Health Net
Medicare Programs

A COMPLETE

explanation of your plan

For University of California Medicare Retirees residing in the Imperial or San Luis Obispo Counties

Effective 1/1/2008

Evidence of Coverage

Health Net Private Fee-for-Service Plan

PLAN 2G9
EOCID: 193613

EVIDENCE OF COVERAGE:

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. Please keep it in a safe place.

Health Net Member Services:

For help or information, please call Member Services, 8:00 am to 8:00 p.m., 7 days a week. A Member Services representative will be available to answer your call directly during the annual enrollment period and 60 days after from 8 am until 8 pm. On Saturdays, Sundays and holidays, your call will be handled by our automated phone system. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than the next business day. Calls to these numbers are free:

1-800-539-4072

TTY: 1-800-929-9955

Schedule changes in 2008

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

Changes to this Plan

Schedule of Benefits and Copayments

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

Welcome to Health Net's Private Fee-for-Service Plan

We are pleased that you've chosen Health Net Life.

This Medicare Private Fee-for-Service (herein referred to as Health Net's PPFS) Plan is for people with Medicare.

Now that you are enrolled in this Plan, you are getting your care through Health Net Life Insurance Company (Health Net Life). This Plan, a **Medicare Health Net's PPFS plan**, is offered by Health Net's PPFS Plan. **(This is *not* a "Medigap" or supplemental Medicare insurance policy.)**

This booklet, together with your enrollment form, Summary of Benefits and any amendments that we may send to you, explain your rights, benefits, and responsibilities as a member of Health Net's PPFS Plan. They also explain our responsibilities to you.

You are still covered by Original Medicare, but you are getting your Medicare services as a member of Health Net's PPFS Plan. This booklet gives you the details, including:

- What is covered by this Plan and what is not covered.
- How to get the care you need, including some rules you must follow.
- What you will have to pay for your health plan.
- What to do if you are unhappy about something related to getting your covered services.
- How to leave this Plan, including other Medicare options.

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

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 of this booklet tells you how to contact us). Your comments are always welcome, whether they are positive or negative. From time to time, we do surveys that ask our members to tell about their experiences. If you are contacted, we hope you will participate in a member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

Health Net Life has signed a contract with Centers for Medicare & Medicaid Services (CMS) and your Group, agreeing to cover you. In addition, either CMS, Health Net Life or the Group may choose to not renew all or a portion of the contract. The costs and benefits for this Plan 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 this Plan and your coverage will be changed to Original Medicare unless you decide to change to another Medicare managed care plan.

If either CMS or we 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.

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

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

ELIGIBILITY

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

Subscriber

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

* Lecturers - see your benefits office for eligibility.

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

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

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

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

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

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

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

Eligible Dependents (Family Members)

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

Spouse: Your legal spouse.

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

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

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

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

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

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

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

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

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

No Dual Coverage

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

More Information

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

Enrollment

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

During a Period of Initial Eligibility (PIE)

A PIE ends 31 days after it begins.

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

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

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

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

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

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

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

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

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

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

At Other Times For Employees And Retirees

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

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

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

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

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

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

If you are a Retiree, you may continue coverage for yourself and your enrolled Family Members in the same plan (or its Medicare version) you were enrolled in immediately before retiring. You

must elect to continue enrollment for yourself and enrolled Family Members before the effective date of retirement (or the date disability or survivor benefits begin).

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

Effective Date

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

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

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

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

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

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

(a) the date the Child becomes eligible, or

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

Change in Coverage

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

Effect of Medicare on Retiree Enrollment

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

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

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

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

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

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

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

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

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

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

Medicare Secondary Payer Law (MSP)

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

Medicare Private Contracting Provision and Providers Who do Not Accept Medicare

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

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

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

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

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

TERMINATION OF COVERAGE

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

Deenrollment Due to Loss of Eligible Status

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

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

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

Deenrollment Due to Fraud

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

Leave of Absence, Layoff or Retirement

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

Optional Continuation of Coverage

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

PLAN ADMINISTRATION

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

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

Sponsorship and Administration of the Plan

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

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

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

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

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

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Group Contract Number

The Group Contract Number for this Plan is: 5047RE, 5047RJ, 5047RP, 5047RT, 5047RX, 5047SB, 5047SF, 5047TZ, 5047UE, 5047UJ, 5047UQ, 5047UV, 5047VA, 5047VE, 5047VK, 5047SL, 5047DQ, 5047SU, 5047SY, 5047TE, 5047TK, 5047TP, 5047TU.

Type of Plan

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

Plan Year

The plan year is January 1 through December 31.

