.

You are still covered by Original Medicare, but you are getting your Medicare services as a Member of Seniority Plus. This booklet gives you the details, including:

- What is covered in Seniority Plus and what is not
- What you will have to pay for when you get care
- How to get the care you need, including some rules you must follow
- What to do if you are unhappy about something related to your coverage or payment for care
- How to leave Seniority Plus, including your choices for continuing Medicare if you or your Group leave, and new rules from the Medicare program about when and how often you can make changes

If you need to receive this booklet in a different format (such as in Spanish, large print, or audio tapes) please call us so we can send you a copy. Section 1 of this booklet tells how to contact us.

Health Net has signed a contract with Centers for Medicare & Medicaid Services (CMS) and your Group, agreeing to cover you. In addition, either CMS or Health Net or the Group may choose to not renew all or a portion of the contract. Seniority Plus costs and benefits may change from year to year, and we would notify you before any changes were made. If the contract is not renewed, your Medicare coverage will not end, but we will have to Disenroll you from Seniority Plus and your coverage will be changed to Original Medicare unless you decide to change to another Medicare managed care plan. If either we or CMS decide to not renew the contract at the end of the year, we will send you a letter at least ninety (90)-days before the end of the contract. If CMS ends the contract in the middle of the year, you will get a letter at least thirty (30)-days before the end of the contract. Either letter would explain your options for health care coverage in your area and give you information about your right to get Medicare supplemental insurance coverage.

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SECTION 1. TELEPHONE NUMBERS AND OTHER INFORMATION FOR REFERENCE

(How to contact Health Net Member Services and other organizations, including the Medicare program (CMS), Health Insurance Counseling and Advocacy Program (HICAPs), Quality Improvement Organizations (QIOs), state Medicaid agencies, and the Social Security Administration.)

How to contact Health Net Member Services

If you have any questions or concerns, please call or write to Health Net Member Services. We will be happy to help you. Our business hours are 7:30 a.m. to 12:00 p.m. and 1:00 p.m. to 5:00 p.m. Monday through Friday.

CALL	**1-800-275-4737**. This number is also on the first page of this booklet for easy reference. Calls to this number are free.
TTY	**1-800-929-9955**. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. It is also on the first page this booklet for easy reference. Calls to this number are free.
WRITE	Health Net Seniority Plus, Post office Box 10198, Van Nuys, California, 91410-0198.

How to contact other organizations

CMS (Centers for Medicare & Medicaid Services) -- the Medicare program

CMS stands for **C**enters for **M**edicare & Medicaid **S**ervices. CMS is the federal agency in charge of the 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 CMS contracts with and regulates Medicare Health Plans (including Health Net) and Medicare Private Fee-for-Service organizations.

Here are several ways for you to get help and information about Medicare from CMS:

- Call the national Medicare helpline to ask questions or ask for free copies of information materials produced by the Medicare program. Call **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. The TTY number is **1-877-486-2048** (this number requires special telephone equipment and is used by people who have difficulties with hearing or speaking). Calls to these numbers are free.

- Use a computer to look on the Internet at www.medicare.gov on the national Medicare program website. The website includes a great deal of information about Medicare, including booklets you visit this website using their computer.

Health Insurance Counseling and Advocacy Program (HICAP) – an organization in your state that provides free Medicare help and information

HICAP is a state organization paid by the Federal Government to give free health insurance information and help to people with Medicare. HICAP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. HICAP has information about Medicare managed care plans and about Medigap (Medicare supplement insurance) policies. This includes information about special Medigap rights for people who have tried a Medicare Advantage plan (like Seniority Plus) for the first time. (Medicare Advantage is the new name for Medicare+Choice.)

Here is how to contact the HICAP in your state:

ALAMEDA COUNTY
HICAP Legal Assistance for Seniors
464 7th St., Suite 200
Oakland, CA 94607

General Inquiries: **1-510-839-0393** or **1-800-434-0222**
Southern & Eastern Alameda County **1-800-393-0363** or **1-800-434-0222**

CONTRA COSTA COUNTY
HICAP
Contra Costa County Office on Aging
2530 Arnold Drive, Suite 300
Martinez, CA 94553-4068

For HICAP Assistance:
Within Contra Costa County: **1-800-520-2020**
Outside Contra Costa County: **1-925-335-8720** or **1-800-434-0222**

PLACER, SACRAMENTO & YOLO COUNTY
HICAP
LEGAL CENTER FOR THE ELDERLY & DISABLED
2862 Arden Way, Suite 200
Sacramento, CA 95825

General Inquiries: **1-800-434-0222**

KERN COUNTY
HICAP
Kern County Office of Aging
5357 Truxton Ave.
Bakersfield, CA 93309

General Inquiries: **(661) 868-1000** or **(800) 434-0222**

LOS ANGELES COUNTY
HICAP
Centers for Health Care Rights
520 S. Lafayette Park Place, Suite 214
Los Angeles, CA 90057

General Inquiries: **1-213-383-4519** or **1-800-434-0222**

ORANGE COUNTY
HICAP
Orange County Council on Aging
1971 E. 4th Street, Suite 200
Santa Ana, CA 92705

General Inquiries: **1-714-560-0424** or **1-800-434-0222**

RIVERSIDE & SAN BERNARDINO COUNTY
HICAP
Inland Agency
6235 River Crest Drive, Suite P
Riverside, CA 92507

General Inquiries: **1-951-697-6560** or **1-800-434-0222**

SAN DIEGO COUNTY
HICAP
Elder Law and Advocacy
3675 Ruffin Road, Suite 315
San Diego, CA 92123

General Inquiries: **1-858-565-8772** or **1-800-434-0222**

SAN FRANCISCO COUNTY
LEGAL ASSITANCE FOR THE ELDERLY
995 Market St., Suite 1400
San Francisco, CA 94103

General Inquiries: **1-415-538-3333** or **1-800-434-0222**

SAN MATEO COUNTY
HICAP
Self Help for the Elderly
1710 Amphlett Boulevard, Suite 302
San Mateo, CA 94402

General Inquiries: **1-650-627-9350** or **1-800-434-0222**

SANTA BARBARA COUNTY
HICAP
Central Coast Commission for Senior Citizens
528 South Broadway
Santa Maria, CA 93454

General Inquiries: **1-805-928-5663** or **1-800-434-0222**

SANTA CLARA COUNTY
HICAP
Council on Aging of Santa Clara County
2115 The Alameda
San Jose, CA 95126

General Inquiries: **1-408-296-8290** or **1-800-434-0222**

You can also find the website for your local HICAP at www.medicare.gov on the web.

Lumetra/Quality Improvement Organization – a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare

"QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the Federal Government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. In California, the QIO is called Lumetra (formerly known as CMRI). The doctors and other health experts in Lumetra review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their Hospital, skilled nursing facility, home health agency or comprehensive outpatient rehabilitation stay is ending too soon. See Section 10 for more information about complaints.

You can contact Lumetra at:

Lumetra Headquarters
One Sansome Street, Suite 600
San Francisco, 94104-4448

1-415-677-2000 or 1-800-841-1602

Operating hours are Monday through Friday, 9:00 a.m. to 4:00 p.m.
Telecommunications Device for the Deaf (TDD)

1-800-881-5980

Operating hours are Monday through Friday, 9:00 a.m. to 4:00 p.m.

Medicaid agency – a state government agency that handles health care programs for people with low incomes

Medicaid is a joint federal and state medical assistance program. Some people with Medicare are also eligible for Medicaid. Unlike Medicare, Medicaid may cover long-term care, such as custodial nursing home care. Even if you are not eligible for health services under Medicaid, Medicaid may cover all or part of your Original Medicare premiums and/or deductibles and coinsurance, if your income and resources are low enough. Contact your state Medicaid agency to find out about Medicaid. You can call us at the number on the first page this booklet or your state Medicaid agency for information on related programs including Qualified Medicare Beneficiary, Special Low Income Medicare Beneficiary, Qualified Disabled Working Individual, and Qualified Individual.

The applicable state Medicaid agency is MediCal. The contact information for this agency is:

Alameda County – Social Services Agency	**1-510-383-8523**
Contra Costa County – Social Services Department	**1-925-313-7987**
Kern County – Department of Human Services	**1-661-631-6807**
Los Angeles – Department of Public Social Services	**1-213-639-6300**
Orange County – Social Service Agency:	
Anaheim	**1-714-575-2400**
Santa Ana	**1-714-435-5900**
Laguna Hills	**1-949-587-8543**
Garden Groves	**1-714-741-7100**
Placer County (Auburn) – Health and Human Services	**1-530-889-7610**
Placer County (Roseville) – Health and Human Services	**1-916-784-6000**
Riverside County – Department of Public Social Services	**1-951-358-3000**

Sacramento County – Department of Human Assistance	**1-916-874-2215** or **1-916-874-2072**
San Bernardino County – Department of Public Social Services	**1-909-388-0245**
San Diego County – Department of Health and Human Services	**1-858-514-6885**
San Francisco County – Department of Human Services	**1-415-863-9892**
San Mateo County – Human Services Agency	**1-650-802-5018**
Santa Barbara County – Department of Social Services	**1-805-681-4528**
Santa Clara County – Social Services Agency	**1-408-271-5600**
Yolo County – Department of Employment & Social Services	**1-530-661-2750**

Social Security Administration

The Social Security Administration programs provide economic protection for Americans of all ages. The types of programs administered through Social Security include retirement benefits; disability; family benefits; survivors' benefits; needs-based benefits for the aged, blind, and disabled. You can call the Social Security Administration at **1-800-772-1213**. The TTY number is **1-800-325-0778** (this number requires special telephone equipment and is used by people who have difficulties with hearing or speech). Calls to these numbers are free. You can also visit www.ssa.gov on the web.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or **1-800-808-0772** (calls to this number are free). The TTY number, which requires special telephone equipment and is used by people who have difficulties with hearing or speech, is **1-312-751-4701**. You can also visit www.rrb.gov on the web.

Employer (or "Group") Coverage

If you get your benefits from your employer, or your spouse's current or former employer, call the employer's benefits administrator if you have any questions about your benefits or the open enrollment season.

SECTION 2. GETTING STARTED AS A MEMBER OF SENIORITY PLUS

(What it means to be in a managed care plan your rights and responsibilities, your membership card, confidentiality of your medical records.)

What it means to be in a managed care plan

You still have Medicare, but you are getting your Medicare now as a Member of Health Net, which has a Medicare managed care plan. Health Net is not a "Medigap" or "Medicare supplement insurance" policy that pays your Medicare deductibles and coinsurance. Instead, Health Net has a contract with Medicare to arrange your health care when you enroll in Seniority Plus. As a Member of Seniority Plus, you will no longer have to pay Original Medicare deductibles and coinsurance charges because we will cover all services and supplies offered by Original Medicare plus some additional services and supplies not covered by Original Medicare. This booklet explains the benefits and services that are covered for you as a Member of Seniority Plus, and what you have to pay.

The Medicare managed care plan you've chosen, Seniority Plus, is an HMO offered by Health Net. By enrolling in Seniority Plus, you have decided to get all of your health care, except in special situations, from Seniority Plus Providers and facilities. As explained in the next section, you must also follow all plan Member rules, such as getting Referrals and approval in advance (called "prior authorization") for services when required. Of course, if you need emergency or Urgently Needed Services or out-of-area renal (kidney) dialysis services, those services will be covered. However, if you receive any other services from non-Plan Providers (Providers who are not part of Seniority Plus) without prior authorization neither Health Net nor Original Medicare will pay for those services.

Your membership card

You have selected the following medical group for your care. All medical services, with the exception of emergency, urgently needed services, or out of the area renal dialysis for ESRD members, as defined in your Evidence of Coverage, must be provided or arranged by:

Group/Physician Name:
<PPG NAME>
<PCP NAME>
<PCP ADDRESS>
<PCP CITY, STATE, ZIP>

Group Phone: XXX-XXX-XXXX **Copay:** $ XX
Physician Phone: XXX-XXX-XXXX

Health Net Seniority Plus

Claims Mailing Address:
P.O. Box 14703
Lexington, KY 40512
1-800-275-4737
www.healthnet.com

<Member Name>

Subscriber #
XXXXXXXXX

Group #: XXXXXX

Plan: XX WITH [DENTAL, PHARMACY, VISION, CHIRO]

Before removing card, fold back and forth along the upper and lower perforations.

For questions or concerns, call the Seniority Plus Member Services Department at **1-800-275-4737 (TDD/TTY 1-800-929-9955)** 7:30 a.m. to 12:00 p.m. and 1:00 p.m. to 5:00 p.m., Monday through Friday except holidays.

For Provider inquiries, call 1-800-929-

For vision benefits, call Health Net Vision 1-866-392-6058 (TDD/TTY: 1-8

Material ID# 04-10-A
CMS Approval (12/04)

IF AN EMERGENCY ARISES

If you have an emergency, call 911 or go to the nearest hospital. If you receive emergency care from a hospital other than the hospital(s) affiliated with your medical group, please call your PCP/medical group (numbers on reverse) as soon as your condition is stabilized so that your PCP/medical group can access your medical information and discuss your care with the treating physician. The call to request authorization for post-stabilization care may help protect you from financial liability.

For mental health benefits call: MHN at 1-800-646-5610 (TDD/TTY:1-800-327-0801)

To contact a Decision Power Health Coach, call 1-800-893-5597 (TDD/TTY: 1-800-276-3821)

Detach at Perforation, Fold at Center.

<MEMBER NAME>
<MEMBER ADDRESS>
<MEMBER CITY, STATE, ZIP>

To The Health Net Seniority Plus Member: This is your current Health Net Identification card. Carry it with you at all times, and present it to your Health Net Seniority Plus Participating Physician when you receive services. See your Evidence of Coverage for a description of your benefits. When submitting inquiries about your coverage, always include your Subscriber number and group number.

Health Net Use Only
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SENPLUS REG
0U8A
VISION
CAM CHIR
MHN INST KZ
HEALTH NET DENTAL
M

Carry your membership card with you at all times

Now that you are a Member of Seniority Plus, you have a Seniority Plus membership card. You must now start using your membership card to receive Covered Services. Because your membership card carries important information, please carry it with you at all times. You may need to show this card at the doctor's office or emergency room. You may also need it to get your prescriptions at the pharmacy. If your membership card is ever damaged, lost or stolen, please notify Member Services as soon as possible. We will replace your card.

What should you do with your red, white, and blue Medicare card?

Put your red, white, and blue Medicare card away in a safe place, and **do not use** it to get services while you are a Member of Seniority Plus. It is very important that you use only your Seniority Plus membership card to get services and **NOT** your Medicare card. Otherwise, you might get services from non-plan doctors or the Hospital might not know that it needs to notify your usual Seniority Plus doctor (called your Primary Care Provider or "PCP") or Health Net that you are receiving care in the emergency room.

Help us keep your Member records up to date

Health Net has information from your enrollment form including your address and telephone number. It also shows your specific Seniority Plus coverage the PCP the medical Group you chose when you enrolled. These records are very important because they identify you as an eligible Seniority Plus Member and may determine where you can get services.

Please report any changes in your name, address, or phone number to Member Services and your Group as soon as they occur. You should report any changes in health insurance coverage you have from your spouse's employer, and let us know if you have been admitted to a nursing home. You should also report any liability claims (such as claims against another driver in an automobile accident), eligibility under workers' compensation, and Medicaid eligibility.

Please tell us how we're doing

We want to hear from you about how well we are doing as your health plan. You can call or write to us at any time. Section 1, *Telephone numbers and other information for reference*, tells how to contact us. Your comments are always welcome, whether they are positive or negative.

In addition, we may ask about your experience with Seniority Plus through Member satisfaction surveys. These surveys give us useful information about our Providers and the quality of our program. We hope you will participate if you are contacted in a Member survey, because your responses and comments help us identify our strengths and areas for improvement.

Your rights and responsibilities as a Member of Seniority Plus

Your rights as a Member of Health Net are summarized below.

You have the right to get health care services in a language you can understand and in a culturally sensitive way, and to be treated with dignity, respect, and fairness at all times. This includes the right to have someone help you with any language, physical, or communication barrier you may face. It includes the right to be protected from discrimination due to your race, ethnicity, national origin, gender, sexual orientation, age, religion, cultural or educational background, economic or health status, physical or mental ability, or the source of payment for your care.

You have the right to privacy and confidentiality of your medical records and personal information. This includes the right to talk with your health care Providers in private, and to have us keep confidential all communications about your care and all information in your medical records. In addition, any personal information that you give us when you enroll in this plan is protected and will remain confidential. We will make sure that unauthorized individuals cannot see or change your records.

- We must get written permission from you, or from someone you designate, before we give your medical information to anyone who is not directly providing your care or responsible for paying for your care, except for purposes that are specifically permitted by State and Federal laws or requirements (such as for use by programs that review medical records to monitor quality of care or to combat fraud and abuse).
- You have the right to look at, or get a copy of, your medical records. You may be charged a fee for copying your records.

You have the right to get information about your coverage and costs as a Member of Health Net that is easy to understand. This includes getting information about which medical services are covered and not covered by Seniority Plus, what costs are covered by Seniority Plus, what you must pay, and what to do if you have a concern or complaint.

You have rights related to making complaints. These include the right to file a complaint (called a "Grievance") about the quality of care you receive, waiting times at the doctor's office, the physical conditions of the doctor's office, and other types of complaints which are explained in Section 10. You also have the right to complain about getting medical care or payment for care you have received (called a request for reconsideration or Appeal). You have the right to have us be fair in examining and addressing all complaints, and to not discriminate against you if you complain. You have the right to get information about the Grievances and Appeals that Members have filed against Health Net.

You have rights that are related to getting medical services, including timely access to Plan Providers and all services covered by Seniority Plus. As explained in this booklet, you will get most or all of your care from Plan Providers, that is, from doctors and other Providers who are part of Seniority Plus.

- You have the right to choose a qualified Provider who is part of Seniority Plus (we will tell you which doctors are not accepting new patients).
- You have the right to timely access to your Primary Care Provider (PCP) and Referrals to Specialists when medically necessary.
- You have the right to get emergency care when and where you need it. We will pay for Emergency Services without giving our approval in advance if you, acting as a "prudent person," believe that you have a medical condition that requires emergency treatment.
- You have the right to receive Urgently Needed Services when traveling outside of Seniority Plus's Service Area. Also, while you are inside the Service Area, you have the right to receive urgently needed care from Providers who are not part of Seniority Plus if unusual circumstances keep you from getting care from your PCP or other Plan Provider.

You have the right to get explanations and other information whenever you receive medical care (understanding that it may be difficult or impossible to provide full information during an emergency). This includes the right to get information about your Providers, including the names and qualifications of the doctors and other health care professionals involved in your medical care. When you see a doctor or other Provider, you have the right to receive an explanation of your medical condition using language you understand. This includes all of the following:

- To be told about any medical risks involved in your treatment, and about alternative treatments and their risks.
- To know about your prospects of recovering from your illness or injury, and be told of the risks if you refuse any treatments.
- To know whether your medical care or treatment is part of a research experiment, and to refuse any experimental treatments.
- To be informed about any medications you are told to take, how to take them, and their possible side effects.
- To know whether you need any continuing treatments, and to get the time and place of your appointment and the name of your Provider.

You have the right to participate in candid discussion to make decisions about your health and treatment options, and to make informed decisions. Your rights include the following:

- To be given information about treatments or procedures that are recommended for your condition, regardless of what they may cost or whether they are covered by Seniority Plus.
- To have someone help you make decisions, or to give another person the legal responsibility to make decisions about medical care on your behalf.
- To refuse treatment or leave a medical facility, even against the advice of your doctor (and you accept the responsibility if you do this).
- To ask your doctor to withhold or withdraw treatments that could prolong your life, if you have been diagnosed as terminally ill and anticipate that you will eventually be unable to make your own decisions about health care.
- To complete an Advance Directive, a "living will" or other legal document that gives your medical Provider instructions about your wishes for medical care in the event that you are unable to make your own decisions (see Appendix D for information about Advance Directives).

You have rights as a Hospital patient. When you are hospitalized, you should receive a document called *Notice of Discharge & Medicare Appeal Rights*, which explains your rights as a Hospital patient. These include the right to be told why you are being discharged (released from the Hospital), and what to do if you feel you are being discharged too soon.

You have the right to an explanation from us about any bills you may receive for services not covered by Seniority Plus, including the right to file a request for reconsideration or "Appeal" our decision to not cover a service (see Section 10).

You have the right to get certain information about Health Net, including information about its services, our financial condition, how we compensate our Plan Providers, and information about how Seniority Plus compares to other health plans.

You have the right to make recommendations about these rights and responsibilities, including the right to make recommendations about Health Net's rights and responsibilities statement. If you would like to make recommendations, please call Member Services at the telephone number on the first page of this booklet.

Along with the rights you have as a Member of Seniority Plus, you also have some responsibilities, which include the following:

- To become familiar with your coverage and the rules you must follow to get care as a Member of Seniority Plus by reviewing this booklet and other information you receive from Health Net.
- To ask your doctor if you have any questions, and to give your doctor and other Providers the information they need to care for you.

- To follow treatment plans, instructions, and care that are agreed upon by you and your doctors.
- To act in a way that supports the care given to other patients and helps the smooth running of your doctor's office, Hospitals, and other offices.
- To understand your health problems and to participate with your provider to develop mutually agreed-upon treatment plans.
- To pay your Plan Premiums as a Member of Seniority Plus, to pay any Copayments that are part of your covered medical services, and to meet your other financial responsibilities that are described in Section 9 of this booklet.
- To call Health Net Member Services at the telephone number on the first page of this booklet if you have any questions, suggestions, or problems with your care or payment.

SECTION 3. GETTING THE CARE YOU NEED, INCLUDING SOME RULES YOU MUST FOLLOW

(Seniority Plus's Service Area, using Plan Providers to get services covered by Seniority Plus, your Primary Care Provider, getting care from Specialists, when you do and do not need a Referral from your PCP, getting care when the doctor's office is closed, getting care when you are traveling or away from home.)