Continuation of the Plan

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

Financial Arrangements

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

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

Agent for Serving of Legal Process

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

Your Rights under the Plan

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

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

Claims under the Plan

To file a claim or to appeal a denied claim, refer to page 68 of this document.

Nondiscrimination Statement

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

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

Table of Contents

Section 1: Telephone numbers and other information for reference

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. A Member Services representative will be available to answer your call directly during the annual enrollment period and 60 days after from 8 am until 8 pm., 7 days a week. On March 2, 2008, your call will be handled by our automated phone system, Saturdays, Sundays and holidays. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than the next business day). Calls to these numbers are free:

CALL: 1-800-539-4072. This number is also on the cover of this booklet for easy reference. Calls to this number are free

TTY: 1-800-929-9955. This number requires special telephone equipment. It is on the cover of this booklet for easy reference. Calls to this number are free.

WRITE: Health Net Medicare Programs
PO Box 1728
Augusta, GA 30903-1728

How to contact the Medicare program and the 1-800-MEDICARE (TTY 1-877-486-2048) helpline

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the federal agency in charge of the Medicare program. CMS stands for **C**enters for **M**edicare & Medicaid **S**ervices. CMS contracts with and regulates Medicare Health Plans (including Health Net Life). Here are ways to get help and information about Medicare from CMS:

Call **1-800-MEDICARE** (1-800-633-4227) toll free to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. TTY users should call1-877-486-2048.

Use a computer to look at www.medicare.gov, the official government Web site for Medicare information. This Web site gives you a lot of up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Prescription Drug Plans in your area. You can also search the "Helpful Contacts" section for the Medicare contacts in your state. If you do not have a computer, your local library, or senior center may be able to help you visit this Web site using their computer.

SHIP – An organization in your state that provides free Medicare help and information

"SHIP" stands for **S**tate **H**ealth **I**nsurance Assistance **P**rogram. SHIPs are state organizations paid by the federal government to give free health insurance information and help to people with Medicare. SHIPs have different names depending on which state they are in. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Advantage Plans and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in the Medicare Advantage plan. This also includes special Medigap rights for people who disenroll from a Medigap plan when they enroll in a Medicare Advantage Plan (like this Plan) for the first time but then leave the cost plan within 12 months and wish to buy another Medigap policy. (Section 13 has more information about your Medigap guaranteed issue rights).

You can contact the SHIP at:

SHIP	**Contact Number**
Health Insurance Counseling and Advocacy Program (HICAP) of California 1600 K Street Sacramento, CA 95814	800-434-0222

You can also find the website for SHIP at www.medicare.gov on the web.

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 **Q**uality **I**mprovement **O**rganization. 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. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their hospital stay is ending too soon. See Section 9 for more information about complaints.

You can contact the QIO at:

QIO	**Contact Number**
Lumetra One Sansome Street Suite 600 San Francisco, CA 94104	(415) 677-2000 (800) 841-1602 TTY: (800) 735-2922

Other Organizations (including Medicaid, Social Security Administration)

Medicaid Agency – a State Government Agency that handles health care programs for people with low incomes

Medicaid is a joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact:

Medicaid Agency	**Contact Number**
California Department of Health Services P O Box 997413 Sacramento, CA 95899	(916) 445-4171 TTY:(800) 735-2922

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits, disability, family benefits, survivors' benefits, and benefits for the aged, blind, and disabled. You can call the Social Security Administration toll free at 1-800-772-1213. TTY users should call 1-800-325-0778. 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). TTY users should call 312-751-4701. You can also visit www.rrb.gov on the Web.

Employer (or "Group") Coverage

Call your Group's benefits administrator if you have any questions about your benefits, plan premiums, or the open enrollment season.

Section 2: Getting the care you need, including some rules you must follow

What is Health Net's PPFS?

A Private Fee-for-Service plan is a Medicare Advantage health plan offered by private insurance companies like Health Net who are under contract with the federal government to provide coverage to Medicare beneficiaries. These plans allow you the freedom to obtain care from any licensed physician, hospital or service provider who accepts payment from Medicare, including specialists, who are willing to accept Health Net's terms and conditions of payment.