What is the geographic "Service Area" for Seniority Plus?

You can enroll in Seniority Plus and get Covered Services as long as you live in the plan's Service Area:

Alameda County

Contra Costa County

Kern County*

Los Angeles County

Orange County

Placer County*

Riverside County

Sacramento County

San Bernardino County

San Diego County

San Francisco County

San Mateo County*

Santa Barbara County*

Santa Clara County

Yolo County

*Partial county coverage. Please refer to Section 11 for more information on what ZIP codes are covered under these counties.

Using Plan Providers to get services covered by Seniority Plus

As a Member of Seniority Plus, you will get most or all of your care from "Plan Providers."

"**Providers**" is the general term we use for doctors, Hospitals, health care professionals, and health care facilities that are licensed and/or certified by Medicare and by the State to deliver or furnish health care services.

- We call them "**Plan Providers**" when they are part of Seniority Plus – that is, when we have contracted or arranged with them to coordinate or provide Covered Services or supplies to Members of Seniority Plus.
- We call them "**non-Plan Providers**" when they are **not** part of Seniority Plus.

Now that you are a Member of Seniority Plus, you will be getting your covered medical care and services from Plan Providers, with just a few exceptions that are described in this booklet. For a complete list of **Plan Providers**, please refer to the Seniority Plus Provider Directory. If you have any questions about the Providers listed in the directory, please call Member Services at the telephone number on the first page of this booklet.

Your PCP (Primary Care Provider) will coordinate all of your care

What is a "PCP" and how do you get one?

As a Member of Seniority Plus you will have a PCP who coordinates all of your care. Your PCP is a health care professional who is trained to give you basic care. Your PCP is responsible for providing or coordinating Covered Services while you are a Member of Seniority Plus.

When you enroll in Health Net Seniority Plus, you will select a contracting Physician Group from our Network. You'll also choose a PCP from this contracting Physician Group. You can find a list of all contracting Physician Groups (and their affiliated PCP's and Hospital affiliations) from the Health Net Seniority Plus contracting physician group directory. Health Net's Seniority Plus contracting physician directory is updated regularly to ensure it includes the newest physicians in our Network. Health Net Seniority Plus has made every attempt to ensure the accuracy of this directory, but we cannot guarantee the current availability of any Provider listed here. To confirm the availability of a Provider, or to ask about a specific PCP, please contact our Member Services Department at **1-800-274-4737** (or use the Seniority Plus Telecommunication Device for the Deaf at **1-800-929-9955**). Business hours are Monday through Friday, 7:30 a.m. to 12:00 p.m. and 1:00 p.m. to 5:00 p.m.

The name and office telephone number of your PCP is printed on your membership card.

What is "lock-in" and how does it work?

As a Seniority Plus Member, all of your routine health care is provided and arranged by your PCP. Your specialty care, x-rays, laboratory tests, therapy, prescription medications, Hospital

admissions and follow-up care will also be provided, authorized, or coordinated by your PCP. **This is known as "Lock-In."** If you go to a doctor, Hospital, or other Provider without the approval of your PCP --except in an emergency or when you need urgent care, out-of-area renal (kidney) dialysis, or certain gynecological care or other self referred services-- you will be responsible for paying any charges for these services. Neither Original Medicare nor Health Net will pay for non-Emergency Services or non-urgently needed care without the prior authorization of your PCP.

The "lock-in" feature is important to you and Health Net. We are able to offer you this plan because of our contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that oversees Medicare. Under this contract, the Federal Government agrees to pay us a fixed monthly dollar amount for each Member we serve. Since we use this monthly amount to contract with medical Groups, Hospitals, and other Plan Providers to arrange your care, you need to use these Plan Providers to get your Covered Services.

Getting care from your PCP

Since your PCP will coordinate all of your medical care, you should have all of your medical records sent to his/her office. This way your PCP will be able to look at your medical records to see if you have any existing health conditions and to coordinate your care.

If at all possible, call your PCP 24 hours in advance if you cannot keep a scheduled appointment.

If you need to talk to or see your PCP after his or her office has closed for the day, call the physician telephone number located on your Seniority Plus membership ID card or the Telecommunication Device for the Deaf at **1-800-929-9955**. There will always be a physician/Provider on call to help you.

The twenty-four (24) hour emergency and/or urgent care telephone numbers are located on your membership card.

You may also call Health Net Decision Power. This is a decision-support service that gives you 24-hour access to the guidance and expertise of your Health Coaches. This team of specially trained nurses, respiratory therapists and dietitians can provide the fact-based information and human support you need when you're facing a difficult health care decision. Your Health Net Decision Power Health Coach can:

- Provide fact-based information and human support through a severe medical event
- Help you better manage a chronic condition, such as diabetes or asthma
- Facilitate better communication between you and your doctor
- Send you additional written materials about a specific condition or treatment
- Provide you with an informative videotape of others who have faced similar decisions
- Help you understand all of your treatment options, so you can make the best choice

To use this service, please call **1-800-893-5597** or TTY/TDD **1-800-276-3821**, 24 hours a day, 7 days a week.

If you have any questions about this or any other benefit, please call the Member Services Department at **1-800-275-4737**, or TTY/TDD **1-800-929-9955** for the hearing impaired. Hours of operation are 7:30 a.m. to 12:00 p.m. and 1:00 p.m. to 5:00 p.m. Monday through Friday.

If you believe you are suffering from an Medical Emergency, contact **911** or proceed directly to the nearest emergency room.

Getting care from Specialists

Even though your PCP is trained to handle most of your common health needs, there may be times when he or she feels you need more specialized treatment. In that case, you may receive a Referral (written permission) to see a Specialist. Specialists are doctors who provide health care services for a specific disease or part of the body. Examples include oncologists (care for cancer patients), cardiologists (care for the heart), and orthopedists (care for bones).

Please note the following:

- It is very important to get a Referral from your PCP before seeing a Specialist. **If you don't have a Referral before you receive the services, you may have to pay for these services yourself**. As explained later in this section, there are a few services you can get on your own, without a Referral or other involvement of your PCP.
- If your Specialist recommends that you continue to see him/her for more services, check first with your PCP to be sure your Referral covers any additional visits to the Specialist.
- PCPs often have certain Specialists they use for Referrals. **Depending on who you chose as your PCP, you may be limited to what Specialists you can see.** In most cases, when you select a PCP, you are also selecting a specific Network of Specialists who are also affiliated with your selected medical Group. Your PCP will refer to these affiliated Specialists primarily, although in some cases, your PCP may refer you to a Specialist outside of his or her Network. Please be sure to consult with your PCP if there are specific Specialists or facilities that you want to use. Not all Specialists are available to all patients.
- In some cases, our Medical Management Department must give prior approval for a Referral. Your PCP will request this approval and let you know if it is given.

There are some services you can get on your own, without a Referral

You do not always need a Referral to see certain Specialists or get services. You are allowed to go on your own, without a Referral, for the following services -- as long as you get these services from a **Plan Provider**:

- Routine women's health care which includes breast exams, mammograms (x-rays of the breast), pap tests and pelvic exams.
- Flu shots and pneumonia vaccinations.
- Emergency services, whether you get these services from Plan Providers or non-Plan Providers (see Section 4 for more information).
- Urgently needed care that you get from non-Plan Providers when you are temporarily outside the plan's service area. Also, urgently needed care that you get from non-Plan Providers when you are in the service area but, because of unusual or extraordinary circumstances, the Plan Providers are temporarily unavailable or inaccessible. (See Section 4 for more information about urgently needed care. Earlier in this section, we explain the plan's service area.)
- Renal dialysis (kidney) services that you get when you are temporarily outside the plan's service area.

It is called "**self-refer**" when you get these services without a Referral from your PCP. You still have to pay your Copayment for these services.

How to change your PCP (Primary Care Physician)

You may request to change your PCP for any reason, at any time. Your request will be effective on the first day of the month following the date Health Net receives the request. Simply call Member Services and we will check to make sure the doctor you choose is accepting new patients. You should also ask whether the PCP has a Referral relationship with any Specialist you are currently seeing. Also, please let us know if you are getting Home Health Agency services or using Durable Medical Equipment so we can help with the transfer of your care or equipment. We will make the change for you and tell you over the phone when this change will go into effect and send you a new membership card.

What if your doctor leaves Seniority Plus?

Sometimes a PCP, Specialist, clinic or other Plan Provider you are using might leave the plan. If this happens, you will have to switch to another plan provider who is part of Seniority Plus. If your PCP leaves Seniority Plus, we will let you know, and help you switch to another PCP so that you can keep getting covered services.

The doctor-patient relationship

We do not prohibit or otherwise restrict a Provider, acting within the lawful scope of practice, from advising or advocating on your behalf about:

- your health status, medical care, or treatment options;
- the risks, benefits, and consequences of treatment or non-treatment;

- your right to refuse treatment and to express preferences about future treatment decisions.

Getting care when you travel or are away from the Service Area

When you are outside Seniority Plus's Service Area, we will only pay for Emergency Services, Urgently Needed Services, renal dialysis, and care that we have approved in advance. Be sure to check with Member Services at the telephone number on the first page of this booklet if you have questions about what medical care is covered when you travel.

If you plan to permanently move or be away from the Service Area for more than six months, we will have to disenroll you. For more information, see Section 11.

SECTION 4. GETTING CARE IF YOU HAVE AN EMERGENCY OR AN URGENT NEED FOR CARE

Getting care if you have an emergency

You are covered for a Medical Emergency whether you are inside or outside the Service Area.

We also offer world-wide emergency coverage.

What is a "Medical Emergency"?

A "medical emergency" includes severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse. A medical emergency is when **you reasonably believe that your health is in serious danger** - when every second counts and could result in:

- 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;
- Serious impairment to bodily functions; or
- Serious dysfunction of any bodily organ or part.

"Emergency services" are Covered Services inpatient and outpatient services that are given by any qualified Provider, and needed to evaluate or stabilize an medical emergency.

In an emergency, go to the closest emergency room or call **911** for help. **You do not need prior authorization for treatment of a Medical Emergency**. However, it is best if you can have someone telephone your medical Group as soon as possible so they can know you are being treated. The number to call is located on your Health Net membership card.

Even if you can't make the call when you are being treated, please have someone notify your medical Group that you were treated for a Medical Emergency as soon as possible, preferably within 48 hours. This will ensure that they can help manage your health care and can arrange your transfer when your medical condition is stable (as determined by your treating physician).

If you are treated for an Medical Emergency while out of the Service Area, we prefer that you return to the Service Area to receive follow-up care through your PCP. However, we will cover services given out of the Service Area as long as the care you need still meets the definition for either Emergency Services or Urgently Needed Services.

Post stabilization care

In most cases, if the emergency room physicians determine that you do not have a Medical Emergency, we will not cover any additional care that you receive if you are seeing non-Plan Providers. However, if you have had a Medical Emergency, we will cover medically necessary services related to the emergency from the time the non-Plan Provider requests authorization from us until:

- A Plan Provider assumes responsibility for your care; or
- We agree with the non-Plan Provider on a treatment plan for you; or
- Under certain circumstances, you are discharged.

Getting care if you have an urgent need for care that is not an emergency

What are "Urgently Needed Services"?

"Urgently needed services" are immediately needed as a result of an unforeseen illness, injury, or condition when it is not reasonable given the circumstances to get the services through your PCP or other Plan Providers. Ordinarily, these services are provided when you are out of the Service Area. In extraordinary cases, these are services provided when you are in the Service Area but Plan Providers are not available.

Getting Urgently Needed Services when you are <u>outside</u> the plan's Service Area

If you need urgent care when you are out of the Seniority Plus Service Area, we ask that, if possible, you first telephone your PCP. If you are treated for an urgent care condition while out of the Service Area, we prefer that you return to the Service Area to receive follow-up care through your PCP. However, we will cover follow-up services given out of the Service Area as long as the care you need still meets the definition for Urgently Needed Services.

Please remember that routine or elective medical services not authorized by Health Net, which are provided by non-Plan Providers, are not Covered Services. Neither Health Net nor Original Medicare will pay for such services. One exception: renal dialysis services are covered while you are temporarily out of the Service Area (for up to six months in a row) and Seniority Plus will cover these services.

Getting Urgently Needed Services when you are <u>in</u> the plan's Service Area

Even though Urgently Needed Services usually apply to care when you are out of the Service Area, sometimes you might feel that you need immediate medical advice or care even when you are in the Service Area. In these situations, please call your PCP for instructions.

SECTION 5. YOUR COVERAGE – THE MEDICAL BENEFITS AND SERVICES YOU GET AS A MEMBER OF SENIORITY PLUS

(An introduction to your benefits followed by a chart that lists your coverage for each type of benefits and services, with a section at the end that tells how you can purchase additional benefits.)

Introduction to your medical care benefits and services

This section describes the benefits and coverage you get as a Member of Health Net. Here is a definition of a term that we use:

Covered Services – The medically necessary benefits, services and supplies listed in the "Schedule of Medical Benefits" in this section, which are:

- Services provided or furnished by Seniority Plus Plan Providers or authorized by its Plan Providers.
- Emergency services and Urgently Needed Services which may be provided by Plan Providers and non-Plan Providers. (Please see Section 4 for more information about Emergency Services and Urgently Needed Services.)
- Post-stabilization services furnished by non-Plan Providers or facilities that are authorized by us or were not pre-approved because *we* did not respond to a request for pre-authorization for such services within 1 hour of the request (or because we could not be contacted for pre-authorization).
- Renal dialysis services (kidney) provided while you are temporarily outside the Service Area.

Your Schedule of Medical Benefits

All coverage will be provided in accordance with Medicare guidelines.

Covered Services	What You Pay for Covered Services
Inpatient Hospital Care* - *For more information, see Section 7.*	
• Semiprivate room (or a private room if medically necessary); • Meals including special diets; • Regular nursing services; • Costs of special care units, e.g., intensive or coronary care units; • Drugs and medications; • Lab tests; • X-rays and other radiology services; • Necessary surgical and medical supplies; • Use of appliances, such as wheelchairs; • Operating and recovery room costs; • Rehabilitation services, e.g., physical or occupational therapy and speech pathology services; • Transplants (kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal), under certain conditions; • Blood - Coverage begins with the fourth pint of blood that you need - you pay for the first 3 pints of unreplaced blood. Coverage of storage and administration begins with the first pint of blood that you need; and • Physician Services.	You pay a $250 Copayment for the Medicare-covered service(s) listed. Hospital Copayment are required for the first three admissions per Calendar Year. Once the Copayment is met, no Copayment is required for further admissions in the same Calendar Year. You are covered for unlimited days each Benefit Period.

Covered Services	What You Pay for Covered Services
Inpatient Hospital Transgender Surgery/Services** (including hysterectomy, oophorectomy and mastectomy) • Travel and lodging services. 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 Associationn (HBIGDA) standards. Psychotherapy and hormonal treatment are excluded from the lifetime maximum.	You pay a $250 Copayment for transgender surgery or services. Transgender surgery and related services (including travel and lodging 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*	You pay a $250 for services in a network Hospital. Hospital copayments are required for the first three admissions in each calendar year for covered services. Once the requirement is met, no copayment is required for further admissions in the same calendar-year. There is a 190-day lifetime limit in a psychiatric Hospital.
Inpatient Substance Abuse Care* • Residential care in a Hospital or substance abuse facility *For more information about inpatient substance abuse benefits, please see "Using Your Mental Health Care and Substance Abuse Benefits" in Section 7.*	You pay a $250 for services in a network Hospital. Hospital copayments are required for the first three admissions in each calendar year for covered services. Once the requirement is met, no copayment is required for further admissions in the same calendar-year.

Covered Services	What You Pay for Covered Services
Inpatient Services (when the inpatient stay itself is not or is no longer covered)*: *For more information, please see Section 7.* • Physician services; • Diagnostic tests (like X-ray or lab tests); • X-ray, radium, and isotope therapy including technician materials and services; • Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations; • Prosthetic 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; • Ambulance services.	There is no Copayment for the Medicare-covered service(s) listed.
Acute Care Detoxification* *For more information, please see Section 7.*	There is a $250 Copayment for acute care detoxification services. Hospital copayments are required for the first three admissions in each calendar year for covered services. Once the requirement is met, no copayment is required for further admissions in the same calendar-year.

Covered Services	What You Pay for Covered Services
Skilled Nursing Facility Care* *For more information, please see Section 7.* • Semiprivate room (or a private room if medically necessary); • Meals including special diets; • Regular nursing services; • Physical, occupational and speech therapy; • Drugs and biologicals; • Blood including storage and administration. Coverage begins with the fourth pint of blood that you need – you pay for the first 3 pints of unreplaced blood; • Medical and surgical supplies; • Laboratory test(s); • X-rays and other radiology services; • Use of appliances such as wheelchairs; • Physician Services.	There is no Copayment for services in a Skilled Nursing Facility. You are covered for 100 days each Benefit Period. No Hospital stay is required.
Home Health Care* *For more information, please see Section 7.* **Home Health Agency Care:** • Part-time or intermittent skilled nursing and home health aide services; • Physical therapy, occupational therapy and speech therapy; • Medical social services; • Medical equipment and supplies.	There is no Copayment for Medicare-covered home health visits.
Hospice Care *For more information, please see Section 7.* • Drugs for symptom control and pain relief, short-term respite care, and services not otherwise covered by Medicare. • Home care. • Hospice consultation services (one time only) for a terminally ill individual who has not yet elected the hospice benefit.	Hospice services in a Medicare-participating Hospice are reimbursed directly by Medicare when you enroll in a Medicare-certified Hospice. The terminally ill individual who has not yet elected the hospice benefit will pay $10 for the "one time only" Hospice consultation.

Covered Services	What You Pay for Covered Services
Outpatient Physician Services* • Office Visits including medical and surgical care in a physician's office or certified ambulatory surgical center; • Consultation, diagnosis and treatment by a Specialist; • Second opinion by another Plan Provider prior to surgery; • Outpatient Hospital services; • Non-routine-dental care (covered services is limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of the teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor).	You pay $10 for each primary care doctor Office Visit for Medicare-Covered Services. You pay $10 for each Specialist visit for Medicare-Covered Services.
Chiropractic Services* • Manual manipulation of the spine to correct subluxation.	You pay $10 per visit when using our Chiropractic Network (20 visits per Calendar Year)
Podiatry Services* • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs); • Routine foot care for members with certain medical conditions affecting the lower limbs.	You pay $10 for each Medicare-covered visit (medically necessary foot care). You pay $10 for each routine visit. Care is limited to one visit per calendar month with additional visits or Referrals arranged and approved by your PCP.

Covered Services	What You Pay for Covered Services
Outpatient Mental Health Care (including Partial Hospitalization Services)* - *For more information, please see Section 7.* Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other mental health care professional as allowed under applicable state laws. "Partial Hospitalization" is a structured program of active treatment that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	For Medicare-covered Mental Health services, you pay $20 for individual/group therapy visit(s) 1 and beyond For Medicare-covered Mental Health services with a psychiatrist, you pay $20 for individual/group therapy visit(s) 1 and beyond.
Outpatient Substance Abuse Services* - *For more information, please see Section 7.*	For Medicare-Covered Services, you pay $20 for individual/group visit(s) 1 and beyond.
Outpatient Surgery*	There is no Copayment for Medicare-covered visit to an ambulatory surgical center. There is no Copayment for Medicare-covered visit to an outpatient Hospital facility.
Outpatient Transgender Surgery/Services** (including hysterectomy, oophorectomy and mastectomy) • Travel and lodging services. 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 Associationn (HBIGDA) standards. Psychotherapy and hormonal treatment are excluded from the lifetime maximum.	There is no Copayment for transgender surgery or services. Transgender surgery and related services (including travel and lodging expenses) approved by the plan are subject to a combined inpatient and outpatient lifetime benefit maximum of $75,000 for each Member.

Covered Services	What You Pay for Covered Services
Ambulance Transportation - Includes ambulance services to an institution (like a hospital or SNF), from an institution to another institution, from an institution to your home, and services dispatched through **911**, where other means of transportation could endanger your life.	There is no Copayment for Medicare-covered ambulance services.
Emergency Services- *For more information, please see Section 4.*	You pay $50 for each Medicare-covered emergency room visit; you do not pay this amount if you are directly admitted to the Hospital.
World Wide Coverage	There is no Copayment for World Wide Coverage.
Urgently Needed Services *For more information, please see Section 4.*	You pay $50 for each Medicare-covered urgently needed care visit; you do not pay this amount if you are directly admitted to the Hospital.
World Wide Coverage	There is no Copayment for World Wide Coverage.
Outpatient Rehabilitation Services (Physical and Occupational Therapy and Speech and Language Therapy)*	There is no Copayment for Medicare-covered Occupational Therapy visit.
Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris.	There is no Copayment for Medicare-covered Physical Therapy and/or Speech/Language Therapy visit.
Durable Medical Equipment and Related Supplies* – Such as wheelchairs, crutches, Hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.	There is no Copayment for Medicare-covered items.

Covered Services	What You Pay for Covered Services
Prosthetic Devices *- (other than dental) which replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see Vision Care later in this section for more details.	There is no Copayment for Medicare-covered items.
Diabetes self-monitoring, training and supplies* • For all people who have diabetes (insulin and non-insulin users); • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors;	There is no Copayment for Diabetes supplies.
• One pair per calendar year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts;	There is no copayment for therapeutic shoes for people with diabetes who have severe diabetic foot disease.
• Self-management training is covered under certain conditions.	There is no Copayment for Diabetes self-monitoring training.
• For persons at risk of diabetes: Fasting plasma glucose tests. Contact Member Services for information on how often we will cover these tests.	There is no copayment for fasting plasma glucose tests for persons at risk of diabetes.
Medical Nutrition Therapy - for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.	You pay $10 for each Medicare-covered Medical Nutrition Therapy visit.

Covered Services	What You Pay for Covered Services
Outpatient Diagnostic Tests and Therapeutic Services and Supplies* • X-rays; • Outpatient radiation therapy; • Surgical Supplies, such as dressings; • Supplies, such as splints and casts; • Blood - Coverage begins with the fourth pint of blood that you need - you pay for the first 3 pints of unreplaced blood. Coverage of storage and administration begins with the first pint of blood that you need; and • Laboratory tests.	There is no Copayment for the Medicare-covered service(s) listed.
Bone Mass Measurements* For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no Copayment for each Medicare-covered Bone Mass Measurement

Covered Services	What You Pay for Covered Services
Colorectal Screening * *For people 50 and older, the following are covered:* • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • Fecal occult blood test, every 12 months. *For people at high risk of colorectal cancer, the following are covered:* • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. *For people not at high risk, the following is covered:* • Screening colonoscopy every 10 years, but not within 48 months of a screening flexible sigmoidoscopy.	There is no Copayment for Medicare-covered Colorectal Screening Exams.

Covered Services	What You Pay for Covered Services
Preventive Care Services	
Mammography Screening: • One screening for women age 40 and over every 12 months. • One baseline exam for women age 35 to 39 years of age.	There is no Copayment for Medicare-covered Screening Mammograms.
Cervical Cancer Screening tests (pap test): • For all woman, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months; • If you are at high risk of cervical cancer or have had abnormal Pap tests and are of childbearing age – one Pap test every 12 months.	There is no Copayment for Medicare-covered Pap Tests and Pelvic Exams.
Prostate Cancer Screening (For men age 50 and older)*: • Digital Rectal Exam – Once every 12 months; • Prostate Specific Antigen (PSA) Test - Once every 12 months.	There is no Copayment for Medicare-covered Prostate Cancer Screening exams.
Immunizations: • Pneumococcal pneumonia vaccine; • Flu shots; • Hepatitis B vaccine (if at risk of contracting the disease)*; • Other vaccines for those at risk.	There is no Copayment for the Pneumonia vaccine. There is no Copayment for the Flu vaccine. There is no Copayment for the Hepatitis B vaccine. You may self refer for mammography screening, cervical cancer screening tests, flu shots and pneumococcal shots.

Covered Services	What You Pay for Covered Services
Cardiovascular screening blood tests* Cholesterol and other lipid or triglyceride level blood tests for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). Contact Member Services for information on how often we will cover these tests.	There is no Copayment for Medicare-covered cardiovascular screening blood tests.
"Welcome to Medicare" physical exam* *For members whose Medicare Part B coverage begins on or after January 1, 2005*: A one-time physical exam within the first 6 months that you have Medicare Part B. Includes measurement of height, weight and blood pressure; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services. Does not include lab tests. Please refer to "Routine physical exams" for more information.	You pay $10 for each exam.
Renal Dialysis (Kidney) • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Sections 3 and 4); • Inpatient dialysis treatments (if you are admitted to a Hospital for special care; • Self-dialysis training (includes training for you and for the person 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 when needed, and check your dialysis equipment and water supply).	There is no Copayment for Medicare-covered Renal Dialysis.

Drugs and Biologicals
For more information, see Section 6.

"Drugs" includes substances that are naturally present in the body, such as blood clotting factors.

- Drugs that are usually not self-administered by the patient and are injected while receiving physician services.;
- Drugs you take using Durable Medical Equipment (such as nebulizers) that were authorized by Health Net;
- Clotting factors you give yourself by injection if you have hemophilia;
- Immunosuppressive drugs for individuals who get a Medicare covered organ transplant (as long as the transplant was paid for by Medicare);
- Injectable osteoporosis drugs, if you are home-bound, 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; and
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, Erythropoietin (Epogen®) or Epoetin alfa, and Darboetin Alfa (Aranesp®).
    - Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home.
- Injections for hormonal therapy related to a Gender Identity Disorder (GID).

Coverage for outpatient prescription drugs is very limited. The drugs covered under Original Medicare are generally drugs that must be administered by a health professional. In addition to the drugs listed here that are covered under Original Medicare, Seniority Plus offers an outpatient prescription drug benefit. This additional benefit is described below under the heading that says, "Seniority Plus Prescription Drug Benefit (Outpatient prescription drugs)."

There are no Copayments or coinsurances for Medicare-covered Drugs and Biologicals listed except for the Immunosuppressive drugs, certain oral anti-cancer drugs and anti-nausea drugs and injectable drugs for the treatment of osteoporosis for the home-bound who cannot self-administer and drugs used with Durable Medical Equipment:

The applicable Brand Name or Generic Drug Copayment applies.

For prescription drugs not covered by Medicare on the Recommended Drug List (RDL) (formulary), you pay for each prescription or refill:

- Level I (primarily generic) $10
- Level II (primarily brand) $20
- Level III (not on the RDL) $35

For up to a 30 days supply from a retail pharmacy.

- Level I (primarily generic) $20
- Level II (primarily brand) $40
- Level III (not on the RDL) $70

For mail order drugs up to a 90-day supply.

Covered Services	What You Pay for Covered Services
Drugs and Biologicals (continued)	For prescription drugs not covered by Medicare there is a $2000 Out of Pocket maximum per calendar year.
Dental Services Limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.	In general, you pay 100% for dental services.
Hearing Services* Diagnostic hearing exams	2 Standard Hearing Aids (one pair) are covered every 36 months that adequately meet the Member's medical needs and are determined to be Medically Necessary. You pay $10 for each Medicare-covered hearing exam (diagnostic hearing exams). You pay $10 for each routine hearing test up to 1 test every year.

Covered Services	What You Pay for Covered Services
Vision Care* Outpatient physician services for eye care; *For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older:* Glaucoma screening once per year; Original Medicare will pay for one pair of Eyeglasses or Contact Lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	There is no Copayment for the following items: Medicare-covered eye wear (one pair of Eyeglasses or Contact Lenses after each cataract surgery). You pay $10 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye). You pay $10 for each Routine eye exam, limited to 1 exam(s) every year. No Referral necessary for eye wear for any Network providers.
Routine Physical Exams	You pay $10 for each exam. You are covered up to 1 exam every year.

Covered Services	What You Pay for Covered Services
Health Education Programs Programs focused on clinical health conditions such as diabetes management, hypertension, cholesterol, asthma and special diets.	There is no Copayment for the following: - Health Ed classes - Newsletter - Nutritional Training - Smoking Cessation - Congestive Heart Program - Disease Management - Health Net Decision Power Ask Health Net of CA for details. No Referral necessary for Network providers.
Health Promotion Programs* Programs designed to enrich the health and lifestyles of Members include weight management, smoking cessation, fitness & stress management.	There is no Copayment.

** Services with an (*) require prior authorization unless provided by your selected PCP.*
*** Services with two (**) require prior authorization by Health Net.*

SECTION 6. USING YOUR COVERAGE FOR PRESCRIPTION MEDICINES

Coverage for outpatient Prescription Drugs

The Seniority Plus Prescription Drug benefit is above and beyond the basic Original Medicare benefit. Original Medicare covers a limited number of Prescription Drugs, usually those that must be administered by a health professional. See Section 5 for more information on Original Medicare-covered drugs. Original Medicare-covered prescriptions do not apply toward your Annual prescription benefit maximum (discussed below).

Seniority Plus offers a Prescription Drug benefit for covered outpatient Prescription Drugs when prescribed by a Seniority Plus physician and filled at a Plan Pharmacy or by our mail order service.

You are eligible for our Prescription Drug benefit if you are a Member of Seniority Plus.

How does the Prescription Drug benefit work?

Your Prescription Drug benefit allows you to get covered drugs through a two-tiered Copayment structure. You are not covered for Prescription Drugs that are not on the plan approved list (Recommended Drug List) (see "*What is the Recommended Drug List?*" below.) If your physician prescribes a drug from Seniority Plus Recommended Drug List, you will pay a $10 Copayment for Level I (primarily generic) drugs for up to a 30 day supply or a $20 Copayment for Level II (primarily brand-name drugs) for up to a 30 day supply. For drugs not on the Recommended Drug List you will pay a $35 Level III copayment. There is a $2000 Out of Pocket maximum for prescription drugs not covered by Medicare. The maximum will be reached once you have paid a total of $2000 in prescription drug copayments accumulated through the calendar year. If your physician prescribes a drug that is not on the Seniority Plus Recommended Drug List, you pay the full amount because only Recommended Drug List medications are covered.

How do you fill your prescriptions?

Retail Pharmacies

You can fill your prescription at any of our participating pharmacies. Please call Member Services at **1-800- 275-4737** (or use the Seniority Plus Telecommunication Device for the Deaf at **1-800-929-9955**) to obtain a list of participating pharmacies. Operating hours are Monday through Friday, 7:30 a.m. to 12:00 p.m. and 1:00 p.m. to 5:00 p.m.

If you are refilling a prescription, whenever possible please call the pharmacy 24 hours in advance so that your prescription will be ready for you when you come to pick it up. If you are a new Member and need to have an existing prescription refilled, call your Plan Provider so that you can arrange to have the prescription filled at a Seniority Plus pharmacy.

Mail order services

You may order up to a 90-day supply of "maintenance medications" by mail. A "maintenance medication" is a Prescription Drug used for treatment of long-term, ongoing medical problems in which the drug dosage has already been determined to manage chronic long term conditions and dosage adjustments are no longer required. When ordering by mail, your Copayment will be for mail order Generic Drugs on the Recommended Drug List and $20 for mail order for Level I (primarily generic drugs) on the Recommended Drug List and $40 for mail order Level II (primarily brand name drugs) on the Recommended Drug List and $70 for mail order Level III (drugs not on the Recommended Drug List) per prescription

If you purchase a Brand Name Drug and a Generic Drug equivalent exists, you pay the contracted cost difference between the equivalent Generic Drug and the Brand Name Drug, in addition to the Generic Copayment.

Call Member Services at the number on the front of this booklet for more information about ordering maintenance medications by mail. Mail order forms are available from Member Services or on the Health Net website at www.healthnet.com.

What is the "Recommended Drug List"?

Seniority Plus Prescription Drug benefit includes Recommended Drug List which is a list of preferred or recommended drugs that have been selected by Seniority Plus physicians and pharmacists based upon the safety, efficacy and value of those drugs.

The Seniority Plus Recommended Drug List is a comprehensive list of medications used by Seniority Plus physicians to guide their medication prescribing decisions. The Recommended Drug List is reviewed and revised quarterly and is subject to change without advance notice throughout the year. The Seniority Plus Recommended Drug List includes FDA-approved Brand Name and Generic Drugs.

A **Generic Drug** is a drug product that is not under a patent and made by many different companies that meets the approval of the FDA and that is equivalent to a brand name product in terms of quality and performance but may differ in certain other characteristics (e.g., shape, flavor, or preservatives). Generic drugs are made by many different companies in comparison to a brand name product which is only produced by one company. By law, Generic Drug products must contain the identical amounts of the same active drug ingredient as the brand name product. Seniority Plus pharmacies dispense Generic Drugs whenever possible.

You may use the Seniority Plus Grievance process (as described in Section 10) if you have complaints about which drugs are or are not included in the Recommended Drug List, or about the administration of the Recommended Drug List.

If your Seniority Plus Provider determines that you need a medication not on Seniority Plus Recommended Drug List, your physician must obtain prior authorization from Health Net. Upon

receipt of the request for prior approval, Health Net will either grant prior approval or deny the request. You have the right to Appeal any denial made by Health Net using the Appeals process described in Section 10.

How can you get a copy of the Recommended Drug List?

You may obtain a copy of the Seniority Plus Recommended Drug List by calling Member Services at **1-800- 275-4737** (or use the Seniority Plus Telecommunication Device for the Deaf at **1-800-929-9955**). Operating hours are Monday through Friday, 7:30 a.m. to 12:00 p.m. and 1:00 p.m. to 5:00 p.m. You may also go to the Health Net web site on the Internet at www.healthnet.com under Pharmacy, go to "See My Plan," "Recommended Drug List," "Print Recommended Drug List."

Medications covered by Original Medicare

The following medications are covered by Original Medicare:

- Medications administered to Seniority Plus Members as part of a covered Hospital or a covered Skilled Nursing Facility stay.
- Medications and vaccines administered in Seniority Plus Provider's office or Hospital outpatient department as incident to a physician service.
- Immunosuppressive drugs following a covered transplant (as long as the transplant was paid for by Medicare), certain oral anti-cancer drugs and anti-nausea drugs, antigens, and injectable drugs for the treatment of osteoporosis for the home confined who cannot self administer.
- Drugs used with authorized Durable Medical Equipment.

Generally, medications you can buy without a prescription are not covered by Seniority Plus.

Medicare-Approved Discount Drug Card Program

Health Net offers a Discount Drug Card Program with the Medicare-approved seal for people with Medicare. This means Medicare has approved our drug discount card program. While Medicare has approved our drug discount card, it is separate from the Medicare program and is not intended to replace any prescription drug benefits that you get with Seniority Plus.

This program is designed to help you lower the costs of your prescription drugs. As a member of the program you will be able to receive discount prices when you use your membership card at a plan pharmacy. You may also qualify for additional assistance up to $600 from Medicare this year and again next year to be used toward the cost of your prescription drugs from plan pharmacies. This assistance is in addition to the discounts you would get through our discount drug card program.

You can get more information on this program from Member Services (call the number on the cover of this booklet).

SECTION 7. USING YOUR COVERAGE FOR HOSPITAL CARE, CARE IN A SKILLED NURSING FACILITY, AND OTHER SERVICES

Using your coverage for Hospital care

If you need Hospital care Health Net will arrange Covered Services for you. Covered services are listed in the Schedule of Medical Benefits in Section 5 under the heading “Inpatient Hospital Care.” We use "Hospital," to mean a facility that is certified by the Medicare program and licensed by the State to provide inpatient, outpatient, diagnostic and therapeutic services. The term "Hospital" does not include facilities that mainly provide custodial care (such as convalescent nursing homes or rest homes). By “Custodial Care” we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

Hospital benefits are measured in terms of Benefit Periods. A Benefit Period is a period of consecutive days during which you get Covered Services. As long as you continue to be entitled, there is no limit on the number of Benefit Periods you may have.

Note: If your Seniority Plus coverage began while you were an inpatient in a Hospital, Health Net may not be responsible for the inpatient services until the date after your discharge. If we are not responsible for the inpatient services, either Original Medicare or the previous Medicare managed care plan you were enrolled is responsible for the inpatient Hospital services. We have Member Services representatives available at **1-800- 275-4737** (or TDD **1-800-929-9955** for hearing impaired), Monday through Friday, 7:30 a.m. to 12:00 p.m. and 1:00 p.m. to 5:00 p.m. They can tell you if we would be responsible for your inpatient services.

Seniority Plus is responsible for services, other than inpatient Hospital services, beginning on your effective date of enrollment.

When your inpatient stay is not covered

If the inpatient stay itself is not covered, you may still be eligible for coverage of some services when arranged by Health Net and furnished in a Plan Hospital or Skilled Nursing Facility. These services are listed in the Schedule of Medical Benefits in Section 5.

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

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

- Pre-operation;
- Operation;
- Post-operation visits to Northern CA Transgender surgeon only;
- Meals at a maximum of $55 per day;
- Coach airfare (patient will pay the difference to upgrade); and

- Airport parking limited to long term parking rates for all overnight trips in excess of one night.

The transgender surgery or services must be more than 100 miles from the provider in order for Health Net to cover the travel and lodging expenses.

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

Using your coverage for organ transplants

If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some Hospitals that perform transplants are approved by Medicare, and others are not). A Medicare-approved transplant center will decide whether you are a candidate for a transplant. When all requirements are met, the following types of transplants are covered: corneal, kidney, pancreas (when performed with or after a Medicare covered kidney transplant), liver, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. Please be aware that the following transplants are covered only if they are preformed in a Medicare approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

Using your coverage for care in a Skilled Nursing Facility (SNF)

If you need Skilled Nursing Facility care, we will arrange these services for you. Inpatient SNF coverage is limited to 100 days each Benefit Period. The purpose of this subsection is to tell you more about some rules that apply to your covered services.

A Skilled Nursing Facility is **a place that provides skilled nursing or rehabilitation services and is certified by Medicare**. It can be a separate facility, or part of a Hospital or other health care facility. A Skilled Nursing Facility is called a "SNF" for short. The term "Skilled Nursing Facility" does not include places that mainly provide Custodial Care, such as a convalescent nursing home or rest home. (By "Custodial Care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.)

What is skilled nursing facility care?

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

To be covered, the care you get in a SNF must meet certain requirements

To be covered, you must need daily skilled nursing or skilled rehabilitation care, or both. If you do not need daily skilled care, other arrangements for care would need to be made. Note that medical services and other skilled care will still be covered when you start needing less than daily skilled care in the SNF.

What is a "Benefit Period"?

A Benefit Period is used to determine Original Medicare coverage, and coverage under Seniority Plus. A Benefit Period begins on the first day you go to a Medicare covered inpatient Hospital or Skilled Nursing Facility (SNF). The benefit period ends when you have not been an inpatient at any Hospital or SNF for 60 days in a row. If you go to the Hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

Generally, you are an inpatient of a Hospital if you are receiving inpatient services in the Hospital. However, for Benefit Period purposes you are an inpatient in a SNF only if your care in the SNF meets certain skilled level of care criteria. This means that in order to have been an inpatient while in a SNF, you must have required skilled services on a daily basis and received daily skilled services that could, as a practical matter, only have been provided in a SNF on an inpatient basis. If any of these factors is not met then a stay in a SNF, even though it might include the delivery of some skilled services, is not covered.

Inpatient stays solely to provide Custodial Care are not covered

"Custodial care" is defined as care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by Seniority Plus unless it is provided as other care your are getting *in addition* to daily Skilled Nursing Care and/or skilled rehabilitation services.

What are "Home Care SNF" Services?

If you have been in the Hospital and were in a SNF when you were admitted to the Hospital, Health Net will allow you to choose to return to a Home SNF for post-Hospital extended care services upon discharge from the Hospital. The term "Home SNF" means either:

- The SNF where you resided at the time you were admitted to the Hospital;
- A SNF providing post-Hospital extended care services through a continuing care retirement community that provided residence to you at the time you were admitted to the Hospital; or
- The SNF in which your spouse is residing at the time you are discharged from the Hospital.

There are some restrictions on which Home SNFs are covered by Health Net (for example, the Home SNF must have a contract with us, or agree to accept payment under the terms that usually apply to SNFs that have contracts with us, and the Home SNF should be accessible and available to

our geographic Service Area). Therefore, you will need to call us at **1-800-275-4737** when choosing a Home SNF to make sure we cover the services it provides.

What happens if you join or drop out of Seniority Plus during a SNF stay?

If you either join or leave Seniority Plus during a SNF stay, special rules apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Member Services at the telephone number listed in Section 1. Member Services can explain how your services are covered for this stay, and what you owe to Health Net, if any, for the periods of your stay when you were and were not a plan member.

Using your coverage for home health agency care

To qualify for home health agency care benefits you must be confined to your home, be under a plan of treatment reviewed and approved by a physician, and require a medically necessary qualifying skilled service.

When you qualify for coverage of home health services, Seniority Plus covers either part-time or intermittent skilled nursing and home health aide services.

- "**Part-time or Intermittent**" means your skilled nursing and home health aide services combined total less than 8 hours per day and 35 or fewer hours each week.

You do not have to be bedridden to be considered confined to the home. However, your condition should be such that there exists a normal inability to leave the home and, consequently, leaving the home would require a considerable and taxing effort. If you leave the home, you may be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or to receive medical treatment.

Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

Using your coverage for Hospice care

(care for people who are near death)

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

As a Member of Seniority Plus, you may receive care from any Medicare-certified hospice. Your doctor can help you arrange for your care in a hospice. If you are interested in using hospice services, you can call Member Services at the number in Section 1 to get a list of the Medicare-certified hospice providers in your area, or you can call the Regional Home Health Intermediary at **1-414-226-6972**.

If you enroll in a Medicare-certified hospice, Original Medicare (rather than Seniority Plus) pays the hospice for the hospice services you receive. Your hospice doctor can be a Plan Provider or a non-Plan Provider. If you choose to enroll in a Medicare-certified hospice, you are still a plan Member and continue to get the rest of your care that is unrelated to your terminal condition through Seniority Plus. If you use non-plan providers for your routine care, Original Medicare (rather than Seniority Plus) will cover your care and you will have to pay Original Medicare out-of-pocket amounts.

The Medicare program has written a booklet about "Medicare Hospice Benefits." To get a free copy call **1-800-MEDICARE** (**1-800-633-4227;** TTY **1-877-486-2048**), 24 hours a day 7 days a week, which is the national Medicare help line, or visit the Medicare website at www.medicare.gov. Section 1 tells more about how to contact the Medicare program and about the website.

Using your coverage for clinical trials

A “clinical trial” is a way of testing new types of medical care, like how well a new cancer drug works. Clinical trials are one of the final stages of a research process to find better ways to prevent, diagnose, or treat diseases. The trials help doctors and researchers see if a new approach works and if it is safe.

Original Medicare covers routine costs of qualifying clinical trials. If you join a clinical trial, you will be responsible for any coinsurance under Original Medicare.

When you enroll in a clinical trial, the Providers are paid directly by Original Medicare for all the Covered Services you receive. The clinical trial Providers do not have to be Seniority Plus Providers.

This means that you do not need to get a Referral to join a clinical trial. However, you should tell us before you start a clinical trial. That way, we can still keep track of your health care services. You may remain enrolled in Seniority Plus even if you elect to participate in a clinical trial. Your care unrelated to the clinical trial can still be delivered by Seniority Plus.