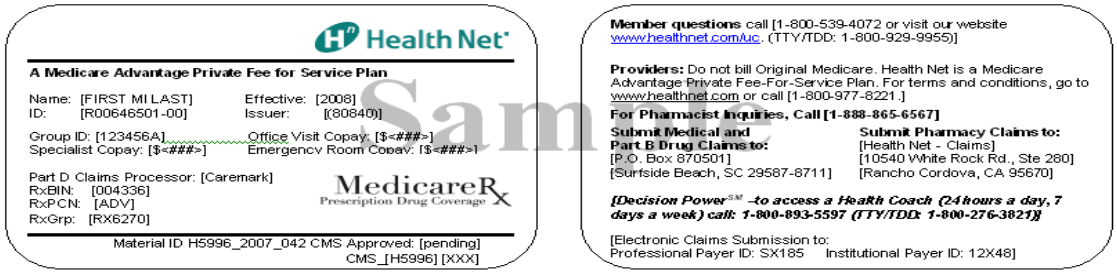
Since this is a Health Net's PPFS plan you may go to any eligible doctor or hospital anywhere in the U.S. that is willing to provide care and to whom you have informed, that you are a member of Health Net's PPFS Plan by showing them your Member ID Card. A doctor or hospital is eligible to furnish your care if they are eligible to be paid by the Medicare program. You can always ask Health Net Life at 1-800-539-4072, (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week. If you have questions if a particular service is covered by your plan or if a doctor or hospital can treat you. When you go to a doctor or hospital, for non-emergent care, you must inform the provider, that you are enrolled in this Plan, a Medicare Health Net's PPFS plan by showing them your Member ID Card. If the doctor or hospital decides to treat you, you are only required to pay the cost-sharing amount allowed by your Health Net's PPFS plan. The doctor or hospital will bill Health Net Life for the rest of the fee.

If you have any questions about whether Health Net Life will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding advance coverage determination made for the service. Call Health Net Life at 1-800-539-4072, (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week. and tell us you would like a decision if the service will be covered.

In most cases, use your plan ID Card instead of your red, white, and blue Medicare card

Now that you are a member of this Plan, you should have a Health Net Life ID Card. Here is a sample card to show what it looks like:

Health Net 2008 Employer Group (UC) MAPD PFFS ID Card – H5996



Card Dimensions: H=2 1/8" x W=3 3/8"

During the time you are a plan member and using plan services, **you *must* use your plan ID Card instead of your red, white, and blue Medicare card to get covered services.** (See Section 4 for a definition and list of covered services.) Keep your red, white, and blue Medicare card in a safe place in case you are asked to show it, but you will not use it to get services while you are a member of a Medicare Advantage Health Net's PPFS plan. When you go to a doctor or hospital you must inform them that you are a member of Health Net's PPFS plan and show them your Health Net's PPFS plan ID Card. Your provider will decide if he or she will treat you as a member of a Health Net's PPFS plan. Providers are not required to furnish services to enrollees in a Health Net's PPFS plan. If your provider does not want to participate in Health Net's PPFS plan then you must seek care from another provider who is willing to furnish services. If you get covered services using your red, white, and blue Medicare card instead of your Health Net ID Card while you are a plan member, the Medicare program will not pay for these services and you may have to pay the full cost yourself.

Please carry your Health Net ID Card with you at all times. You will need to show this card when you get covered services or covered drugs at the pharmacy. See Section 4 for a list of services and drugs that are covered under this Plan. If your ID Card is ever damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Help us keep your membership record up-to-date

Health Net Life has a membership record about you as a plan member. Doctors, hospitals, and pharmacists use this membership record to know what services and drugs are covered for you. The membership record has information from your enrollment form, including your address and telephone number. It shows your specific Health Net Life coverage and other information. Section 9 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up-to-date by letting Member Services know right away if there are any changes to your name, address, or phone number, or if you go into a nursing home. Also, tell Member Services about any changes in health insurance coverage you have from other sources, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims, such as claims from an automobile accident. See Section 1 for how to contact Member Services.

What is the geographic service area for Health Net's PPFS Plan?

In order to enroll in Health Net's PPFS Plan your permanent residence must be in its geographic service area. However, members of Health Net may obtain care from any certified provider in the U.S. who is willing to accept the Health Net terms and conditions of payment whether or not these providers are located in the geographic service area and whether or not these providers directly contract with Health Net.

This Plan's geographic service area includes all counties in the state of California.

Employer-sponsored coverage may be available to you in other states. Please check with your employer group for the geographic service area applicable to your group.

Getting care from doctors, specialists and hospitals

You can receive care from any doctor, specialist or hospital in the U.S. who is eligible to be paid by Medicare and accepts Health Net's Terms and Conditions of payment. This Plan covers you for all Medicare A and B services and the supplemental benefits described in this document. You may also receive renal dialysis (kidney) services from any dialysis provider in the U.S. who is eligible to be paid by the Medicare program. If a particular provider does not accept your plan's Terms and Conditions of payment you must seek care from another provider who will. If you have any questions about what services Health Net covers or if a particular provider can be paid by this Plan you can contact us at 1-800-539-4072, (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week.