Using your coverage for care in Religious Nonmedical Health Care Institutions

Services in a Medicare certified Religious Non-medical Health Care Institutions (RNHCIs) are covered by Seniority Plus under certain conditions. However, as with most services from Specialists, you will need authorization for care in a RNHCI. Religious aspects of care provided in RNHCIs are not covered.

To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you receive inpatient Hospital care or extended care services. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "nonexcepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under Federal, State or local law. "Nonexcepted" medical treatment is any other medical care or treatment.) You must also get authorization (approval) in advance from Seniority Plus, or your stay in the RNHCI may not be covered.

Using your Mental Health Care and Substance Abuse Benefits

The Mental Health and Chemical Dependency benefits are administered by MHN, a specialized health care service plan which contracts with Health Net to underwrite and administer these benefits.

To be covered, the Behavioral Health Administrator (MHN) must authorize these services and supplies.

The Behavioral Health Administrator will refer you to a nearby Participating Mental Health Professional. That professional will evaluate you to determine if additional treatment is necessary. If you need treatment, the Participating Mental Health Professional will develop a treatment plan

and submit that plan to the Behavioral Health Administrator for review. When authorized by the Behavioral Health Administrator, the proposed services will be covered by this Plan.

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

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

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

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

The following benefits are provided:

Outpatient Services
Outpatient crisis intervention, short-term evaluation and therapy, longer-term specialized therapy and any rehabilitative care that is related to Chemical Dependency are covered with unlimited visits. Medication management care is also covered when appropriate. Refer to the "Outpatient mental health care" and "Outpatient substance abuse services" portions of the Section 5 for Member cost shares.

Second Opinion
You may request a second opinion when:

- Your Participating Mental Health Professional renders a diagnosis or recommends a treatment plan that you are not satisfied with;
- You are not satisfied with the result of the treatment you have received;
- You 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 PCP or a referral Physician is unable to diagnose your condition or test results are conflicting.

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

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

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

Inpatient Services

Inpatient treatment of a Mental Disorder or Chemical Dependency is covered. Inpatient Mental Disorders is limited to a lifetime maximum of 190 days per Member.

Covered services and supplies include:

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

Detoxification

Inpatient services for acute detoxification and treatment of acute medical conditions relating to Chemical Dependency are covered, except as stated in the "Mental Disorders and Chemical Dependency Exclusions and Limitations" portion of "Medicare care and services that are not covered (list of exclusions)."

Serious Emotional Disturbances of a Child (SED)

The treatment and diagnosis of Serious Emotional Disturbances of a Child under the age of 18 is covered.

Severe Mental Illness
Treatment of Severe Mental Illness is covered.

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

Using your coverage for Chiropractic Services

Coverage for chiropractic services are limited to those services performed by a doctor of chiropractic, osteopathy or medicine licensed in the State of California. Services are only for treatment by means of manual manipulation of the spine to correct a subluxation.

Using your coverage for 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 contracting physician group. Please refer to the "Vision Care" portion of the Benefit Chart in this section for Member cost shares. We also offer coverage for your eyewear. The Health Net Vision Plan is offered by Health Net Seniority Plus 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 Medical Seniority Plus contracted optometrist or ophthalmologist will not be covered.

- Go to your eye exam and if you require eyeglasses or contact lenses, a prescription will be written. You are able to purchase eyewear from a list of Health Net Vision participating eyewear providers in California. Please note that the specialist who is authorized to provide your eye exam may not be a Health Net Vision contracting provider. Eyewear supplied by providers other than Health Net Vision Participating Eyewear providers are not covered. For more information or a list of Health Net Vision participating eyewear providers in California, please contact Health Net Vision at **1-866-392-6058** or visit our website at www.healthnet.com.

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

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

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

Eyewear Benefits

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

Eyewear Schedule:

	Cost Sharing:
Frames (one pair of Frames during a 24-month period) ……	Health Net Vision pays the first $100, then the Member pays 80% of the remaining balance, if applicable.
Standard Plastic Eyeglass Lenses (one pair every 24 months*):	
Single vision	Health Net Vision pays in full
Bifocal	Health Net Vision pays in full
Trifocal	Health Net Vision pays in full
Lenticular or aphakic monofocal	Health Net Vision pays the first $120, Member pays the remaining balance.
Lenticular or aphakic multifocal	Health Net Vision pays the first $200, Member pays the remaining balance.
Eyeglass Lens Options(one pair every 24 months*):	
Tint Pink or Rose #1 or #2 (only).....	Health Net Vision pays in full

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

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

Eyewear Schedule (continued):

Cost Sharing:

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

Conventional/Cosmetic (one pair every 24 months*) ..... Health Net Vision pays the first $100, then the Member pays 85% of the remaining balance, if applicable.

Disposable/Cosmetic
(If disposable Contact Lenses are used, you need to purchase enough pairs of disposable contact lenses to reach the allowable amount shown in "Eyewear Schedule" at one visit. If you do not use the full $100 allowed amount during the initial purchase, the remaining balance will not carry over) ..... Health Net Vision pays the first $100, Member pays the remaining balance.

Medically necessary** (one pair every 24 months*)
- Conventional or Disposable ..... Health Net Vision pays the first $250, Member pays the remaining balance.

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

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

*** Contact lenses are defined as medically necessary if the individual is diagnosed with one of the following conditions:*

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

If the Member is diagnosed with a medically necessary condition, the Health Net Vision provider will submit a request for pre-authorization to EyeMed. The EyeMed Medical Director reviews all requests for medically necessary contact lenses. If approved, the individual will be covered for medically necessary contact lenses up to the plan allowance.

Using your coverage for Chiropractic Services

American Specialty Health Plans of California, Inc. (ASH Plans) will arrange covered Chiropractic Services for you. You may access any Seniority Plus Contracted Chiropractor without a physician Referral, including without a Referral from your PCP. All covered Chiropractic Services require prior authorization by ASH Plans, except as listed below. The Seniority Plus Contracted Chiropractor you select will provide the initial examination and will contact ASH Plans for authorization of the treatment plan he/she develops for you. For a list of Seniority Plus Contracted Chiropractors, please call ASH Plans at **1-800-678-9133** (TDD/TTY **1-800-774-4344**), Monday through Friday 5:00 a.m. to 6:00 p.m., excluding holidays.

Chiropractic Services are covered up to the maximum number of 20 visits per Calendar Year for each Member.

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

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

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

- An initial examination by a Seniority Plus Contracted Chiropractor and the provision or commencement, in the initial examination, of Medically Necessary services that are covered Chiropractic Services, to the extent consistent with professionally recognized standards of practice; and

- Emergency Chiropractic Services.

When ASH Plans approves a treatment plan, the approved services for the subsequent Office Visits covered by the approved treatment plan include not only the authorized services but also a brief re-examination, in each subsequent Office Visit, if deemed necessary by the Seniority Plus Contracted Chiropractor, without additional approval by ASH Plans.

The following benefits are provided for Chiropractic Services:

Office Visits

- An initial examination is performed by a Seniority Plus Contracted Chiropractor to determine the nature of your problem, to provide or commence, in the initial examination, Medically Necessary Chiropractic Services that are Covered Services, to the extent consistent with professionally recognized standards of practice, and to prepare a treatment plan of services to be furnished. An initial examination will be provided to you if you seek services from a Seniority Plus Contracted Chiropractor for any injury, illness, disease, functional disorder, or condition with regard to which you are not, at that time, receiving services from the Seniority Plus Contracted Chiropractor. A **$10.00** Copayment will be required.
- Subsequent Office Visits, as set forth in a treatment plan approved by ASH Plans, may involve an adjustment, a brief re-examination, and other services, in various combinations. A Copayment will be required for each visit to the office.
- Adjunctive therapies, as set forth in a treatment plan approved by ASH Plans, may involve therapies such as ultrasound, hot packs, cold packs, electrical muscle stimulation and other therapies.
- A re-examination may be performed by the Seniority Plus Contracted Chiropractor to assess the need to continue, extend or change a treatment plan approved by ASH Plans. A re-evaluation may be performed during a subsequent Office Visit or separately. If performed separately, a Copayment will be required.

Second Opinion

If you would like a second opinion with regard to Covered Services provided by a Seniority Plus Contracted Chiropractor, you will have direct access to any other Seniority Plus Contracted Chiropractor. Your visit to a Seniority Plus 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 Seniority Plus Contracted Chiropractor.

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

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

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

Chiropractic Appliances
Chiropractic Appliances are covered when a Seniority Plus Contracted Chiropractor prescribes and issues them, for up to the maximum benefit of $50.00 per year.

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

SECTION 8. MEDICAL CARE AND SERVICES THAT ARE NOT COVERED (LIST OF EXCLUSIONS)

An "**exclusion" is an item or service** that Seniority Plus does not cover. You are responsible for paying for excluded items or services.

Any service (except for an emergency service or urgently needed service) that is not provided or arranged by a Plan Provider or not prior authorized is not covered by Seniority Plus or by Medicare.

Medical care and services that are not covered (list of exclusions)

In addition to any exclusions or limitations described in the Schedule of Medical Benefits (in Section 5), the following items and services are limited or not covered by Seniority Plus:

- Acupuncture.
- Charges imposed by immediate relatives or members of your household.
- Chiropractic care, *except* for Medicare-covered manual manipulation of the spine.
- Cosmetic surgery or procedures, *unless* it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery and all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast is covered.

Drugs prescribed for hormonal therapy for individuals who have been diagnosed with a covered Gender Identity Disorder (GID) may be covered.

- Cosmetic procedures, beyond surgery, that are related to transgender services are not covered.
- Custodial care is not covered by Seniority Plus unless it is provided in conjunction with skilled nursing care and/or skilled rehabilitation services. “Custodial care” includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
- Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency. (Please refer to Section 4 for more information on Emergency Services.)
- Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance *unless* medically necessary.

- Experimental or investigational medical and surgical procedures, equipment and medications, *unless* covered by Original Medicare or under an approved clinical trial. Experimental procedures and items are those items and procedures determined by Health Net and Original Medicare to not be generally accepted by the medical community. When deciding if a service or item is experimental, Health Net will follow Medicare's manuals or will follow decisions already made by Medicare
- Homemaker services.
- Hospice services in a Medicare-participating Hospice are not paid for by Health Net, but reimbursed directly by Original Medicare when you enroll in a Medicare-certified Hospice.
- Meals delivered to your home.
- Naturopaths' services.
- New procedures, services, supplies and medications are excluded until they are reviewed for safety, efficacy and cost-effectiveness and approved by Health Net Seniority Plus *unless* medically necessary and covered by Original Medicare.
- Non-emergency transportation *unless* ambulance transportation is determined to be medically necessary and other means of transportation would be inadvisable.
- Non-Medicare-covered organ transplants. Medical and Hospital services of a donor when the recipient of an organ transplant is not a Member of Health Net Seniority Plus.
- Nursing care on a full-time basis in your home.
- Orthopedic shoes, *unless* they are part of a leg brace and are included in the cost of the leg brace. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease as outlined in the schedule of medical benefits for "Outpatient Medical Services."
- Personal convenience items, such as a telephone or television in your room at a Hospital or Skilled Nursing Facility.
- Physical examinations for the purpose of maintaining or obtaining employment, licenses, insurance, court hearing, travel or for premarital and pre-adoption purposes and/or other non-preventive reasons, *unless* otherwise medically necessary.
- Prenatal, maternity or post-partum care for a non-Health Net Seniority Plus Member acting as a surrogate.
- Private duty nurses.
- Private room in a Hospital, *unless* medically necessary.
- Procedures, services, supplies, and medications until they are reviewed for safety, efficacy, and cost effectiveness and approved by Health Net or Medicare.

- Radial keratotomy and low vision aids and services.
- Reversal of sterilization procedures; sex change operations; and non-prescription contraceptive supplies and devices. (Medically necessary services for infertility are covered according to Original Medicare guidelines.)
- Routine dental care (such as cleanings, filling, or dentures) or other dental services. Certain dental services that you get when you are in the Hospital will be covered.
- Routine foot care is generally not covered under the plan or is limited according to Medicare guidelines.
- Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy or hyporgasmy.
- Services, procedures, treatment, supply or medication not specifically listed as a covered benefit or service in this Evidence of Coverage.
- Services provided to veterans in Veteran's Affairs (VA) facilities, *unless* the services are emergency services and the VA hospital is the closest facility.
- Services that are not covered under Original Medicare, *unless* such services are specifically listed in your Summary of Benefit or in this Evidence of Coverage.
- Services that are not reasonable and necessary under Original Medicare program standards unless otherwise listed as a covered service. Health Net provides all covered services according to Medicare guidelines.
- Services you receive from non-Plan Providers, *except* for care for a medical emergency and urgently needed care, renal (kidney) dialysis services that you get when you are temporarily outside the plan's service area (when provided by a Medicare certified dialysis center), and care from non-Plan Providers that is arranged or approved by a Plan Provider.
- Services you receive without a referral from your PCP, when a referral from your PCP is required for getting that service.
- Services you receive without Prior Authorization, when prior authorization is required for getting that service. (Please refer to Appendix A for a definition of Prior Authorization.)
- Stem cell harvesting and storage not associated with an approved transplant.
- Supportive devices for the feet, *except* for orthopedic or therapeutic shoes for people with diabetic foot disease as outlined in the Schedule of Medical Benefits.
- Surgical treatment of morbid obesity *unless* determined medically necessary by a Health Net Medical Director or designee and covered under Original Medicare.
- Vision Care Services other than Medicare allowable services.

Mental Disorders and Chemical Dependency Exclusions and Limitations

Mental health care as a condition of parole, probation or court-ordered testing for Mental Disorders is limited to Medically Necessary services and subject to this Plan's visit limits described in Section 5.

Services and supplies for treating Mental Disorders and Chemical Dependency are covered only as specified in the Section 5 under "Inpatient mental health care," "Outpatient mental health care" and "Outpatient substance abuse services." The treatment and diagnosis of Serious Emotional Disturbances of a Child under the age of 18 is also covered.

Additional exclusions and limitations:

The following exclusions apply specifically to Mental Disorders and Chemical Dependency.

- Aversion Therapy; therapy intended to change behavior by inducing a dislike for the behavior through association with a noxious stimulus is not covered.
- Services for obtaining or maintaining insurance are not covered.
- Services related to educational and professional purposes are not covered, including ancillary services such as:

  1. Vocational rehabilitation.
  2. Employment counseling, training or educational therapy for learning disabilities.
  3. Investigations required for employment.
  4. Education for obtaining or maintaining employment, or for professional certification.
  5. Education for personal or professional growth, development or training.
  6. Academic education during residential treatment.

- Chemical Dependency treatment not based on abstinence is not covered.
- Services, treatment or supplies rendered in a non-emergency by a non-participating provider or non-participating facility, are only covered when authorized by the Behavioral Health Administrator's Medical Director or his/her designee or otherwise provided by the Plan.

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

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

1. Treatment ordered by a court of law.
2. Treatment of chronic Pain. However, such treatment is covered as a medical benefit.
3. Treatment for co-dependency.
4. Treatment for psychological stress.
5. Treatment of marital or family dysfunction.

Treatment for smoking cessation, weight reduction, obesity, stammering, sleeping disorders, stuttering or sexual addiction is not covered under the Mental Disorders and Chemical Dependency benefits of this plan. However, treatment for smoking cessation and morbid obesity may be covered as a medical or Prescription Drug Benefit. Treatment related to judicial or administrative proceedings that is not Medically Necessary is also not covered.

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

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

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

- Mental Disorders or conditions of Chemical Dependency that the Behavioral Health Administrator determines are not likely to improve with generally accepted methods of treatment are not covered.
- Outpatient Prescription Drugs or over-the-counter drugs are not covered.
- Private duty nursing services in the home or in a Hospital are not covered.
- Services in a state Hospital are limited to treatment or confinement as the result of an emergency or Urgently Needed Care as defined in the "Appendix A."
- Treatment or consultations provided by telephone are not covered.
- Psychological testing is only covered when ordered by a licensed Participating Mental Health Professional and is Medically Necessary to diagnose a Mental Disorder for purposes of developing a mental health treatment plan or when Medically Necessary to treat a Mental Disorder or condition of Chemical Dependency.
- Treatment or consultation provided by the Member's parents, siblings, children, current or former spouse or any adults who live in the Member’s household, is not covered.
- Treatment of physiological diseases or defects, including but not limited to organic brain disease is not covered. However, some conditions shall be covered, provided that their

level of severity meets the criteria described in the definitions of "Serious Emotional Disturbances of a Child" and/or "Severe Mental Illness" in the “Appendix A” section.

- Testing, screening or treatment for learning disabilities are not covered. However, some conditions shall be, provided that their level of severity meets the criteria described in the definitions of "Serious Emotional Disturbances of a Child" and/or "Severe Mental Illness" in the “Appendix A” section and the conditions are treated by Participating Mental Health Professionals
- Treatment of detoxification in newborns is not covered.
- Services in excess of those authorized by the Behavioral Health Administrator's Medical Director or his/her designee, unless such services are determined to be Medically Necessary.

Prescription Drug Exclusions and Limitations

In addition to the above standard exclusions, the following items and services are limited or excluded from your Prescription Drugs benefits.

***Note*: Services or supplies excluded under the non Medicare-covered Prescription Drug benefits may be covered under your medical benefits portion of this *Evidence of Coverage*.**

- Medications you can buy without a prescription are not covered by Health Net Seniority Plus.
- Drugs prescribed by any physician who is not a plan physician, an authorized Specialist, or is not a physician to whom you are referred by a plan physician, *except* in conjunction with emergency or Urgently Needed Services.
- Prescription drugs dispensed by nonparticipating pharmacies (plan pharmacies). (For a list of plan pharmacies, please contact Health Net.)
- Services or supplies for which you are not legally required to pay.
- Prescriptions, services, or supplies in which no charge is made including, but not limited to, any provision in Workers' Compensation or similar law.
- A drug which can be purchased without a prescription order (These are commonly called over-the-counter drugs).
- Devices or appliances whether or not prescribed by a plan physician (These items may be covered under your Durable Medical Equipment benefit).
- Oxygen (This is covered under the Durable Medical Equipment benefit).
- Drugs prescribed for cosmetic purposes as determined by Health Net.
- Cosmetics and health or beauty aids.
- Anorectics (appetite suppressants) or any drugs used for the purpose of weight loss.
- Biological sera, blood, blood derivatives, or blood plasma. (Covered under Inpatient

Hospital or Skilled Nursing Facility benefit).

- Allergy desensitization products, whether administered to the patient by the attending plan physician, or which are billed by a Hospital or Skilled Nursing Facility. (These are covered under the Medicare-covered Drugs and Biologicals).
- Prescription drugs or medicines delivered or administered to the patient by the attending plan physician, or which are billed by a Hospital or Skilled Nursing Facility. (These are covered under the Medicare-covered Drug and Biologicals, Inpatient Hospital or Skilled Nursing Facility benefit.)
- Medications limited by law to "investigational use."
- Medications prescribed for experimental purposes or indications not approved by the U.S. Food and Drug Administration (FDA), *unless* the drug is being prescribed to treat a life-threatening or chronic and seriously debilitating condition and the off-label use of the drug for that purpose has generally been recognized as safe and effective or as covered by Medicare.
- Injectables (*except* insulin) and pharmaceutical agents purchased for surgical implantation. Injectables such as Erythropoietin, Osteoporosis drugs, and certain Oral anti-cancer drugs. (Covered under Medicare-covered Drugs and Biologicals benefit.)
- Drugs prescribed to treat baldness or conditions of hair loss.
- Drugs prescribed to remove or lessen wrinkles in the skin.
- Contraceptive foams, abortifactients, or menstrual induction drugs.
- Vaginal contraceptives, *except* diaphragms and cervical caps which are covered as a Prescription Drug benefit when a plan physician performs a fitting examination and prescribes the device.
- Therapeutic devices or appliances, support garments. (These may be covered under Durable Medical Equipment.)
- Blood/urine monitoring aids and devices (These may be covered under Diabetes Monitoring), and other non-medical substances, regardless of intended use.
- Dietary food or nutritional supplements, vitamins, or homeopathic drugs.
- Unit dose or "Bubble" packaging which are individual doses of medication dispensed in plastic or foil packages, *unless* medically necessary or only available in that form.
- Drugs (including injectable medications) when Medically Necessary for treating sexual dysfunction are limited to two doses per week or eight tablets per month. Sexual Dysfunction drugs are not available through the mail order program.
- Replacement drugs for lost, stolen or destroyed drugs.
- Medical devices (other than diaphragms or cervical caps) even if prescribed by a member

physician.

- Drugs prescribed for a condition, or treatment that is not covered by this plan.
- Drugs prescribed by a physician who is not a member physician or an authorized Specialist, *except* when the physician's services have been authorized, or because of a medical emergency condition, illness, or injury, or as specifically stated.
- Compounded drugs.
- Drugs for infertility are not covered *unless* medically necessary.

Vision Care Exclusions and Limitations

In addition to the above standard Exclusions, the following items and services are also limited or excluded under the Using your coverage for Vision Care portion of the "Using your coverage for Hospital care, care in a Skilled Nursing Facility, and other services" section:

- Eye exams are not covered. For covered eye exams please refer to the "Your Coverage – the medical benefits and services you get as a Member of Seniority Plus" 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 (refer to footnote #1).
- 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 please refer to "Your Coverage – the medical benefits and services you get as a Member of Seniority Plus" 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 please refer to "Your Coverage – the medical benefits and services you get as a Member of Seniority Plus" section.
- Vision aids (other than Eyeglasses or Contact Lenses) are not covered.
- The Eyewear allowance for Progressive Lenses is the same as for trifocal Lenses. Any difference between that and the retail price is your responsibility.
- The cost of tinting Lenses is limited to pink or rose #1 and #2 tints.

- 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.