Getting care when you travel or are away from the plan's service area

You may go to any eligible doctor or hospital in the U.S. that is willing to provide care and accepts Health Net terms and conditions of participation. If you require dialysis services you may go to any dialysis provider in the U.S. that is eligible to be paid by Medicare and accepts Health Net's Terms and Conditions of payment. When you go to a doctor or hospital be sure to show them your Health Net's PPFS enrollment card. The card ensures that the provider has a reasonable opportunity to obtain the terms and conditions of payment under the plan. If the doctor or hospital decides to treat you, you are only required to pay the cost-sharing amount allowed by Health Net Life. The doctor or hospital will bill Health Net Life for the rest of its fee. You can call Health Net Life at 1-800-539-4072, (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, in advance of receiving health care services and we will provide an Advance Coverage Determination for the care you need. You may also ask us for a coverage determination in writing confirming if the service will be paid for by Health Net Life.

What if your doctor will not furnish your care as a member of Health Net's PPFS Plan?

Sometimes a doctor, specialist, hospital, clinic, or other provider you are using might decide to not participate in Health Net's PPFS Plan. This could occur because your doctor has decided to not accept Health Net's Terms and Conditions of payment. If this happens, you will have to switch to another provider who is willing to treat you as a member of Health Net Life. Any Medicare participating doctor is eligible to participate in the Health Net's PPFS Plan. If you need help finding a provider, you can go to www.medicare.gov to access a list of participating doctors in your area. Please confirm that they will accept Health Net Life members before scheduling an appointment. You can also contact us at 1-800-539-4072, (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, and we will try and help you find a doctor that meets your needs.

Section 3: Getting care if you have a medical emergency or an urgent need for care

What is a "medical emergency"?

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

What should you do if you have a medical emergency?

If you have a medical emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency hospital, or urgent care center. You do not need to get approval or a referral first from your doctor or other provider.

What is covered if you have a medical emergency?

- You can get covered emergency medical care whenever you need it, anywhere in the United States.
- **Ambulance** services are covered in situations where other means of transportation in the United States would endanger your health.

What if it wasn't really a medical emergency?

Sometimes it can be hard to know if you have a real medical emergency. For example, you might go in for emergency care—thinking that your health is in serious danger—and the doctor may say that it was not a medical emergency after all. If you decide to get follow-up care from the provider treating you as soon as possible you should advise them of your enrollment in Health Net's PPFS Plan. Your plan will pay for all medically necessary plan covered services furnished by the provider. Health Net's PPFS Plan covers non-emergent care that you get from any provider in the U.S. to whom you have informed, by showing your member ID Card, that you are a member of Health Net Life.

Section 4: Benefits chart

A list of the covered services you get as a member of Health Net's PPFS Plan.

What are "covered services"?

This section describes the medical benefits and coverage you get as a member of Health Net's PPFS Plan. **"Covered services" means the medical care, services, supplies, and equipment that are covered by** Health Net Life**.** This section has a Benefits Chart that gives a list of your covered services and tells what you must pay for each covered service. The section that follows (Section 5) tells about **services that are *not* covered** (these are called "exclusions"). Section 5 also tells about limitations on certain services

You can get covered benefits from any provider qualified to furnish the benefit in question and who is willing to accept Health Net Life's Terms and Conditions of payment. We urge you to call Member Services at the phone number in Section 1 to ask if a particular service is covered by your plan. Your plan does not have to pay for services that are not covered by the plan.

There are some conditions that apply in order to get covered services

Some general requirements apply to *all* covered services

The covered services listed in the Benefits Chart in this section are covered only when *all* requirements listed below are met:

Services must be provided according to the Medicare coverage guidelines established by the Medicare program.

You can get covered benefits from any provider qualified to furnish the benefit in question and who is willing to accept Health Net Life's terms and conditions of payment. If you have any questions about what services Health Net Life will pay for we urge you to call Member Services at 1-800-539-4072, (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, to ask if a particular service is covered by Health Net Life. Your plan does not have to pay for services that are not covered by the plan.

- The medical care, services, supplies, and equipment that are listed as covered services must be medically necessary. Certain preventive care and screening tests are also covered. Medically necessary means services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor.

Benefits Chart – a list of covered services

Benefits chart – your covered services	What you must pay when you get these covered services
Inpatient Services	
• Inpatient hospital care • For more information about hospital care, see Section 6. • You are covered for unlimited days of inpatient hospital care. Covered services include, but are not limited to, the following: • Semiprivate room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Physical therapy, occupational therapy, and speech therapy services. • Under certain conditions, the following types of transplants are covered: Corneal, kidney, pancreas, heart, liver, lung, heart/lung, bone marrow, stem cell, intestinal/multivisceral. See Section 6 for more information about transplants. • Blood – including storage and administration. Coverage of whole blood and package red cells begins with the first pint of blood that you need. • Physician Services.	You pay $250 per admission. You are covered for unlimited days each Benefit Period. Hospital Copayments are required for the first three admissions per Calendar Year. Once the Copayment is met, no Copayment is required for further admissions in the same Calendar Year.

Benefits chart – your covered services	What you must pay when you get these covered services
Inpatient hospital transgender surgery/services** (including hysterectomy, oophorectomy and mastectomy) • Travel, lodging and meals included. The transgender surgery must be performed by a Health Net qualified provider in conjunction with gender transformation treatment. The treatment plan must conform to Harry Benjamin International Gender Dysphoria Association (HBIGDA) standards. Psychotherapy and hormonal treatment are excluded from the lifetime maximum.	You pay a $250 Copayment for transgender services. Hospital Copayments are required for the first three admissions per Calendar Year. Once the Copayment is met, no Copayment is required for further admissions in the same Calendar Year. Transgender surgery and related services (including travel, lodging and meal expenses) approved by the plan are subject to a combined inpatient and outpatient lifetime benefit maximum of $75,000 for each Member.
Inpatient mental health care Includes mental health care services that require a hospital stay. There is a 190-day lifetime limit in a Medicare-certified psychiatric hospital. The 190-day limit does not apply to Mental Health services provided in a psychiatric unit of a general hospital.	You pay a $250 copayment. Hospital Copayments are required for the first three admissions per Calendar Year. Once the Copayment is met, no Copayment is required for further admissions in the same Calendar Year.

Benefits chart – your covered services	What you must pay when you get these covered services
Inpatient substance abuse care*	You pay a $250 Copayment for services in a network Hospital.
•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.	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.
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.

Benefits chart – your covered services	What you must pay when you get these covered services
Skilled nursing facility care For more information about skilled nursing facility care, see Section 6. Covered for 100 days each benefit period*. No prior hospital stay is required. Covered services include, but are not limited to, the following: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Regular nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs (this includes substances that are naturally present in the body, such as blood clotting factors). • Blood – including storage and administration. Coverage of whole blood and package red cells begins with the first pint of blood that you need • Medical and surgical supplies. • Laboratory tests. • 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. *A benefit period begins the day you go to a hospital or skilled nursing facility. The benefit period ends when you have not received hospital or skilled nursing care for 60 days in a row. If you go into the hospital or skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have. No Hospital stay is required.

Benefits chart – your covered services	What you must pay when you get these covered services
Inpatient services (when the hospital or SNF days are not covered or are no longer covered) For more information, see Section 6. • Physician services. • Tests (like X-ray or lab tests). • X-ray, radium, and isotope therapy including technician materials and services. • Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations. • 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.	There is no copayment for Medicare-covered services listed.
Home health care For more information about home health care, see Section 6. *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.

Benefits chart – your covered services	What you must pay when you get these covered services
Hospice care For more information about hospice services, see Section 6. • Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Medicare. • Home care. • Hospice consultation services (one time only) for a terminally ill individual who has not elected the hospice benefit.	When you enroll in a Medicare-certified hospice, your hospice services are paid by Medicare (see Section 6 for more information about hospice services).
Outpatient Services	
Physician services, including doctor office visits • 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 provided by a dentist (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a doctor).	You pay $15 for each office visit for Medicare-covered services. You pay $15 for each specialist visit for Medicare-covered services. You may go to any doctor, specialist, or hospital that accepts the plan's payment.
Periodic Health Evaluations	There is no Copayment.

Benefits chart – your covered services	What you must pay when you get these covered services
Chiropractic services	
• Manual manipulation of the spine to correct subluxation.	You pay $15 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation).
• Routine Chiropractic care (non Medicare-covered).	You pay $15 per visit (20 visits per Calendar Year). (non Medicare-covered)
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. • Routine foot care (non Medicare-covered).	You pay $15 for each Medicare-covered visit for podiatry services. You pay $15 for each routine (non Medicare-covered) visit. Care is limited to one visit per calendar month.

Benefits chart – your covered services	What you must pay when you get these covered services
Outpatient mental health care (including partial hospitalization services) 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: - $15 for each individual therapy visit 1 and beyond. - $7.50 for each group therapy visit 1 and beyond. For Medicare-covered Mental Health services with a psychiatrist, you pay: - $15 for individual visit(s) 1 and beyond. - $7.50 for individual/group therapy visit(s) 1 and beyond. For partial hospitalization, you pay $250. Hospital Copayments are required for the first three admissions in each calendar year for covered services. Once the requirement is met, no Copayment is required for further admissions in the same calendar-year.