Chiropractic Services Exclusions and Limitations

In addition to the above standard Exclusions, the following items and services are also limited or excluded under the “Using your coverage for Chiropractic Services” portion of the "Using your coverage for Hospital care, care in a Skilled Nursing Facility, and other services" section:

- Prescription drugs and over-the-counter drugs are not covered.
- Durable Medical Equipment is not covered.
- Educational programs, nonmedical self-care, self-help training or any self-help physical exercise training or related diagnostic testing are not covered.
- Hypnotherapy, behavior training, sleep therapy and weight programs are not covered.
- Services provided by chiropractors who do not contract with ASH Plans are not covered, except with regard to Emergency Chiropractic Services or upon a Referral by American Specialty Health Plans of California, Inc.
- Examinations or treatments for conditions unrelated to Neuromusculo-skeletal Disorders are not covered. This means physical therapy not associated with spinal, muscle and joint manipulation, is not covered.
- Services provided by a chiropractor practicing outside California are not covered, except with regard to Emergency Chiropractic Services.
- Services that are not within the scope of licensure for a licensed chiropractor in California.
- The diagnostic measuring and recording of body heat variations (thermography) are not covered.
- Transportation costs are not covered, including local ambulance charges.
- Services or treatments that are not documented as Medically Necessary chiropractic care are not covered.
- Vitamins, minerals, nutritional supplements or other similar products are not covered.

Dental Services Exclusions and Limitations

In addition to the above standard Exclusions, the following items and services are also limited or excluded under the “Using your coverage for Dental Services” portion of the "Using your coverage for Hospital care, care in a Skilled Nursing Facility, and other services" section:

- Prophylaxis at "No charge" is limited to one every 12-consecutive months. "Additional Prophylaxis" at $25.00 is limited to one every 12-consecutive months.
- Fluoride treatment is a covered benefit up to the age of 18, once every 12-consecutive months.
- Bitewing X-rays are limited to one series of four films in any 12-consecutive months.
- Full mouth X-rays are limited to once every 24-consecutive months.
- Sealants are covered to the age of 14 and are limited to permanent first and second molars only.
- Periodontal treatments are limited to four treatments in any 12-consecutive months.
- Replacement of a restoration is covered only when it is Dentally Necessary.
- Extractions solely for orthodontic purposes are considered to be Elective Dentistry and therefore are not covered.
- Fixed bridgework will be covered only when a partial cannot satisfactorily restore the case. If fixed bridges are used when a partial could satisfactorily restore the case, they are considered to be Elective Dentistry. Replacement of existing bridgework is covered only when it cannot be made satisfactory by repair.
- Partial dentures are not to be replaced within any five year period *unless* necessary due to natural tooth loss where the addition or replacement of teeth to the existing partial is not feasible.
- Full upper and/or lower dentures are not to exceed one for each arch in any five year period. Replacement will be provided by Plan for an existing full or partial denture only if it is unsatisfactory and cannot be made satisfactory by either reline or repair.
- Denture relines are limited to one per arch per 12-consecutive months.
- Only 24-months of usual and customary orthodontic treatment is covered.
- Any treatment requested or appliances made which are either not Dentally Necessary for maintaining or improving dental health, or are for Aesthetic (performed for cosmetic purposes) or Elective Dentistry purposes.
- Any inpatient/outpatient Hospital charges of any kind including Dentist and/or physician charges, including prescriptions and medications not normally supplied or dispensed by a dental office. These services may be provided directly by your PCP if determined to be Medically Necessary and a Covered Service.

- General anesthesia and/or intravenous sedation used specifically for dental Covered Services.
- Replacement of lost or stolen dentures, appliances, or bridgework.
- Treatment of malignancies, cysts, and neoplasms. These services will be provided by or through the PCP.
- Procedures, appliances, or restorations to correct congenital, developmental or medically induced dental disorders, including, but not limited to, treatment of myofunctional, myoskeletal, or temporomandibular joint dysfunctions. These services will be provided by or through the PCP, if they are Medically Necessary and a Covered Service.
- Any procedure of implantation or of an Experimental or Investigational nature.
- Dental treatment started prior to your eligibility under Seniority Plus, or started after your termination from Seniority Plus.
- Any dental procedure unable to be performed in the dental office because of your general health and physical limits in accordance with professionally recognized standards of practice.
- Any procedure performed for the purpose of correcting contour, contact or occlusion.
- Any procedure to correct tooth structure lost due to attrition, erosion, or abrasion.
- Any procedure not specifically listed as a Covered Service.
- If patient and Provider elect a treatment plan disallowed by Health Net Dental, Seniority Plus will not assume further liability for additional treatment on that tooth/teeth.

Note: In addition to the above Dental Services Exclusions, the following orthodontic items and services are also limited or excluded under the Dental Services portion of the "Using your coverage for Hospital care, care in a Skilled Nursing Facility, and other services" section:

- No benefits will be paid for an orthodontic treatment program that began before you enrolled in the Health Net Dental Seniority Plus Plan.
- No benefits will be paid for orthodontic care required in excess of 24-months from the time bands (braces) are placed on your teeth.
- No benefits will be paid for damage to your orthodontic appliances (headgear and non-repairable retainers) and metal bands.
- Cases involving surgical orthodontics are not covered.
- Charges for lost metal bands, headgear, and retainers are not covered.
- If you relocate and are unable to receive treatment from a Seniority Plus Participating

Orthodontist, coverage under Seniority Plus ceases and it becomes your obligation to pay the usual and customary fee of the orthodontist where the treatment is completed.

- After orthodontic treatment begins or when you change your residence, your choice of orthodontic Providers is limited to Seniority Plus Participating Orthodontists participating in this program or willing to accept the fees outlined.
- If you become ineligible during the course of treatment, coverage under this program ceases and it becomes your obligation to pay the entire remaining balance due for your treatment plan.
- No benefits will be paid for initial work-ups for orthodontic treatment that include, but are not limited to x-rays, study models, and cephalometric records.

SECTION 9. WHAT YOU MUST PAY FOR YOUR MEDICARE HEALTH PLAN COVERAGE AND FOR THE CARE YOUR RECEIVE

(Paying the Plan Premium for your membership in Seniority Plus, paying for Medicare Part A and Part B, paying your share of the cost when you receive care (such as Copayments or other charges for Office Visits, prescriptions, Hospital stays, etc.), what happens when you have other insurance.)

Introduction: a summary list of your financial obligations

The list below is a summary of your financial responsibilities as a Member of Seniority Plus. Each item in this list is explained in this section.

As a Member of Seniority Plus, you must:

1. Pay any applicable Plan Premium (see details below under "Paying the premium for your health plan coverage as a Member of Seniority Plus").
2. Pay your plan deductible (see details below under "Deductibles, Copayments and other charges you must pay when you receive care and services").
3. Pay any applicable Copayments (see details below under "Deductibles, Copayments and other charges you must pay when you receive care and services").
4. Continue to pay your Medicare Part B premium (see details below under "Paying for Medicare Part A and Part B").
5. Pay for services not covered by Original Medicare or Health Net (see "You must pay for services that are not covered by Original Medicare or Health Net" below).
6. Pay for services you receive after a benefit such as a Prescription Drug benefit has been used up (see details below under "You must pay for services that are not covered by Original Medicare or Health Net.").
7. Keep Health Net up-to-date about other health insurance coverage you have, so that we can "coordinate your benefits" (see "What if you have other health insurance coverage besides Seniority Plus?" below).

Paying the premium for your health plan coverage as a Member of Seniority Plus

What happens if you or the Group don't pay the Plan Premiums or don't pay them on time?

We will disenroll you from Seniority Plus if you or your Group do not pay the Plan Premiums within the 90-day grace period. You will then have Original Medicare coverage. We will tell you in writing when that grace period begins if you have not paid your Plan Premiums.

Can the Plan Premium change?

We are allowed to decrease your Plan Premium described in the Group Service Agreement, but we cannot increase it. Increases in your Plan Premium are only allowed at the beginning of each Calendar Year, and must be approved by the Medicare program. Your Group will let you know if there will be any changes in your premiums or what you have to pay. Your Group will also let you know if we plan to decrease your Plan Premium.

Paying for Medicare Part A and Part B

- Medicare Part A Premium -- Most people do not have to pay a monthly premium to cover Medicare Hospital Insurance (Part A) because they or their spouse paid Medicare taxes while they were working. If you have to pay for Part A, you must continue to pay your Medicare Part A premium. If you would like to purchase Part A, please call your local Social Security Office or call **1-800-772-1213** toll free. The TTY number for Social Security is **1-800-325-0778**.
- Medicare Part B Premium -- This is a monthly premium paid to Medicare to cover supplemental Medical Insurance (Part B). If you receive Social Security benefits, this premium is usually taken out of your benefits. Otherwise your premium is paid directly to Medicare by you or by someone on your behalf (such as your State Medicaid agency).

Copayments, and other charges you must pay when you get care

What are "deductibles" and "Copayments"?

- Deductible **--** The amount you must pay for health care, before Seniority Plus begins to pay.
- Copayment -- The amount that you pay for each medical service you get, such as a doctor visit. It is a set amount per visit. All Copayments should be paid at the time of service.

You must pay for all care and services that are not covered by Original Medicare, your Group or Health Net.

You are personally responsible for paying for care and services that are not covered by Original Medicare, your Group or Health Net. With just a few exceptions, you must pay for services you receive from Providers who are not part of Seniority Plus unless Health Net has approved these

services in advance. The exceptions are Emergency Services, Urgently Needed Services, and out-of-area renal (kidney) dialysis services, and services that are found upon appeal to be services that we should have paid or covered.

What happens if you have other insurance?

You must use other insurance coverage if you have it

If you have other health insurance in addition to coverage with Seniority Plus, you may need to use this other insurance coverage in combination with your coverage as a Member of Seniority Plus to pay for the care you receive. This is called "coordination of benefits" because it involves *coordinating* all of the health *benefits* that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

Please keep us up to date on any additional insurance you have

You must tell us if you have any other health insurance coverage besides Seniority Plus, and let us know whenever there are any *changes* in your additional insurance coverage. These types of additional insurance you might have include the following:

- Coverage that you have from an employer's Group health insurance for *employees* or *retirees*, either through yourself or your spouse;
- Coverage that you have under workers' compensation because of a job-related illness or injury, or under the Federal Black Lung Program;
- Coverage you have for an accident where no-fault insurance or liability insurance is involved;
- Coverage you have through Medicaid or through the "Tricare for Life" program (veteran's benefits);
- Coverage you have for dental insurance or Prescription Drugs; or
- "Continuation coverage" that you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their Group health coverage for a time after they leave their Group health plan under certain conditions) or coverage under Health Net's Seniority Plus Individual Agreement.

Who pays first when you have additional insurance?

If you have additional insurance coverage, how we coordinate your benefits as a Member of Seniority Plus with your benefits from other insurance depends on your situation. With coordination of benefits, you will often get your care as usual through Seniority Plus, and the other insurance you have will simply help pay for the care you receive. In other situations, such as for benefits that are not covered by Seniority Plus, you may get your care outside of Seniority Plus.

In general, the insurance company that pays its share of your bills *first* is called the **"primary payer**." Then the other company or companies that are involved -- called the "**secondary payers**" -- each pay their share of what is left of your bills. Often your other insurance company will settle its share of payment directly with Health Net and you will not have to be involved. However, if payment owed to Health Net is sent directly to you, you are required under Medicare law to give this payment to Seniority Plus.

When you have additional health insurance, **whether we pay first or second --or at all-- depends on what type or types of additional insurance you have and the rules that apply to your situation.** Many of these rules are set by Medicare. Some of them take into account whether you have a disability or have End-Stage Renal Disease (permanent kidney failure), or how many employees are covered by an employer's Group insurance.

If you have additional health insurance, please call Member Services at the phone number on the first page of this booklet to find out which rules apply to your situation, and how payment will be handled. Also, the Medicare program has written a booklet with general information about what happens when people with Medicare have additional insurance. It's called *Medicare and Other Health Benefits: Your Guide to Who Pays First (publication number 02179)*. You can get a copy by calling **1-800-MEDICARE** (**1-800-633-4227**; TTY **1-877-486-2048**), 24 hours a day, 7 days a week, or by visiting the www.medicare.gov website.

How we pay the doctors and other Providers who take care of you

In order to get quality service in an efficient manner, Health Net pays its Providers using various payment methods, including capitation, per diem, incentive and discounted fee-for-service arrangements.

- Capitation means paying a fixed dollar amount per month for each Member assigned to the Provider.
- Per diem means paying a fixed dollar amount per day for all services rendered.
- Incentive means a payment that is based on appropriate medical management by the Provider.
- Discounted fee-for-service means paying the Provider's usual, customary and regular fee discounted by an agreed-to percentage.

You have the right to ask if we have special financial arrangements with our physicians that can affect the use of Referrals and other services that you might need. To get this information, call Member Services at the number on the first page of this booklet and ask for information about our physician payment arrangements.

Note that it is Health Net responsibility to pay Provider charges for the covered benefits and services you receive (other than the Copayments, or other payments that are your responsibility).

This includes paying Plan Providers (those that are part of Seniority Plus), and paying non-Plan Providers who have been authorized by us to provide services to you, or who provide covered emergency, post-emergency, Urgently Needed Services, or out-of-area dialysis. In the event we fail to pay Provider charges for Covered Services or prior authorized services, you will not be liable for any payment owed by Health Net.

What if you pay or are billed for services you believe we should pay for?

If you *pay for* covered emergency, urgently needed, or out-of-area renal (kidney) dialysis services which you receive from a non-Plan Provider, please send your bill to us at the following address and we will reimburse you for the covered amount:

Health Net Seniority Plus
Member Services Department
P.O. Box 10198
Van Nuys, CA 91410-0198

If you *receive a bill* from any non-Plan Provider in the United States, please do not pay it. Instead, please send it to us at this same address above; we will pay for the covered amount.

All Foreign or Cruise Claims must be mailed to:
Health Net Seniority Plus
"Attention Foreign Claims"
P.O. Box 10198,
Van Nuys, CA 91410-0198.

SECTION 10. APPEALS AND GRIEVANCES: WHAT TO DO IF YOU HAVE CONCERNS OR COMPLAINTS

(How to handle problems related to your coverage, including payment for your care; problems about Hospital discharge; and other types of problems.)

We encourage you to let us know right away if you have questions, concerns, or problems with any part of your coverage. Please call Member Services at the number on the first page of this booklet.

This section explains what you can do to deal with any problems you may have. It gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your medical care as a Member of Seniority Plus. The Medicare program has helped set the rules about what you need to do to make a complaint, and what we are required to do when we receive a complaint. You cannot be dropped from Seniority Plus or penalized in any way if you make a complaint.

Benefits that are Employer-Sponsored Benefits to Health Net Seniority Plus are not subject to review or approval by CMS. Only Health Net Seniority Plus Plan's Basic Benefits provided to Members of the Group are subject to CMS review and approval.

For information on Appeals and Grievances procedures for your Employer-Sponsored Benefits, please refer to “Grievance and Appeals Procedures for your Employer-Sponsored Benefits” later in this section.

In this section, **we use the word "complaint" in a general way to mean an action you can take to deal with a problem**. There are different rules for making complaints depending on the type of problem you are having. This section has separate parts that give the rules for each of the following situations:

- Complaints related to your coverage, including payment for your care. This includes whether a particular treatment or other care you want is covered by Seniority Plus. It also includes whether Health Net will pay for care you have received that you think is covered by Seniority Plus.
- Making complaints (appeals) if you think your coverage for SNF, home health or comprehensive outpatient rehabilitation services is ending too soon.
- Complaints about being discharged from the Hospital too soon.
- Complaints (called" grievances") about *all other* types of problems.

As you will see later in this section, a complaint that asks for a decision about coverage or payment for care to be reconsidered is called an "**Appeal**" or a "request for reconsideration." A

complaint about quality of care is called a "**Grievance**" (complaints about quality of care fall under the category of "complaints about all other types of problems").

Complaints related to your coverage, including payment for care

This part of Section 10 explains what you can do if you have problems getting the medical care you believe that we should provide. We use the word "provide" in a general way to include such things as authorizing care, paying for it, arranging for someone to provide it, or continuing to provide a medical treatment you have been getting. Problems getting the medical care you believe we should provide include the following situations:

- If you are not getting the care you want, and you believe that this care is covered by Seniority Plus;
- If Health Net will not authorize the medical treatment your doctor or other medical Provider wants to give you, and you believe that this treatment is covered by Health Net;
- If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health;
- If you have received care that you believe is covered by Seniority Plus, while you were a Member of Seniority Plus, but we have refused to pay for this care.

Six possible steps for requesting care or payment from Seniority Plus

If you are having a problem getting care or payment for care, there are six possible steps you can take to request the care or payment you want from Health Net. At each step, your request is considered and a decision is made. If you are unhappy with the decision, there may be another step you can take if you want to continue requesting the care or payment.

- In Steps 1 and 2, you make your request directly to Health Net. We review it and give you our decision.
- In Steps 3 through 6, people in organizations that are not connected to Health Net make the decisions about your request. To keep the review independent and impartial, those who conduct the review and make the decision in Steps 3 through 6 are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.

The six possible steps are summarized below. **These same six steps are covered in more detail in Appendix B at the end of this booklet.**

STEP 1: The Initial Decision by Health Net

The starting point is when Health Net makes an "Initial Decision" (also called an "organizational decision") about your medical 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. As explained in Appendix B, you can ask for a "fast Initial Decision" if you have a request for medical care that needs to be decided more quickly than the standard time frame.

STEP 2: Appealing the Initial Decision by Health Net

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an "**Appeal**" or a "request for reconsideration." As explained in Appendix B, you can ask for a "fast Appeal" if your request is for medical care and it needs to be decided more quickly than the standard time frame. 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 we turn down part or all of your request in Step 2, we are **required** to send your request to an independent review organization that has a contract with the federal government and is not part of Health Net. This organization will review your request and make a decision about whether we must give you the care or payment you want.

STEP 4: Review by an Administrative Law Judge

If you are unhappy with the decision made by the organization that reviews your case in Step 3, you may ask for an **Administrative Law Judge** to consider your case and make a decision. The Administrative Law Judge works for the federal government. The dollar value of your medical care must be at least $100 to be considered in Step 4.

STEP 5: Review by a Medicare Appeals Council

If you or Health Net are unhappy with the decision made in Step 4, you or Health Net may be able to ask a **Medicare Appeals Council** to review your case. This Council is part of the federal department that runs Medicare.

STEP 6: Federal Court

If you or Health Net are unhappy with the decision made by the Medicare Appeals Council in Step 5, either you or Health Net may be able to take your case to a Federal Court. The dollar value of your medical care must be at least $1,050 to go to a Federal Court.

For a more detailed explanation of all six steps outlined above, please see Appendix B at the end of this booklet.

What to do if you think coverage of your Hospital stay is ending too soon

When you are hospitalized, you have the right to get all the Hospital care covered by Seniority Plus that is necessary to diagnose and treat your illness or injury. According to Federal law, the date you leave the Hospital (your "**discharge date**") must be determined solely by your medical

needs. This part of Section 10 explains what to do if you believe that you are being discharged too soon.

Information you should receive during your Hospital stay

When you are admitted to the Hospital, someone at the Hospital should show you a notice called the *Notice of Discharge & Medicare Appeal Rights*. This notice explains:

- Your right to get all medically necessary Hospital services covered.
- Your right to know about any decisions that the Hospital, your doctor, or anyone else makes about your Hospital stay and who will pay for it.
- That your doctor or the Hospital may arrange for services you will need after you leave the Hospital.
- Your right to appeal a discharge decision.
- Review of your Hospital discharge by the Quality Improvement Organization

If you think that you are being discharged too soon, you must ask your health plan to give you a notice called the *Notice of Discharge & Medicare Appeal Rights.* This notice will tell you:

- Why you are being discharged.
- The date that we will stop covering your Hospital stay (stop paying our share of your Hospital costs).
- What you can do if you think you are being discharged too soon.
- Who to contact for help.

You (or someone you authorize) may be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that you are ready to leave the Hospital – it only means that you received the notice. If you do not get the notice after you have said that you think you are being discharged too soon, be sure to ask for it immediately.

You have the right by law to ask for a review of your discharge date. As explained in the Notice of Discharge & Medicare Appeal Rights, if you act quickly, you can ask an outside agency called the Quality Improvement Organization to review whether your discharge is medically appropriate.

What is the "Quality Improvement Organization?"

"QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of Health Net or your Hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. In California, the QIO is called Lumetra. The doctors and other health experts in Lumetra review certain types of complaints made by Medicare patients. These include complaints about quality of care and

complaints from Medicare patients who think the coverage for their Hospital stay is ending too soon. Section 1 tells how to contact the QIO.

Getting a QIO review of your Hospital discharge

If you want to have your discharge reviewed, you must act quickly to contact the QIO. The *Notice of Discharge & Medicare Appeal Rights* gives the name and telephone number of your QIO and tells you what you must do:

- You must ask the QIO for a **"fast review"** of whether you are ready to leave the Hospital. This "fast review" is also called a "fast Appeal" because you are Appealing the discharge date that has been set for you.
- You must be sure that you have made your request to the QIO **no later than noon** on the first working day after you are given written notice that you are being discharged from the Hospital. This deadline is very important. If you meet this deadline, you are allowed to stay in the Hospital past your discharge date without paying for it yourself, while you wait to get the decision from the QIO (see below).

If the QIO reviews your discharge, it will examine your medical information then give an opinion about whether it is medically appropriate for you to be discharged on the date that has been set for you. The QIO will make this decision within one day after it has received all of the medical information it needs to make a decision.

- If the QIO decides that your discharge date was medically appropriate, you will not be responsible for paying the Hospital charges until noon the day after the QIO gives you its decision.
- If the QIO agrees with you, then Health Net will continue to cover your Hospital stay for as long as medically necessary while you are a Member of Seniority Plus.