Benefits chart – your covered services	What you must pay when you get these covered services
Outpatient substance abuse services	For Medicare-covered Substance Abuse services, you pay: - $15 for each individual therapy visit 1 and beyond. - $7.50 for each group therapy visit 1 and beyond. For Medicare-covered Substance Abuse services with a psychiatrist, you pay: - $15 for individual visit(s) 1 and beyond. - $7.50 for individual/group therapy visit(s) 1 and beyond.
Behavioral health care telephonic clinical consultations (Limited to a maximum of 3 consultations per member per calendar year). (Mental Health Care Telephonic clinical consultation services are provided by a licensed counselor - 1-800-663-9355.)	There is no Copayment for each Medicare-covered Telephonic clinical consultations.
Outpatient surgery	There is no Copayment for each Medicare-covered visit to an ambulatory surgical center. There is no Copayment for each Medicare-covered visit to an outpatient hospital facility.

Benefits chart – your covered services	What you must pay when you get these covered services
Outpatient transgender surgery/services**	
(including hysterectomy, oophorectomy and mastectomy)	There is no Copayment for transgender surgery
• Travel, lodging and meals included. The transgender surgery must be performed by a Health Net qualified provider in conjunction with gender transformation treatment. The treatment plan must conform to Harry Benjamin International Gender Dysphoria Association (HBIGDA) standards. Psychotherapy and hormonal treatment are excluded from the lifetime maximum.	Transgender surgery and related services (including travel, lodging and meal expenses) approved by the plan are subject to a combined inpatient and outpatient lifetime benefit maximum of $75,000 for each Member.
Ambulance services	
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 health.	There is no Copayment for Medicare-covered ambulance services.
Emergency care	
For more information, see Section 3.	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.

Benefits chart – your covered services	What you must pay when you get these covered services
Urgently needed care For more information, see Section 3.	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 therapy, occupational therapy, cardiac rehabilitation, and speech and language therapy)*** Cardiac rehabilitation therapy covered for patients who have had a heart attack in the last 12 months, have had coronary bypass surgery, and/or have stable angina pectoris.	There is no Copayment for each Medicare-covered rehabilitation therapy visit.
Durable medical equipment and related supplies This includes wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.	There is no Copayment for each Medicare-covered durable medical equipment or related supply.
Prosthetic devices and related supplies (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 and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision Care" below for more detail.	There is no Copayment for each Medicare-covered prosthetic device or related supply.

Benefits chart – your covered services	What you must pay when you get these covered services
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 insert.	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. Please call the Member Services Department at the phone number in Section 1 for more 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.	There is no Copayment for Medicare-covered Medical Nutrition Therapy visit(s).

Benefits chart – your covered services	What you must pay when you get these 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. • Laboratory tests. • 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.	There is no Copayment for each Medicare-covered clinical/diagnostic lab service. There is no Copayment for each Medicare-covered X-ray visit. There is no Copayment for each Medicare-covered radiation therapy service.
Preventive Care and Screening Tests	
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.

Benefits chart – your covered services	What you must pay when you get these 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 of colorectal cancer, the following is covered: • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy.	There is no Copayment for Medicare-covered colorectal screening exams.
Immunizations • Pneumonia vaccine. • Flu shots, once a year in the fall or winter. You can get this service on your own, without a referral from another doctor (as long as you get the service from a plan provider). • *If you are at high or intermediate risk of getting Hepatitis B*: Hepatitis B vaccine. • Other vaccines if you are at risk. • Immunizations for Foreign Travel and Occupational Purposes	There is no Copayment for the Pneumonia and Flu vaccines. There is no copayment for the Hepatitis B vaccine. You pay 20% of the charges travel or occupational purposes.
Allergy testing	You pay a $15 copayment for each Medicare-covered Allergy testing services.

Benefits chart – your covered services	What you must pay when you get these covered services
Allergy desensitizing serum	There is no copayment for each Medicare-covered Allergy desensitizing serum service.
Mammography screening • One baseline exam between the ages of 35 and 39. • One screening every 12 months for women age 40 and older.	There is no Copayment for Medicare-covered Screening Mammograms.
Pap smears, pelvic exams, and clinical breast exam For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months. If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months.	There is no Copayment for Medicare-covered Pap Smears and Pelvic Exams.
Prostate cancer screening exams For men age 50 and older, the following are covered once every 12 months: • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	There is no Copayment for Medicare-covered Prostate Cancer Screening exams.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). Please call the Member Services Department at the phone number in Section 1 for more information on how often we will cover these tests.	There is no Copayment for Medicare-covered cardiovascular disease testing.