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

You still have another option: asking Health Net for a "fast Appeal" of your discharge

If you do not ask the QIO for a "fast review" ("fast Appeal") of your discharge by the deadline, you can ask us for a "fast Appeal" of your discharge. How to ask Health Net for a fast Appeal is covered briefly in the first part of this section and in more detail in Appendix B.

If you ask Health Net for a fast Appeal of your discharge and you stay in the Hospital past your discharge date, you run the risk of having to pay for the Hospital care you received past your discharge date. Whether you have to pay or not depends on the decision we make:

- If we decide, based on the fast Appeal, that you need to stay in the Hospital, Health Net will continue to cover your Hospital care for as long as medically necessary.
- However, if we decide that you should not have stayed in the Hospital beyond your discharge date, then Health Net will **not** cover any Hospital care you receive if you

stayed in the Hospital after the discharge date.

You may have to pay if you stay past your discharge date

If you stay in the hospital after your discharge date and do not ask for immediate QIO review, you may be financially responsible for the cost of many of the services you receive. However, you can Appeal any bills for Hospital care you receive, using Step 1 of the Appeals process described in Appendix B.

Making complaints ("filing Grievances") about *all other* types of problems

When you are a patient in a SNF, home health agency, or comprehensive outpatient rehabilitation facility (CORF), you have the right to get all the SNF, home health or CORF care covered by Seniority Plus that is necessary to diagnose and treat your illness or injury. The day we end your SNF, home health agency or CORF coverage is based on when your stay is no longer medically necessary or when you have reached your benefit maximum. This part of Section 10 explains what to do if you believe that your coverage is ending too soon.

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

If we decide to end our coverage for your SNF, HHA, or CORF services, you will get written notice either from us or your provider at least 2 calendar days before your coverage ends. You (or someone you authorize) will be asked to sign and date this document, to show that you received the notice. Signing the notice does not mean that you agree that coverage should end – it only means that you received the notice.

How to appeal your coverage to the Quality Improvement Organization

You have the right by law to ask for an appeal of our termination of your coverage. As will be explained in the notice you get from us or your provider, you can ask the Quality Improvement Organization (the "QIO") to review whether our terminating your coverage is medically appropriate.

How soon you have to ask the QIO to review your coverage?

If you want to have the termination of your coverage appealed, you must act quickly to contact the QIO. The written notice you got from us or your provider gives the name and telephone number of your QIO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must be sure to make your request **no later than noon** of the day after you get the.
- If you get the notice and you have more than 2 days before your coverage ends, then you must make your request **no later than noon** the day before the date that your Medicare coverage ends.

What will happen during the review?

If the QIO reviews your case, the QIO will ask for your opinion about why you believe the services should continue. You do not have to prepare anything in writing, but you may do so if

you wish. The QIO will also look at your medical information, talk to your doctor, and review other information that we have given to the QIO. You and the QIO will each get a copy of our explanation about why your services should not continue.

After reviewing all the information, the QIO will give an opinion about whether it is medically appropriate for your coverage to be terminated on the date that has been set for you. The QIO will make this decision within one full day after it receives the information it needs to make a decision.

What happens if the QIO decides in your favor?

If the QIO agrees with you, then we will continue to cover your SNF, HHA or CORF services for as long as medically necessary.

What happens if the QIO denies your request?

If the QIO decides that our decision to terminate coverage was medically appropriate, you will be responsible for paying the SNF, HHA or CORF charges after the termination date on the advance notice you got from us or your provider. Neither Original Medicare nor Health Net will pay for these services. If you stop receiving services on or before the date given on the notice, you can avoid any financial liability.

What if you do not ask the QIO for a review in time?

You still have another option: asking Health Net for a "fast appeal" of your discharge

If you do not ask the QIO for a "fast appeal" of your discharge by the deadline, you can ask us for a "fast appeal" of your discharge. How to ask us for a fast appeal is covered briefly in the first part of this section and in more detail in Appendix B.

If you ask us for a fast appeal of your termination and you continue getting services from the SNF, HHA , or CORF, you run the risk of having to pay for the care you receive past your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to continue to get your services covered, then we will continue to cover your care for as long as medically necessary.
- If we decide that you should not have continued getting coverage for your care, then we will **not** cover any care you received if you stayed after the termination date.

You may have to pay if you stay past your discharge date

If you do not ask the QIO by noon after the day you are given written notice that we will be terminating coverage for your SNF, HHA or CORF services, and if you stay in the SNF, HHA or CORF after this date, you run the risk of having to pay for the SNF, HHA or CORF care you

receive on and after this date. However, you can appeal any bills for SNF, HHA or CORF care you receive using Step 1 of the appeals process described in Appendix B.

Making complaints ("filing Grievances") *about any other* type of problem you have with Health Net Seniority Plus or one of our Plan Providers

This last part of Section 10 explains how to make complaints about any *other* type of problem that has not already been discussed earlier in this section. (The problems that have already been discussed are problems related to coverage or payment for care, problems about being discharged from the Hospital too soon, and problems about coverage for SNF, HHA or CORF services ending to soon.)

What is included in "all other types of problems?"

Here are some examples of problems that are included in this category of "all other types of problems":

- Problems with the quality of the medical care you receive, including quality of care during a Hospital stay;
- If you believe that mistakes have been made;
- If you feel that you are being encouraged to leave (disenroll from) Seniority Plus;
- If you feel that you are being discouraged from seeking the care you think you need;
- Problems with the customer service you receive;
- Problems with how long you have to spend waiting on the phone, in the waiting room, or in the exam room;
- Problems with getting appointments when you need them, or having to wait a long time for an appointment;
- Disrespectful or rude behavior by doctors, nurses, receptionists, or other staff; or
- Cleanliness or condition of doctor's offices, clinics, or Hospitals.

If you have one of these types of problems and want to make a complaint, it is called 'filing a Grievance." In addition, you have the right to ask for a "fast grievance" if you disagree with our decision to not give you a "fast appeal" or if we take an extension on our initial decision or appeal. See below for more detail.

Filing a Grievance with Seniority Plus

If you have a complaint, we encourage you to first call Member Services at the number on the first page of this booklet. We will try to resolve any complaint that you might have over the phone. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the Member Grievance procedure.

To use the formal Grievance procedure submit your Grievance in writing to the Health Net Seniority Plus, Appeals and Grievances Department, P.O. Box 10344, Van Nuys, CA 91410-0344. We will acknowledge receipt of your request in writing within 5 business days of receipt.

Thereafter you will receive written notification to let you know how we have addressed your concern within 30 calendar days of receiving your Grievance. In some instances we will need additional time to address your concern. If additional time is needed, we will notify you in writing regarding the status of your Grievance within 30 calendar days of receipt of your Grievance. In either event, whether you use the formal (written) or informal (telephone) Grievance procedure, we are required to track all Appeals and Grievances in order to report cumulative data to CMS and to our Members, upon request.

If you do not agree with the resolution, you may request a Grievance Hearing. The request for the Grievance Hearing must be made in writing within 30 days of the date of the Grievance resolution letter. Once your request is received, a Grievance Hearing will be scheduled within 45 days. The hearing will allow you the opportunity to present any information regarding your Grievance in person.

The Grievance Hearing will be assembled on an ad hoc basis, i.e., organized for the sole purpose of resolving your concern and then disbanding as soon as that concern has been resolved or adjudicated, with no attorneys present. The Grievance Hearing committee may consist of a Health Net Vice President, a management representative from Seniority Plus Member Services Department, the Health Net Medical Director or assigned designee, and possibly a representative from your medical Group or PCP. Health Net will send you the written decision of the Grievance Hearing within 10 days of the commencement of the hearing.

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

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

If you are concerned about the quality of care you received, including care during a Hospital stay, you can also complain to an independent organization called the QIO See Section 1, *Telephone numbers and other information for reference*, for more about the QIO.

Grievance and Appeals Procedures for your Employer-Sponsored Benefits

If you are not satisfied with efforts to solve a problem with your Employer-Sponsored Benefits, you must first file a grievance against Health Net by calling the Member Services Department at **1-800-275-4737** or by submitting a Member Grievance Form through the Health Net website at www.healthnet.com. You may also file your complaint in writing by sending information to:

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

Department of Managed Health Care

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

If you have a grievance against Health Net, you should first telephone Health Net at **1-800-275-4737** and use our grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you.

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

The Department also has a toll-free telephone number (**1-888-HMO-2219**) and a TDD line (**1-877-688-9891**) for the hearing and speech impaired. The Department' s Internet Web site http://www.hmohelp.ca.gov has complaint forms and instructions online.

SECTION 11. DISENROLLMENT: LEAVING SENIORITY PLUS AND YOUR CHOICES FOR CONTINUING MEDICARE AFTER YOU LEAVE

(Including new rules about when and how often you can make changes, and what happens if you move or if Seniority Plus leaves Medicare.)

What is "disenrollment?"

"Disenrollment" from Seniority Plus means **ending your membership** in Health Net. Disenrollment can be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave Seniority Plus because you have decided that you *want* to leave. You can do this for any reason.
- There are also a few situations where you would be *required* to leave. For example, you would have to leave Seniority Plus if you move out of our geographic Service Area or if Seniority Plus leaves the Medicare program. We are not allowed to ask you to leave the plan because of your health.

Whether leaving Seniority Plus is your choice or not, this section explains your Medicare coverage choices after you leave and explains the rules that apply.

Until your membership officially ends, you must keep getting your routine care through Seniority Plus or you will have to pay for it yourself

If you leave Seniority Plus, it takes some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect later in this section). While you are waiting for your membership to end, you are still a Member of Seniority Plus and must continue to get your routine care as usual through Seniority Plus.

If you get unauthorized services from doctors or other medical Providers who are not Plan Providers before your membership in Seniority Plus ends, neither Health Net nor the Medicare program will pay for these services, with just a few exceptions. The exceptions are Urgently Needed Services, Emergency Services, out-of-area renal (kidney) dialysis services, and Referrals that have been approved by Health Net. There is another possible exception if you happen to be hospitalized on the day your membership in Seniority Plus ends; if this happens to you, call Member Services at the number on the first page of this booklet to find out if your Hospital care will be covered by Seniority Plus. If you have any questions about leaving Seniority Plus, please call us at Member Services.

What are your choices for continuing Medicare if you leave Seniority Plus?

If you leave Seniority Plus, you may have several choices for continuing Medicare. One choice is to go to **Original Medicare**. You may also have the choice of joining another **Medicare managed care plan** or a **Medicare Private Fee-for-Service plan** *if* any of these types of plans are available in your area and they are accepting new Members.

- **Original Medicare** is available throughout the country. It is a pay-per-visit or "fee-for-service" health plan that lets you go to any doctor, Hospital, or other health care Provider *who accepts Medicare*. You must pay a 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).
- **Medicare managed care plans** are available in some parts of the country. In HMOs you go to the doctors, Hospitals, and other Providers *that are part of the plan*. In PPOs, you can usually see any doctor but you may pay more to see doctors, Hospitals, and other providers that are *not* part of the plan. These plans must cover all Medicare Part A and Part B health care. Some plans cover extras, like prescription drugs. Seniority Plus is a Medicare managed care plan offered by Health Net.
- **Medicare Private Fee-for-Service Plans** are available in some parts of the country. In Private Fee-for-Service plans, you may go to *any* Medicare-approved doctor or Hospital that accepts the plan's payment. The Private Fee-for-Service plan, rather that the Medicare program, decides how much it will pay and what you pay for the services you get. You may pay for more Medicare-covered benefits. You may get extra benefits that Original Medicare does not cover. Private Fee-for-Service plans are *not* the same as Medigap (Medicare supplement insurance).

To find out which Medicare managed care plans and Private Fee-for-Service plans are available in your area, you can call the national **1-800-MEDICARE** help line; 24 hours a day 7 days a week. You can also use the "Medicare Personal Plan Finder" at www.medicare.gov on the web. The Medicare Personal Plan Finder is a tool that allows you to narrow down and compare your health plan choices based on what is most important to you. It gives you the ability to compare all your health insurance options and get a personalized page with more detailed information on the plans you select. You can also call your HICAP (which stands for Health Insurance Counseling and Advocacy Program*). Section 1, Telephone numbers and other information for reference*, tells about the Medicare help line, the Medicare website, and the HICAPs (HICAPs have different names depending on the state you live in).

When you change your Medicare choices

All through the year, everyone with Medicare (including Members of Seniority Plus) is allowed to change from their current way of getting Medicare to one of their other choices. As we have explained above, you have one or more of the following choices about how you get your Medicare coverage. They are:

- **Original Medicare**. This choice is available to you throughout the year.
- **A Medicare Managed Care Plan**. This choice is available to you **if** there are Medicare managed care plans in your area, and if they are accepting new Members when you want to join. There is a yearly period from November 15 through December 31 when all Medicare Advantage plans must accept new Members (unless unusual circumstances apply). (Medicare Advantage is the new name for Medicare + Choice).
- **A Medicare Private Fee-for-Service plan**. This choice is available to you **if** there are Medicare Private Fee-for-Service plans in your area, and **if** they are accepting new Members when you want to join. There is a yearly period from November 15 through December 31 when all Medicare Private Fee-for-Service plans must accept new Members (unless unusual circumstances apply).

In most cases, your disenrollment date will be the first day of the month that comes *after* the month we receive your request to leave. For example, if we receive your request to leave during the month of February, your disenrollment date will be March 1. There is an exception: if we receive your request between November 15 and 30, the change will take effect on January 1, unless you specifically ask for a disenrollment date of December 1.

What should you do if you decide to leave Seniority Plus?

If you want to leave Seniority Plus, what you must do to leave depends on whether you want to change to Original Medicare or to one of your other choices.

How to change from Seniority Plus to Original Medicare

If you want to change from Seniority Plus to Original Medicare, and you are thinking about buying Medigap (Medicare supplement insurance) to supplement you Original Medicare coverage, you should first contact the HICAP in your state to learn if you have a guaranteed right to buy a Medigap policy even if you have health problems. You can find the phone number for the HICAP in Section 1.

When you decide to return to Original Medicare, you must tell us that you want to leave Seniority Plus. You do not have to notify Original Medicare, because you will automatically be in Original Medicare when you leave Seniority Plus. Here is how it works:

1. First, use any of the following ways to tell us that you want to leave Seniority Plus.

- You can write a letter to us or fill out a disenrollment form and send it to Health Net Member Services at Health Net Seniority Plus, P.O. Box 10420, Van Nuys, CA 91410-0420. Please make sure you sign and date your letter and form. You will also need to inform your Group of your Disenrollment. To get a disenrollment form, call us at the Member Services telephone number on the first page of this booklet.
- You can call the national **1-800-MEDICARE** help line; 24 hours a day 7 days a week. *Section 1, Telephone numbers and other information for reference,* tells you how to contact the helpline.
- You can contact your nearest Social Security office or, if you have Railroad Retirement benefits, you can contact the Railroad Retirement Board office. *Section 1, Telephone numbers and other information for reference*, tells you how to contact these offices.

2. After we learn about your request to leave the plan, we will then send you a letter that tells you when your membership will end (provided that your request follows the new rules about making changes). This is your **disenrollment date** – the day you officially leave Seniority Plus. In most cases, your disenrollment date will be the first day of the month that comes after the month when we receive your request to leave Seniority Plus. For example, if we receive your request to leave during the month of February, your disenrollment date will be March 1. There is an exception to this general rule about disenrollment dates: the disenrollment date for requests made in November will be January 1. Remember that while you are waiting for your membership to end, you are still a Member of Seniority Plus and must continue to get your medical care as usual through Seniority Plus.

3. When your membership ends on your disenrollment date, you can start using your red, white, and blue Medicare card to get services under Original Medicare. (You can call Social Security at **1-800-772-1213** if you need a new card.) You will not get anything in writing that tells you that you have Original Medicare, because you will *automatically* be in Original Medicare when you leave Seniority Plus.

How to change from Seniority Plus to another Medicare managed care plan or to a Private Fee-for-Service Plan

When you have chosen a different Medicare managed care plan or a Private Fee-for-Service plan that you want to join, here is what to do (provided that the change you want to make follows the new rules about making changes):

1. Simply apply for membership in the new plan you want to be in. ***Please <u>do not</u>*** tell us in advance that you are changing from Seniority Plus to a different plan because **this might cause your enrollment in the new plan to be denied**. We do not need to know that you are leaving Seniority Plus if you enroll into another plan. Once you are enrolled in your new plan, your membership in Seniority Plus will *automatically* end.

2. Your new plan will tell you in writing that date when your membership in that plan begins, and your membership in Seniority Plus will end on that same day (this will be your "disenrollment date" from Seniority Plus). Remember that you are still a Member of Seniority Plus until your disenrollment date, and must continue to get your medical care as usual through Seniority Plus until the date when your membership ends.

What happens to you if Health Net leaves the Medicare program or Seniority Plus leaves the area where you live?

If *we* leave the Medicare program or change our Service Area so that it no longer includes the area where you live, we will tell you in writing**. If any of these things happen, you will be allowed to change to another way of getting Medicare**. Your choices will always include Original Medicare, and they may also include joining another Medicare managed care plan or a Private Fee-for-Service plan if such plans are available in your area and are accepting new Members.

Health Net has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract renews each year. At the end of each year, the contract is reviewed, and either Health Net or CMS can decide to end it. You will get 90 days advance notice in this situation. It is also possible for our contract to end at some other time, too. If the contract is going to end, we will generally tell you at least 90 days in advance. Your advance notice may be as little as 30 days or even fewer days if CMS must end our contract in the middle of the year.

Until we tell you in writing that you must leave Seniority Plus and give you a date when your membership stops, you will continue as a Member of Seniority Plus and will continue to get your medical care in the usual way through Seniority Plus. All of the benefits and rules described in this booklet will continue until your membership ends.

What if you move out of the Health Net Seniority Plus Service Area, or are away from the Service Area for long periods of time?

You must leave the Seniority Plus Plan if you move out of our Service Area or are away from our Service Area for more than six months in a row.

If you plan to move or take a long trip, please call Member Services at the number on the first page this booklet. Health Net has other Seniority Plus plans in California. They are listed below along with their Service Areas. If you move to one of these areas or are there for more than 6 months in a row, you may elect to continue coverage with Seniority Plus by enrolling in the plan serving that area. You must complete a short enrollment election form. Plan premiums, Copayments and benefits often differ from plan to plan. If you do not complete an election form, or if you move to a location outside the Service Area of any Seniority Plus plan, you must disenroll. If you do not leave on your own, we must end your membership ("disenroll") you. An earlier part of this section tells about the choices you have if you leave Seniority Plus and explains how to leave.

Seniority Plus Plan	Service Area
Alameda County Plan	Alameda County –All ZIP codes
Contra Costa County Plan	Contra Costa County – All ZIP codes
Kern County Plan	Kern County – Only ZIP codes 93203, 93205-06, 93215, 93220, 93224-26, 93238, 93240-41, 93250-52, 93255, 93263, 93268, 93276, 93280, 93283, 93285, 93287, 93301-09, 93311-13, 93380-82, 93384-89, 93501-02, 93504, 93518, 93531, 93561.
Los Angeles County Plan	Los Angeles County – All ZIP codes
Orange County Plan	Orange County – All ZIP codes
Placer County Plan	Placer County – Only ZIP codes 95602-04, 95631, 95648, 95650, 95658, 95661, 95663, 95677-78, 95681, 95701, 95703, 95713-15, 95717, 95722, 95736, 95746-47, 95765.
Riverside County Plan	Riverside County – All ZIP codes
Sacramento County Plan	Sacramento County – All ZIP codes
San Bernardino County Plan	San Bernardino County – All ZIP codes
San Diego County Plan	San Diego County – All ZIP codes
San Francisco County Plan	San Francisco County – All ZIP codes
San Mateo County Plan	San Mateo County – Only ZIP codes 94020, 94025-28, 94061-63, 94065, 94070, 94303.
Santa Barbara County Plan	Santa Barbara County -- Only ZIP codes 93013-14, 93067, 93101-03, 93105-11, 93116-18, 93120-21, 93130, 93140, 93150, 93160, 93190, 93199, 93252, 93427, 93436-38, 93440-41, 93460, 93463-64

Santa Clara County Plan	Santa Clara County – All ZIP codes
Yolo County Plan	Yolo County – All ZIP codes

Under certain conditions Seniority Plus can end your membership and make you leave the plan

As we explained above, we must end your membership and require you to leave the plan if you move permanently out of the geographic Service Area or live outside the Service Area of the Seniority Plus plan in which your are enrolled for more than six months at a time.

We cannot ask you to leave because of your health

Seniority Plus is allowed to ask you to leave the plan under certain special conditions that are described below. These conditions do *not* include asking you to leave because of your health: **no Member of any Medicare health plan can be asked to leave the plan for any health-related reasons**.

If you ever feel that you are being encouraged or asked to leave Seniority Plus because of your health, you should call the national Medicare helpline at **1-800-MEDICARE** help line; 24 hours a day 7 days a week. *Section 1, Telephone numbers and other information for reference*, tells you how to contact the helpline.

We can ask you to leave under certain special conditions

As we explained above, we must end your membership and require you to leave the plan if you move out of our geographic Service Area or live outside our Service Area for more than six months at a time. We must also end your membership and make you leave the plan under the following circumstances:

- If you do *not* stay continuously enrolled in both Medicare Part A and Medicare Part B.
- If you give Health Net information on your enrollment form that is false or deliberately misleading, and it affects whether or not you can enroll in Seniority Plus.
- If you behave in a way that is unruly, uncooperative, disruptive, or abusive, and this behavior seriously affects our ability to arrange or provide medical care for you or for others who are Members of Seniority Plus. Before we can make you leave Seniority Plus for this reason, *we must get permission* from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
- If you let someone else use your Seniority Plus membership card to get medical care. Before we ask you to leave Seniority Plus for this reason, we must refer your case to the Inspector General, and this may result in criminal prosecution.
- If you do not pay the Plan Premiums. We will tell you of a 90-day grace period during which you can pay the Plan Premiums before you are required to leave Seniority Plus.