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

Benefits chart – your covered services	What you must pay when you get these covered services
Part B Prescription Drugs THAT ARE COVERED UNDER ORIGINAL MEDICARE. THESE PART B DRUGS ARE COVERED FOR EVERYONE WITH MEDICARE. "Part B Drugs" includes substances that are naturally present in the body, such as blood clotting factors. • Drugs that usually are not self-administered by the patient and are injected while receiving physician services • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by Health Net Life. • Clotting factors you give yourself by injection if you have hemophilia. • Immunosuppressive drugs, if you have had an organ transplant that was covered by Medicare. • Injectables osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug. • Antigens. • Certain oral anti-cancer drugs and anti-nausea drugs. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, 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).	There are no Copayments or coinsurance for Medicare covered Drugs and Biologicals listed except for the Immunosuppressive drugs, certain oral anti-cancer drugs and anti-nausea drugs and injectable drugs for the treatment of osteoporosis for the home bound who cannot self-administer and drugs used with Durable Medical Equipment. The applicable Brand Name, Generic, or Specialty Drug Copayment applies for Part B Drugs. There is no Copayment for injections or injectable substances obtained at a physician's office. Injections or injectable substances obtained through a retail pharmacy are subject to the applicable Specialty Tier I or S Coinsurance.

Benefits chart – your covered services	What you must pay when you get these covered services

Part D Prescription Drugs

Prescription drugs that are covered if you are enrolled in Health Net's PPFS Plan because you have enrolled for Medicare Prescription Drug coverage.

With few exceptions, **you must use network pharmacies to get your prescription drugs covered.**

This plan uses a formulary. A formulary is a preferred list of drugs selected to meet patient needs at a lower cost. If the formulary changes, you will be notified, in writing, before the change. To view the plan's formulary, go to www.healthnet.com/uc on the web.

Section 7 explains about the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. Section 7 also tells about drugs that are not covered by this benefit.

Notes

- If you receive a brand-name drug when a generic equivalent is available, you may be responsible for a higher copayment or the difference in cost between the generic and brand drug.
- In some cases, the plan requires you to first try one drug to treat your medical condition before they will cover another drug for that condition.
- Certain prescription drugs will have maximum quantity limits.
- Your provider must get prior authorization from Health Net Life for certain prescription drugs.
- Covered Part D drugs are available at out-of network pharmacies in special circumstances including illness while traveling outside of the plan's service area where there is no network pharmacy. You may also incur an additional cost for drugs received at an out-of-network pharmacy.

People who have low incomes, who live in long term care facilities, or who have access to Indian/Tribal/Urban (Indian Health Service) facilities may have different out-of-pocket drug costs. Contact our Member Services for details.

There is no deductible.
You pay the following copayments/co-insurance for Part D-covered drugs:

Retail Pharmacies (30-day supply)

- $10 Copayment – Tier 1
- $20 Copayment – Tier 2
- $35 Copayment – Tier 3
- 25% Coinsurance - drugs on Specialty Tier I or S
50% Coinsurance – Sexual Dysfunction drugs, up to 8 doses

Three-month (90-day) supply of Part D Drugs purchased at local pharmacies:
- $30 Copayment – Tier 1
- $60 Copayment – Tier 2
- $105 Copayment – Tier 3
- 25% Coinsurance - drugs on Specialty Tier I or S

Three-month (90-day) supply of Part D Drugs purchased via mail order or obtained through the UC Walk –Up Service:
- $20 Copayment – Tier 1
- $40 Copayment – Tier 2
- $70 Copayment – Tier 3

Benefits chart – your covered services	What you must pay when you get these covered services
Part D Prescription Drugs (continued) Copayments and coinsurances are combined for prescriptions that are filled through mail order or retail pharmacies. The $2000 does not include charges you may have paid for by requesting a brand drug when a generic was available.	After your yearly out-of-pocket drug costs reach $2,510 excluding any generic substitution costs, Copayments and coinsurances will not be required for the remainder of the calendar year until you qualify for Catastrophic Coverage. After your yearly out-of-pocket drug costs, for covered part D drugs, including any additional charges you paid for requesting a brand over a generic, reach $4,050 you will qualify for Catastrophic Coverage and you will pay the greater of: - $2.25 for generic or a preferred brand drug that is a multi-source drug and - $5.60 for all other drugs, or 5% coinsurance. Certain Prescription Drugs will have maximum quantity limits and may have a pre-authorization requirement. Contact plan for details.
Additional Benefits	
Dental services • Services by a dentist limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.	You pay 100% for Medicare-covered dental services. Preventive dental services are not covered.