- The Group Service Agreement (between the Group and Health Net) is terminated or not renewed.

You have the right to make a complaint if we ask you to leave Health Net

If we ask you to leave Seniority Plus, we will tell you our reasons in writing and explain how you can file a complaint against us if you want to.

APPENDIX

APPENDIX A. Reference list of important words used in this booklet

The following definitions apply to this Evidence of Coverage and Disclosure Information.

Act -- The California Knox-Keene Health Care Service Plan Act of 1975, as amended, as set forth at Chapter 2.2. of Division 2 of the California Health and Safety Code (beginning with Section 1340), and its implementing regulations, as set forth at Subchapter 5.5 of Chapter 3 of Title 28 of the California Code of Regulations (beginning with Section 1300.41).

Appeal -- Any of the procedures that deal with the review of adverse Initial Decisions on the health care services a Member is entitled to receive or any amounts that the Member must pay for a covered service. These procedures include reconsiderations by Health Net, review by an independent outside organization, hearings before Administrative Law Judges (of the Social Security Administration), review by the Medicare Appeals Council, and judicial review.

American Specialty Health Plans of California, Inc. (ASH Plans) -- A professional corporation contracting with Health Net to administer the delivery of chiropractic services through a Network of Seniority Plus Contracted Chiropractors.

Basic Benefits -- Basic benefits are all Medicare-covered services, except hospice service, and additional benefits as defined in regulation 422.2 and meeting all requirements in regulation 422.312. Benefits are health care services that are intended to maintain or improve the health status of enrollees for which the Medicare Advantage organization incurs a cost or liability under a Medicare Advantage plan (not solely an administrative processing cost).

Benefit Period -- This is used to determine Original Medicare coverage, and coverage under Seniority Plus. A Benefit Period begins on the first day you go to a Medicare covered inpatient Hospital or Skilled Nursing Facility. The benefit period ends when you have not been and inpatient at any Hospital (or a SNF) for 60 days in a row. Generally, you are an inpatient of a Hospital if you are receiving inpatient services in the Hospital. The type of care actually received is not relevant. However, you are an inpatient in a SNF only if your care in the SNF meets certain skilled level of care standards. This means that in order to have been an inpatient while in a SNF, you must have required skilled services on a daily basis and received daily skilled services that could, as a practical matter, have only been provided in a SNF on an inpatient basis.

Brand Name Drug -- A Prescription Drug or medicine that has been registered under a brand or trade name by its manufacturer and is advertised and sold under that name.

Calendar Year -- The period that begins on January 1 and ends twelve (12) consecutive months later on December 31.

Centers for Medicare & Medicaid Services (CMS) -- The Federal Agency that runs the Medicare program (formerly known as the Health Care Financing Administration).

Chiropractic appliances -- Are support type devices prescribed by a Seniority Plus Contracted Chiropractor specifically for the treatment of a Neuromusculo-skeletal Disorder. The devices this Plan covers are limited to elbow supports, back (thoracic) supports, cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar supports, lumbar cushions, orthotics, wrist supports, rib belts, and home traction units (cervical or lumbar), ankle braces, knee braces, rib supports and wrist braces.

Chiropractic Benefits -- Services furnished by a Seniority Plus Contracted Chiropractor for the treatment or diagnosis of Neuro-musculoskeletal Disorders. All services and treatment must be reviewed and approved by the American Specialty Health Plans of California, Inc. (ASH Plans) prior to their beginning.

Chiropractic services -- Are services rendered or made available to a Member by a chiropractor for treatment or diagnosis of Neuromuscolo-skeletal Disorders.

Contact Lenses -- Are Lenses worn directly on the eye to correct or improve vision.

Contracting Pharmacy -- A Pharmacy that has an agreement with Health Net to provide you the medication(s) prescribed by your contracting medical Provider.

Copayment -- Is a fee charged to you for covered services when you receive them. The Copayment is due and payable to the provider of care at the time the service is received. The Copayment for each covered service is shown in the "Your Schedule of Medical Benefits" in Section 5.

Covered Services -- The general term we use in this booklet to mean all of the health care services and supplies that are covered by Seniority Plus.

Custodial Care -- Care furnished for the purpose of meeting non-medically necessary personal needs which could be provided by persons without professional skills or training, such as assistance in walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial care is not covered by Seniority Plus or Original Medicare unless provided with Skilled Nursing Care and/or skilled rehabilitation services.

Disenroll or Disenrollment -- The process of ending your membership in Seniority Plus. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice).

Durable Medical Equipment -- Equipment that can withstand repeated use; is primarily and usually used to serve a medical purpose; is generally not useful to a person in the absence of illness or injury; and is appropriate for use in the home. However, an institution may not be considered a Member's home if it meets the basic requirements of a Hospital or Skilled Nursing

Facility. DME includes items such as oxygen equipment, wheelchairs, Hospital beds and other items that are determined medically necessary, in accordance with Medicare law, regulations and guidelines.

Emergency Chiropractic Services -- Are covered services that are Chiropractic Services rendered for the sudden and unexpected onset of an injury or condition affecting the neuromusculo-skeletal system which manifests itself by acute symptoms of sufficient severity, including severe Pain, for which a delay of immediate chiropractic attention could decrease the likelihood of maximum recovery. In the event of Emergency Chiropractic Services, a Member may contact his/her PCP before seeking services from a Contracted Chiropractor.

Emergency Services -- Covered services that are 1) furnished by a Provider qualified to furnish Emergency Services; and 2) needed to evaluate or stabilize a Medical Emergency.

Employer-Sponsored Benefits -- Additional non-Medicare covered benefits beyond the benefits included in Basic Benefits, which may be elected at a Group's option. Employer-Sponsored Benefits may include Prescription Drugs, Vision, Chiropractic and Dental services. There may be a Plan Premium associated with Employer-Sponsored Benefits.

Evidence of Coverage and Disclosure Information -- This document, along with your enrollment form, which explains the Covered Services, defines our obligations, and explains your rights and responsibilities as a Member of the Seniority Plus.

Eyeglasses -- The combination of Lenses and Frames worn to correct or improve vision.

EyeMed Vision Care, LLC -- Administers the delivery of Eyewear benefits through a network of Participating Eyewear Dispensers under the Health Net Vision Program.

Eyewear -- It is either Eyeglasses or Contact Lenses.

Exclusion -- Items or services that Seniority Plus does not cover. You are responsible for paying for excluded items or services.

Experimental Procedures and Items -- Items and procedures determined by Medicare not to be generally accepted by the medical community. When deciding if a service or item is experimental, Health Net will follow the Centers for Medicare & Medicaid Services' manuals or will follow decisions already made by Medicare. With the exception of procedures and items under approved clinical trials, experimental procedures and items are not covered under this Evidence of Coverage.

Frames -- Plastic or metal devices that hold Eyeglass Lenses.

Generic Drug -- The pharmaceutical equivalent of a Brand Name Drug that has lost its patent and is produced by more than one company. The Food and Drug Administration must approve

the Generic Drug as meeting the same standards of safety, purity, strength, and effectiveness as the Brand Name Drug. The Generic status of a Drug is determined by a third party pharmacy database administrator.

Grievance -- Any complaint or dispute other than one involving an "Initial Decision." Examples of issues that involve a complaint that will be resolved through the Grievance rather than the Appeal process include: waiting times in physician offices and rude or unresponsive Member Service staff.

Group -- The business organization to which Health Net Seniority Plus has issued the Group Service Agreement to provide the benefits of this Plan.

Group Open Enrollment -- A designated period of time designated by your Group, in which you may Disenroll from Health Net and enroll in any other Medicare Advantage Plan or elect to change your enrollment from an Medicare Advantage Plan to original Medicare. Beneficiaries in original Medicare or any other Medicare Advantage Plan can also enroll in any Medicare Advantage Plan during an Open Enrollment period. Group Open Enrollment period constitutes a Special Election Period, for both enrollment and Disenrollment. Please see the Special Election Period definition for more information.

Group Service Agreement -- The contract Health Net Seniority Plus, in order to provide the benefits of this Plan.

Health Net Vision Program -- Provides Eyewear benefits. The program is administered by EyeMed Vision Care, LLC.

Home Health Agency -- A Medicare-certified agency that provides Skilled Nursing Care and other therapeutic services in your home when medically necessary.

Hospice -- A Medicare-certified organization or agency that is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital -- A Medicare-certified institution licensed by the State, that provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term "Hospital" does not include a convalescent nursing home, rest facility or facility for the aged that primarily provides Custodial Care, including training in routines of daily living.

Independent Practice Association (IPA) -- A partnership, association, or corporation that delivers or arranges for the delivery of health services and which has entered into a contract with health professionals, a majority of whom are licensed to practice medicine or osteopathy.

Initial decision -- In general, a decision by Health Net or a person acting on Health Net's behalf, to approve or deny a payment for a service or a request for provision of service made by you or

on your behalf.

Lenses -- Single vision, bifocal, or trifocal prescription Lenses that correct or improve vision.

Lock-In -- An arrangement under which all Covered Services, except Emergency Services, Urgently Needed Services, or out-of-area renal (kidney) dialysis services, must be provided or authorized by your Plan Provider or your PCP. If you get any other services from a non-Plan Provider or a Plan Provider such as a Specialist without prior authorization, neither Health Net nor Original Medicare will pay for that care. (There are very limited exceptions to this rule, including the right to self-refer for Flu Shots and Mammography Screening services. See the Schedule of Medical Benefits in Section 5 for specific limitations that apply to self-referral for these benefits).

Maintenance Drugs -- Prescription Drugs taken on regular basis used to manage chronic or long term conditions where Members respond positively to drug treatment, and dosage adjustments are either no longer required or are made infrequently.

Medical Emergency -- A medical condition brought on 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 that not getting immediate medical attention could 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 functions; or 3) Serious dysfunction of any bodily organ or part.

Medical Director -- A licensed physician who is responsible for the overall quality of the medical care we provide.

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

Medicare Advantage Organization -- A public or private organization licensed by the State as a risk-bearing entity that is under contract with the Centers for Medicare & Medicaid Services (CMS) to provide Covered Services. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans. Health Net is a Medicare Advantage Organization. (Medicare Advantage is the new name for Medicare + Choice).

Medicare Advantage Plan -- A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform premium and uniform level of cost-sharing to all people with Medicare residing in the Service Area covered by the Plan. A Medicare Advantage Organization may offer more than one plan in the same Service Area. Seniority Plus is a Medicare Advantage plan. (Medicare Advantage is the new name for Medicare Advantage Choice).

Member -- A retiree or employee of the Group with Medicare who is eligible to get Covered Services, who has enrolled in Seniority Plus Group Plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services -- A department within Health Net responsible for answering your questions about your membership, benefits, Grievances, and Appeals. A Health Net Member Services representative is available to assist you during regular business hours by calling **1-800-275-4737**. Hearing or speaking impaired Members may call the Telecommunications Device for the Deaf (TTD) at **1-800-929-9955**. Operating hours are Monday through Friday from 7:30 a.m. to 12:00 p.m. and 1:00 p.m. to 5:00 p.m.

Network -- A Group of health care Providers under contract with Health Net that is licensed and/or certified by Medicare with the purpose of delivering or furnishing health care services. Generally, Members must receive routine services within their designated Network in order to be covered by Health Net.

Non-Participating Pharmacy -- A pharmacy that does not have an Agreement with Health Net to provide Prescription Drugs to Members.

Non-Plan Provider or Non-Plan Facility -- Any professional person, organization, health facility, Hospital, or other person or institution licensed and/or certified by the State or Medicare to deliver or furnish health care services. This type of Provider is not employed, owned, operated by, or under contract to deliver Covered Services to you.

Office Visit -- A visit for Covered Services to your PCP, Specialist, other Plan Provider or non-Plan Provider upon Referral.

Optometrist -- A licensed doctor of optometry (O.D.).

Original Medicare -- A plan that is available everywhere in the United States. It is the way most people get their Medicare Part A and Part B health care. (Original Medicare is also known as Fee-for-Service Medicare).

Physician Group -- A group of Physicians, who are organized as a legal entity, that has an agreement in effect with Health Net to provide medical care to Health Net Members. They are sometimes referred to as a "contracting Physician Group." Another common term is "a medical group." An individual practice association may also be a Physician Group.

Plan Hospital -- A Hospital that has a contract with Health Net or your Plan Medical Group or IPA to give you services and/or supplies.

Plan Medical Group -- Physicians organized as a legal entity to provide medical care. The Plan Medical Group has an agreement with the Health Net to provide medical services to you.

Plan Pharmacy -- A pharmacy that has an agreement to provide you the medication(s) prescribed by your Plan Provider.

Plan Premium -- The monthly payment to Health Net that entitles you to the Covered Services outlined in this Evidence of Coverage. Your Group may pay the whole or part of the Health Net Plan Premium for you.

Plan Provider -- A health professional, a supplier of health items, or a health care facility that has an agreement to provide or coordinate Covered Services to you.

Prescription Drug -- A drug or medicine that can be obtained only by a Prescription Drug Order. All Prescription Drugs are required to be labeled "Caution, Federal Law Prohibits Dispensing Without a Prescription." An exception to this label requirement is insulin and diabetic equipment, which will be considered a Prescription Drug.

Prescription Drug Benefit Manager -- Companies that contract with Medicare Advantage Organizations to manage pharmacy services and processes pharmacy claims.

Prescription Drug Order -- A written or verbal order or refill notice for Prescription Drugs or medicines issued by a Member Physician for coverage purposes.

Primary Care Physician/Provider (PCP) -- A health care professional who is trained to give you basic care. Your PCP is responsible for providing or authorizing Covered Services while you are a Member of Seniority Plus. You are required to see your PCP for Referral to a Specialist. Sometimes PCPs are associated with a Plan Medical Group or IPA.

Prior Authorization -- When a Provider must obtain approval from a Plan Medical Group, IPA, or Health Net before giving you certain health care services.

With regards to Prescription Drug benefits, Prior Authorization is defined as Health Net's approval process for certain medications on the Recommended Drug List. Member's Physician must obtain Health Net's Prior Authorization before certain medications on the Recommended Drug List will be covered.

Provider -- A doctor, Hospital, health care professional or health care facility licensed and/or certified by the State or Medicare to deliver or furnish health care services.

Quality Improvement Organization (QIO) -- Groups of practicing doctors and other health care experts who are paid by the Federal Government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by inpatient Hospitals, Hospital outpatient departments, Hospital emergency rooms, skilled nursing facilities, home health agencies, Private fee-for-service plans and ambulatory surgical centers. See Section 1 for information about how to contact the QIO in your state and Section 10 for information about making complaints (appeals or grievances) to the QIO.

Recommended Drug List (also known as Health Net **Recommended Drug List or the List**) -- is a list of the Prescription Drugs (previously known as the Formulary) that are covered by this Plan. It is prepared and updated by Health Net and distributed to Members, Member Physicians and Seniority Plus Participating Pharmacies and posted on the Health Net website at www.healthnet.com. Some drugs in the Recommended Drug List require Prior Authorization from Health Net. (The List is subject to change within the contracted year without advance notice.)

Referral -- Your PCP's or his/her Plan Medical Group or IPA's approval for you to see a certain Specialist or to receive certain Covered Services.

Rehabilitative Services -- Services including physical, cardiac, speech, and occupational therapies that are rendered under the direction of a contracting health care Provider.

Seniority Plus Contracted Chiropractor -- A duly licensed chiropractor who practices in the State of California and who has executed a service contract with ASH Plans to furnish specific chiropractic care to Members eligible under the terms and provisions of this Evidence of Coverage. A list of Seniority Plus Contracted Chiropractors is available from Health Net upon request.

Seniority Plus Participating Eyewear Dispenser -- A licensed retail dispenser of Eyewear that has a contract in effect with EyeMed Vision Care, LLC.

Seniority Plus Participating Pharmacy -- A licensed pharmacy that has a contract with Health Net to provide you with medications prescribed by your contracting medical Provider in accordance with Seniority Plus.

Service Area -- A geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Managed Health Plan. This is the area within which you generally must get non-emergency and Urgently Needed Services other than dialysis.

Skilled Nursing Care -- Services that can only be performed by or under the supervision of licensed nursing personnel.

Skilled Nursing Facility -- A facility (or distinct part of a facility) which is primarily engaged in providing to its residents skilled nursing or rehabilitation services and is certified by Medicare. The term "Skilled Nursing Facility" does not include a convalescent nursing home, rest facility or facility for the aged which furnishes primarily Custodial Care, including training in routines of daily living.

Specialist -- A doctor who provides health care services for a specific disease or part of the body. Examples include oncologists (care for cancer patients), cardiologists (care for the heart),

and orthopedists (care for bones).

Urgently Needed Services -- Services needed immediately as a result of an unforeseen illness, injury, or condition; and it is not reasonable given the circumstances to get the services through your PCP or other Plan Providers. Ordinarily, these services are provided when you are out of the Service Area. In extraordinary cases, these are services provided when you are in the Service Area, but Plan Providers are not available.

APPENDIX B. More information about the Appeals process: the six possible steps for making complaints related to your coverage or payment for your care

What is the purpose of this Appendix?

The purpose of this Appendix is to give you more information about a topic that is summarized briefly in Section 10 of this booklet, *Appeals and Grievances: what to do if you have concerns or complaints*. Section 10 outlines the six possible steps in the Appeals process for making complaints about your coverage or payment for your care. This Appendix goes through the same six steps in more detail. Since Section 10 also gives general information about making complaints, and discusses how to deal with other types of problems besides problems with coverage or payment for care, **you should read Section 10 before you read this Appendix.**

What are "complaints about your coverage or payment for your care"?

Complaints about your coverage or payment for your care are complaints you may have if you are not getting medical benefits and services you believe are covered for you as a Member of Seniority Plus, including payment for care received while a Member of the Seniority Plus. Complaints about your coverage or payment for your care include complaints about the following situations:

- If you are not getting the care you want, and you believe that this care is covered by Seniority Plus;
- If Health Net will not authorize the medical treatment your doctor or other medical Provider wants to give you, and you believe that this treatment is covered by Seniority Plus;
- If you are being told that coverage for a treatment or service you have been getting will be reduced or stopped, and you feel that this could harm your health; and
- If you have received care that you believe is covered by Seniority Plus, but we have refused to pay for this care.

How does the Appeals process work?

The six possible steps you can take to make complaints related to your coverage or payment for your care are described below. Here are a few things to keep in mind as you read the description of these steps in the Appeals process:

- **Moving from one step to the next**. At each step, your request for care or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may deny (turn down) your request completely. If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the medical care involved or on other factors.
- **"Initial decision" vs. "making an Appeal."** Step 1 deals with the starting point for the

Appeals process. The decision made in Step 1 is called an "Initial Decision." If you continue with your complaint by going on to Step 2, it is called making an "Appeal" or a "request for reconsideration" of our Initial Decision because you are "Appealing" for a change in the Initial Decision that was made in Step 1. Step 2, and all of the remaining possible steps through Step 6, also involve *Appealing* a decision.

- **Who makes the decision at each step**. In Step 1, you make your request for coverage of care or payment for care directly to Health Net. We review this request, then make an Initial Decision. If our Initial Decision turns down your request, you can go on to Step 2, where you "Appeal" this Initial Decision (asking us to reconsider). After Step 2, your Appeal goes outside of Health Net, where *people who are not connected to* Health Net *conduct the review and make the decision*. To help ensure a fair, impartial decision, those who make the decision about your Appeal in Steps 3-6 are part of (or in some way connected to) the Medicare program, the Social Security Administration, or the federal court system.
- **A note about terminology**. Appendix A gives definitions for key terms in this booklet, including terms we use in this Appendix. In this Appendix, we tend to use simpler language instead of certain legal language, including terms that appear in the government regulations for the Appeals process. For example, we generally say "Initial Decision" instead of "initial organization determination," and we generally use the word "fast" rather than "expedited" when referring to decisions that are made more quickly than the standard time frame. Instead of saying "adverse decision," we may say "deny your request," or "turn down your Appeal." We use "independent review organization" rather than "independent review entity."

STEP 1: Health Net makes an "Initial Decision" about your medical care, or about paying for care you have already received

What is an "Initial Decision"?

The "Initial Decision" made by Health Net is the starting point for dealing with requests you may have about your coverage or payment for your care. With this decision, we inform you whether we will provide the medical care or service you request, or pay for a service you have already received. (This "Initial Decision" is sometimes called an "organization determination.") If our Initial Decision is to deny your request (this is sometimes called an "adverse Initial Decision"), you can "Appeal" the decision by going on to Step 2 (see below). You may also go on to Step 2 (an "Appeal") if we fail to make a timely "Initial Decision" on your request.

- If you ask Health Net to pay for medical care you have already received, this is a request for an "Initial Decision" about payment for your care. You can call us at **1-800-275-4737** (or use the Seniority Plus Telecommunication Device for the Deaf at **1-800-929-9955**) to get help in making this request.
- If you ask for a specific type of medical treatment from your doctor or other medical

Provider, this is a request for an "Initial Decision" about whether the treatment you want is covered by Seniority Plus. Depending on the situation, your doctor or other medical Provider may make this decision on behalf of Health Net, or may ask us whether we will authorize the treatment. You may want to ask us for an Initial Decision without involving your doctor. You can call us at **1-800-275-4737** (or use the Seniority Plus Telecommunication Device for the Deaf at **1-800-929-9955**) to get help in making this request.

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. This booklet and any amendments you may receive describe the benefits and services covered by Seniority Plus, including any limitations that may apply to these services. This booklet also lists exclusions (services that are "not covered" by Seniority Plus).

Who may ask for an "Initial Decision" about your medical care or payment?

You can ask us for an Initial Decision yourself, or you can name someone to do it for you. This person you name would be your *authorized representative*. You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and your authorized representative must sign and date a statement that gives this person legal permission to act for you. This statement must be sent to Health Net at Health Net Seniority Plus, Appeals and Grievance Department, Post Office Box 10344, Van Nuys, Ca 91410-0344. You can call Health Net at **1-800-275-4737** to learn how to name your authorized representative. If you have a hearing or speech impairment, please call us at TTY at **1-800-929-9955**.

You also have the right to have an attorney ask for an Initial Decision on your behalf. You can contact your own lawyer, or get the name of a lawyer from your local bar association or other Referral service. There are also Groups that will give you free legal services if you qualify.

"Standard decisions" vs. "fast decisions" about medical care

Do you have a request for medical care that needs to be decided more quickly than the standard time frame?

A decision about whether we will cover medical care can be a "standard decision" that is made within the standard time frame (typically within 14 days; see below), or it can be a "fast decision" that is made more quickly (typically within 72 hours; see below). A fast decision is sometimes called a 72-hour decision or an "expedited organization determination."

You can ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for medical care. You cannot get a fast decision on requests for payment for care you have already received.)

Asking for a standard decision

To ask for a standard decision about medical care or payment for care, you or your authorized representative should mail or deliver a request in writing to this address: Health Net Seniority Plus, Appeals and Grievance Department, Post Office Box 10344, Van Nuys, Ca 91410-0344

Asking for a fast decision

You, any doctor, or your authorized representative can ask us to give a "fast" decision (rather than a "standard" decision) about medical care by calling us at **1-800-275-4737** (for TDD, call **1-800-929-9955**. Or, you can mail a written request to Health Net at Health Net Seniority Plus, Appeals and Grievance Department, Fast (Expedited) 72 Hour review unit, Post Office Box 10344, Van Nuys, Ca 91410-0344, or fax it to **1-818-676-8179**. Be sure to ask for a "fast" or "72-hour" review.

- If **any** doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.
- If you ask for a fast Initial Decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast Initial Decision, we will send you a letter informing you that if you get a doctor's support for a "fast" review, we will automatically give you a fast decision. The letter will also tell you how to file a "Grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast Initial Decision, we will instead give you a standard decision (typically within 14 calendar days; see below).

What happens when you request an "Initial Decision"?

What happens, including how soon we must decide, depends on the type of decision:

1. *For a decision about payment for care you already received:*

After we receive your request, we have 30 calendar days to make a decision. However, if we need more information, we can take up to 30 more days. You will be told in writing when we make a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can Appeal this decision. If you have not received an answer from us within 60 calendar days of your request for payment, then the failure to receive an answer is the same as being told that your request was not approved. You may then Appeal this decision. (An Appeal is also called a reconsideration.) Step 2 tells how to file this Appeal.

2. *For a <u>standard</u> Initial Decision about medical care:*

After we receive your request, we have up to 14 calendar days to make a decision, but we will make it sooner if your health condition requires. However, we are allowed to take up to an additional 14 calendar days to make a decision (a) if you request this extension of time, or (b) if we need more time to gather information that may benefit you. For example, we may need more

time to get information that would help us approve your request for medical care (such as medical records). When we take additional days, we will notify you in writing of this extension. If you feel that we should not take additional days, you can make a specific type of complaint called a "Grievance." Section 10 of this booklet, *Appeals and Grievances: what to do if you have concerns or complaints,* tells how to make this kind of complaint.

We will tell you in writing of our Initial Decision concerning the medical care you have requested. You will receive this notification when we make our decision, under the time frame explained above. If we do not approve your request, we must explain why, and tell you of your right to Appeal our decision. Step 2 tells how to file this Appeal.

If you have not received an answer from us within 14 calendar days of your request for the Initial Decision, this failure to receive an answer is the same as being told that your request was not approved, and you have the right to Appeal. If we tell you that we extended the number of days needed for a decision and you have not received an answer from us by the end of the extension period, this failure to receive an answer is the same as being told that your request was not approved, and you have the right to Appeal. Step 2 tells how to file this Appeal.

3. *For a fast Initial Decision about medical care:*

If you receive a "fast" review, we will give you the result of our decision about your medical care within 72 hours after you or your doctor ask for a "fast" review -- sooner if your health requires. However, we are allowed to take up to 14 more calendar days to make this decision if we find that some information is missing which may benefit you, or if you need more time to prepare for this review. If you feel that we should not take any additional days, you can make a specific type of complaint called a "Grievance." Section 10 of this booklet, *Appeals and Grievances: what to do if you have concerns or complaints,* tells how to make this kind of complaint.

We will tell you our decision by phone as soon as we make the decision. Within three calendar days after we tell you of our decision in person or by phone, we will send you a letter that explains the decision. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), this is the same as denying your request. If we deny your request for a fast decision, you may file a Grievance about this decision. Section 10 of this booklet, *Appeals and Grievances: what to do if you have concerns or complaints,* tells how to file a Grievance.

What happens next if we decide completely in your favor?

If we make an "Initial Decision" that is completely in your favor, what happens next depends on the situation:

1. *For a decision about payment for care you already received:* We must pay within 30 calendar days of your request for payment, unless your request has errors or missing information. Then, we must pay within 60 calendar days.
2. *For a standard decision about medical care:* We must authorize or provide you with the care you have requested as quickly as your health requires, but no later than 14 calendar days after

we received the request you made for the Initial Decision. If we extended the time needed to make the decision, we will approve or provide your medical care when we make our decision.

3. *For a fast decision about medical care:* We must authorize or provide you with the medical care you have requested within 72 hours of receiving your request. If your health would be affected by waiting this long, we must provide it sooner.

What happens next if we deny your request?

If we deny your request, we may decide *completely* or only *partly* against you. For example, if we deny your request for payment for care that you have already received, we may say that we will pay nothing or only part of the amount you requested. In denying a request for medical care, we might decide not to approve any of the care you want, or only some of the care you want. If any Initial Decision does not give you *all* that you requested, you have the right to ask us to reconsider the decision, as explained below in Step 2.

STEP 2: If we deny part or all of your request in Step 1, you may ask us to reconsider our decision. This is called an "Appeal" or "request for reconsideration."

Please call us at **1-800-275-4737** if you need help in filing your Appeal. You may ask us to reconsider the Initial Decision we made in Step 1, even if only part of our decision is not what you requested. When we receive your request to reconsider the Initial Decision, we give the request to different people than those who were involved in making the Initial Decision. This helps ensure that we will give your request a fresh look.

How you make your Appeal depends on whether it is about payment for care you already received, or about authorizing medical care. If your Appeal concerns a decision we made about authorizing medical care, then you and/or your doctor will first need to decide whether you need a "fast" *Appeal*. The procedures for deciding on a "standard" or a "fast" *Appeal* in Step 2 are the same as those described for a "standard" or "fast" *Initial Decision* in Step 1. Please see the discussion in Step 1 under "Do you have a request for medical care that needs to be decided more quickly than the standard time frame?" and "Asking for a fast decision. "Asking for a fast decision. Please send Appeal requests to Health Net Seniority Plus, Appeals and Grievance Department, Post Office Box 10344, Van Nuys, Ca 91410-0344.

Getting information to support your Appeal

We must gather all the information we need to make a decision about your Appeal. You have the right to obtain and include additional information as part of your Appeal. For example, you may already have documents related to the issue, or you may want to get the doctor's records or the doctor's opinion to help support your request. You may need to give the doctor a written request to get information.

You can give us your additional information in any of the following ways:

- In writing, to Health Net Seniority Plus, Appeals and Grievances Department, P.O. Box 10344, Van Nuys, Ca 91410-0344.
- By fax, at 1-818-676-8179.
- By telephone -- if it is a "fast" Appeal -- at **1-800-275-4737**.
- In person at 21281 Burbank Boulevard, Woodland Hills, CA 91367.

You also have the right to ask us for a copy of your file that contains the information regarding your Appeal. You can call or write us and ask for a copy of your file at **1-800-275-4737**, Health Net Seniority Plus, Appeals and Grievances Department, P.O. Box 10344, Van Nuys, Ca 91410-0344.

How do you file your Appeal of the Initial Decision?

The rules about who may file the Appeal in Step 2 are the same as the rules about who may ask for an "Initial Decision" in Step 1. Please follow the instructions in Step 1 under "Who may ask for an 'Initial Decision'" about medical care or payment?"

Either you, someone you appoint, or your Provider may file this Appeal.

However, Providers who do not have a contract with Seniority Plus must sign a "waiver of payment" statement which says that they will not ask you to pay for the medical service under review, regardless of the outcome of the Appeal.

How soon must you file your Appeal?

The Appeal should be given to us in writing at Health Net Seniority Plus, Appeals and Grievances Department, P.O. Box 10344, Van Nuys, Ca 91410-0344 within 60 calendar days after we notify you of the Initial Decision from Step 1. We can give you more time if you have a good reason for missing the deadline.

You may also send your Appeal to your Social Security Administration office. Please note that sending your Appeal to this office instead of to us will delay when we begin the Appeal, since this office must forward your Appeal request to us.

What if you want a "fast" Appeal?

The rules about *asking for a "fast"* Appeal in Step 2 are the same as the rules about *asking for a "fast"* Initial Decision in Step 1. If you want to ask for a "fast" Appeal in Step 2, please follow the instructions in Step 1 under "Asking for a fast decision."

How soon must we decide on your Appeal?

How quickly we decide on the Appeal depends on the type of Appeal:

1. *For a decision about payment for care you already received*: After we receive your Appeal, we have 60 calendar days to make a decision. If we do not decide within 60 calendar days, your Appeal *automatically* goes to Step 3, where an independent organization will review your case.

2. *For a standard decision about medical care*: After we receive your Appeal, we have up to 30 calendar days to make a decision, but will make it sooner if your health condition requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 30 calendar days (or by the end of the extended time period), your request will *automatically* go to Step 3, where an independent organization will review your case.

3. *For a fast decision about medical care*: After we receive your Appeal, we have up to 72 hours to make a decision, but will make it sooner if your health requires. However, if you request it, or if we find that some information is missing which can help you, we can take up to 14 more calendar days to make our decision. If we do not tell you our decision within 72 hours (or by the end of the extended time period), your request will automatically go to Step 3, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. *For a decision about payment for care you already received:* We must pay within 60 calendar days of the day we received your request for us to reconsider our Initial Decision. If we decide only partially in your favor, your Appeal automatically goes to Step 3, where an independent organization will review your case.

2. *For a standard decision about medical care:* We must authorize or provide you with the care you have asked for as quickly as your health requires, but no later than 30 calendar days after we received your Appeal. If we extend the time needed to decide your Appeal, we will authorize or provide your medical care when we make our decision.

3. *For a fast decision about medical care:* We must authorize or provide you with the care you have asked for within 72 hours of receiving your Appeal -- or sooner, if your health would be affected by waiting this long. If we extended the time needed to decide your Appeal, we will authorize or provide your medical care at the time we make our decision.

What happens next if we deny your Appeal?

If we deny any part of your Appeal in Step 2, then your Appeal *automatically* goes on to Step 3 where an independent organization will review your case. This independent review organization contracts with the federal government and is not part of Health Net. We will tell you in writing that your Appeal has been sent to this organization for review. How quickly we must forward your Appeal to the independent review organization that performs the review in Step 3 depends

on the type of Appeal:

1. *For a decision about payment for care you already received:* We must send all the information about your Appeal to the independent review organization within 60 calendar days from the date we received your Appeal in Step 2.
2. *For a standard decision about medical care:* We must send all of the information about your Appeal to the independent review organization as quickly as your health requires, but no later than 30 calendar days after we received your Appeal in Step 2.
3. *For a fast decision about medical care:* We must send all of the information about your Appeal to the independent review organization within 24 hours of our decision.

STEP 3: If we deny any part of your Appeal in Step 2, your Appeal automatically goes on for review by a government-contracted independent review organization

What independent review organization does this review?

In Step 3, your Appeal is given a new review by an outside, independent review organization that has a contract with CMS (Centers for Medicare & Medicaid Services), the government agency that runs the Medicare program. This organization has no connection to Health Net. We will tell you when we have sent your Appeal to this organization. You have the right to get a copy from us of your case file that we sent to this organization.

How soon must the independent review organization decide?

After the independent review organization receives your Appeal, how long the organization can take to make a decision depends on the type of Appeal:

1. *For an Appeal about payment for care,* the independent review organization has up to 60 calendar days to make a decision.
2. *For a standard Appeal about medical care,* the independent review organization has up to 30 calendar days to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension will benefit you.
3. *For a fast Appeal about medical care,* the independent review organization has up to 72 hours to make a decision. This time period can be extended by up to 14 calendar days if more information is needed and the extension will benefit you.

If the independent review organization decides completely in your favor:

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of Appeal:

1. *For an Appeal about payment for care,* we must pay within 30 calendar days after receiving the decision.

2. *For a standard Appeal about medical care,* we must *authorize* the care you have asked for within 72 hours after receiving notice of the decision from the independent review organization, or *provide* the care as quickly as your health requires, but no later than 14 calendar days after receiving the decision.
3. *For a fast Appeal about medical care,* we must authorize or provide you with the care you have asked for within 72 hours of receiving the decision.

What happens next if the review organization decides against you (either partly or completely)?
The independent review organization will tell you in writing about its decision and the reasons for it. You may continue your Appeal by asking for a review by an Administrative Law Judge (see Step 4), provided that the dollar value of the medical care or the payment in your Appeal is $100 or more.

You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date you were notified of the decision made in Step 3. You can extend this deadline for good cause. You have a choice about where you send your written request:

- You can send it directly to the independent review organization that reviewed your Appeal in Step 3. They will then send your request along with your Appeal information to the Administrative Law Judge who will hear your Appeal in Step 4.
- Instead of sending your request directly to the independent review organization that reviewed your Appeal in Step 3, you can send it to Health Net, or to your local Social Security Administration office. If you do this, starting Step 4 will take longer because your request must first be forwarded to the independent review organization that reviewed your Appeal in Step 3. The independent review organization will then send your request along with your Appeal information to the Administrative Law Judge who will hear your Appeal in Step 4.

STEP 4: If the organization that reviews your case in Step 3 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

As stated in Step 3, if the independent review organization does not rule completely in your favor, you may ask them to forward your Appeal for a review by an Administrative Law Judge. The Administrative Law Judge will not review the Appeal if the dollar value of the medical care is less than $100. If the dollar value is less than $100, you may not Appeal any further.

How soon does the Judge make a decision?
The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor:
We must pay for, authorize, or provide the service you have asked for within 60 calendar days from the date we receive notice of the decision. We have the right to Appeal this decision by asking for a review by the Medicare Appeals Council (Step 5).

If the Judge rules against you:
You have the right to Appeal this decision by asking for a review by the Medicare Appeals Council (Step 5). The letter you get from the Administrative Law Judge will tell you how to request this review.

STEP 5: Your case is reviewed by a Medicare Appeals Council

This Council will first decide whether to review your case
If the Medicare Appeals Council decides not to review your case, then either you or Health Net may request a review by a Federal Court Judge. However, the Federal Court Judge will only review cases when the amount involved is $1,050 or more. If the dollar value is less than $1,050, you may not Appeal any further.

How soon will the Council make a decision?
If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor:
We must pay for, authorize, or provide the medical service you have asked for within 60 calendar days from the date we receive notice of the decision. However, we have the right to Appeal this decision by asking a Federal Court Judge to review the case (Step 6), provided the amount involved is at least $1,050. If the dollar value is less than $1,050, the Council's decision is final.

If the Council decides against you:
If the amount involved is $1,050 or more, you have the right to continue your Appeal by asking a Federal Court Judge to review the case (Step 6). If the value is less than $1,050, the Council's decision is final and you may not take the Appeal any further.

STEP 6: Your case goes to a Federal Court

If the amount is $1,050 or more, you or Health Net may ask a Federal Court Judge to review the case.

APPENDIX C. Legal Notices

Notice about governing law:

Many different laws apply to this Evidence of Coverage. Some additional provisions may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The laws that may apply to this document are: all of the laws of the State of California and the United States of America, including 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 (formerly known as the Health Care Financing Administration, or HCFA). If this Evidence of Coverage and a law are inconsistent or in conflict, the law will decide what should happen.

Notice about non-discrimination:

When Health Net makes decisions about the provision of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare managed care, like Health Net, 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 receive federal funding, and any other laws and rules that apply for any other reason.

Member Non-Liability

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

If you go to a doctor, Hospital, or other Provider without the approval of your PCP -- except in an emergency or when you need urgent care, out-of-area renal (kidney) dialysis, or certain gynecological care or other self referred services-- you will be responsible for paying any charges for these services. Neither Original Medicare nor Health Net will pay for non-Emergency Services or non-urgently needed care without the prior authorization of your PCP.

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 the facilities, or personnel, of Health Net not being available to provide or arrange for services or benefits under this Evidence of Coverage, Health Net's obligation to provide such services or benefits shall be limited to the requirement that Health Net make a good faith effort to provide or arrange for the provision of such services or benefits within the resulting limitations on the availability of its facilities or personnel.

When A Third Party Causes A Member Injuries

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

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

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

Steps You Must Take

Health Net's legal right to reimbursement is called a lien.

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

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

How The Amount Of your Reimbursement Is Determined

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

- The amount of the reimbursement that you owe Health Net or the physician Group will be reduced by the percentage that your recovery is reduced if a judge, jury or arbitrator

determines that you were responsible for some portion of your injuries.

- The amount of the reimbursement that you owe Health Net or the physician Group will also be reduced a pro rata share for any legal fees or costs that you paid from the money you received.
- The amount that you will be required to reimburse Health Net or the physician Group for services you receive under this plan will not exceed one-third of the money that you receive if you do engage a lawyer, or one-half of the money you receive if you do not engage a lawyer.

Coordination of benefits protects you from higher Plan Premiums. The end result is more affordable health care.

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

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

For more information on organ donations, including how to elect to be an organ donor, please contact the Member Services Department at the telephone number on your Health Net ID Card, or visit the Department of Health and Human Services organ donation website at www.organdonor.gov.

Notice Of Privacy Practices

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

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

We are required by federal and state laws to provide you with this Notice about your rights and

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

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

- **Payment**. We use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment.
- **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 a group health plan to the plan sponsor, which is usually the employer.

  If the plan sponsor provides plan administration services, we may also provide access to health information to support its performance of health plan operations 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 firewalls in place to ensure that only employees with a legitimate need to know will have access to health information in order to provide plan administration functions.

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.

- **Contact Information for Exercising Your Rights**. You may exercise any of the rights described above by contacting our privacy office. See the end of this Notice for the contact information.

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

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

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

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

Contact the plan
If you have any complaints or questions about this Notice or you want to submit a written request to the Plan as required in any of the previous sections of this Notice, 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: **1-818-676-8981**
Email: Privacy@healthnet.com

This "Notice of Privacy Practices" also applies to enrollees in any of the following Health Net entities: • Health Net of California, Inc. • Managed Health Network, Inc (MHN). • Health Life Insurance Company, Inc.

APPENDIX D. Information about "*advance directives*"

(Information about using a legal form such as a "living will" or "power of attorney" to give *directions in advance* about your health care in case you become unable to make your own health care decisions.)

You have the right to make your own health care decisions. But what if you had an accident or illness so serious that you *became unable* to make these decisions for yourself? If this were to happen:

- You might want a particular person you trust to make these decisions for you.
- You might want to let health care Providers know the types of medical care you would *want* and *not want* if you were not able to make decisions for yourself.
- You might want to do both – to appoint someone else to make decisions for you, and to let this person and your health care Providers know the kinds of medical care you would want if you were unable to make these decisions for yourself.

If you wish, you can fill out and sign a special form that lets others know what you want done if you cannot make health care decisions for yourself. This form is a legal document. It is sometimes called an "**advance directive**," because it lets you give *directions* in *advance* about what you want to happen if you ever become unable to make your own health care decisions.

There are different types of advance directives and different names for them depending on your state or local area. For example, documents called "living will" and "power of attorney for health care" are examples of advance directives.

It's *your choice* whether you want to fill out an advance directive. The law forbids any discrimination against you in your medical care based on whether you have an advance directive or not.

How can you use a legal form to give your instructions in advance?

If you decide that you do want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, and from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as your HICAP (which stands for **H**ealth **I**nsurance **C**ounseling **A**dvocacy **P**rogram). Section 1 of this booklet, *Telephone numbers and other information for reference*, tells how to contact your HICAP (HICAPs have different names depending on which state you are in). Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family Members as well. If you know ahead of time that you are going to be hospitalized, take a copy with

you.

If you are hospitalized, they will ask you about an advance directive

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. It is your choice whether to sign or not. If you decide not to sign an advance directive form, you will not be denied care or be discriminated against in the care you are given.

What if Providers don't follow the instructions you have given?

If you believe that a doctor or Hospital has not followed the instructions in your advance directive you may file a complaint with. California Department of Health Services, P.O. Box 997413, M.S. 3200, Sacramento, CA 95899-7413. Telephone number **1-800-236-9747**. Operating hours are Monday through Friday 8:00 a.m. to 5:00 p.m. The relay number for Telecommunications Device for the Deaf (TDD) is **1-916-440-7399** Operating hours are Monday through Friday 8:00 a.m. to 5:00 p.m.

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For more information, please contact us at:

Health Net Seniority Plus
Post Office Box 10198
Van Nuys, California 91410-0198

Member Services Department
1-800-275-4737
Our office hours are from 7:30 a.m. to 12:00 p.m.
and 1:00 p.m. to 5:00 p.m., open Monday through Friday.

Para los que hablan español
1-800-331-1777
Our office hours are from 7:30 a.m. to 12:00 p.m.
and 1:00 p.m. to 5:00 p.m., open Monday through Friday.

Telecommunications Device for the Deaf
1-800-929-9955
Our office hours are from 7:30 a.m. to 12:00 p.m.
and 1:00 p.m. to 5:00 p.m., open Monday through Friday.

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