Benefits chart – your covered services	What you must pay when you get these covered services
Hearing services	
• Diagnostic hearing exams	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. Hearing screenings, provided as part of a periodic health evaluation, are covered at no charge.
• Routine hearing exams.	You pay $15 for each Medicare-covered hearing exam (diagnostic hearing exams). You pay $15 for each routine hearing test up to 1 test every year.

Benefits chart – your covered services	What you must pay when you get these covered services
Vision care	
• Outpatient physician services for eye care. • *For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older*: glaucoma screening once per year • Routine vision exams.	You pay $15 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye). -You pay $15 for each Routine eye exam, limited to 1 exam(s) every year. Vision screenings, provided as part of a periodic health evaluation, are covered at no charge.
• 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	-$15 for Medicare-covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery). Lenses are covered (in full or subject to an eyewear allowance) $100 allowance for frames every 2 years.

Benefits chart – your covered services	What you must pay when you get these covered services
Health and wellness 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 Education Classes - Newsletter - Nutritional Training - Smoking Cessation - Congestive Heart Program - Disease Management - Health Net Decision Power Ask Health Net Life 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

What if you have problems getting services you believe are covered for you?

If you have any concerns or problems getting the services you believe are covered as a member, we want to help. Please call us at Member Services at the telephone number in Section 1. You have the right to make a complaint if you have problems related to getting services or payment for services that you believe are covered as a member. See Section 11 for information about making a complaint.

Can your benefits change during the year?

At any time during the year, the Medicare program can change its national coverage. Since we cover what Original Medicare covers, we would have to make any change that the Medicare program makes. These changes could be to increase or decrease your benefits, depending on what change the Medicare program makes.

Section 5: Medical care and services that are NOT covered or are limited (list of exclusions and limitations)

Introduction

The purpose of this section is to tell you about medical care and services that are not covered ("excluded") or are limited by Health Net Life. The list below tells about these exclusions and limitations. The list describes services that are not covered under *any* conditions, and some services that are covered only under specific conditions. (The Benefits Chart in Section 4 also explains about some restrictions or limitations that apply to certain services).

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

We will not pay for the exclusions that are listed in this section (or elsewhere in this booklet), and neither will Original Medicare, unless they are found upon appeal to be services that we should have paid or covered (appeals are discussed in Sections 9 and 10).

What services are not covered or are limited, by Health Net Life?

If you have any question whether Health Net Life will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding advance coverage determination made for the service. Call Health Net Life at 1-800-539-4072, (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, and tell us you would like a decision if the service will be covered.

In addition to any exclusions or limitations described in the Benefits Chart in Section 4, or anywhere else in this booklet, **the following items and services are <u>not</u> covered except as indicated by Health Net Life:**

1. Services that are not covered under Original Medicare, unless such services are specifically listed as covered in Section 4.
2. Services that are not reasonable and necessary according to the standards of original Medicare unless these services are otherwise listed by Health Net Life as a covered service. As noted in Section 4, we provide all covered services according to Medicare guidelines.
3. Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency. (See Section 3 for more information about getting care for a medical emergency).

4. Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or unless, for certain services, the procedures are covered under an approved clinical trial. Experimental procedures and items are those items and procedures determined by Health Net Life and Original Medicare to not be generally accepted by the medical community. See Section 6 for information about participation in clinical trials while you are a member of Health Net's PPFS Plan.
5. Surgical treatment of morbid obesity unless medically necessary and covered under Original Medicare.
6. Private room in a hospital, unless medically necessary.
7. Private duty nurses.
8. Personal convenience items, such as a telephone or television in your room at a hospital or skilled nursing facility.
9. Nursing care on a full-time basis in your home.
10. Custodial care is not covered by this Plan 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.
11. Homemaker services.
12. Charges imposed by immediate relatives or members of your household.
13. Meals delivered to your home.
14. 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.
15. Cosmetic procedures, beyond surgery, that are related to transgender services are not covered.
16. 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 is covered 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.
17. Drugs prescribed for hormonal therapy for individuals who have been diagnosed with a covered Gender Identity Disorder (GID) may be covered.
18. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. Certain dental services that you get when you are in the hospital will be covered.

19. Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.

20. 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 shown in Section 4, in the Benefits Chart under "Outpatient Medical Services").

21. Supportive devices for the feet. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4, in the Benefits Chart under "Outpatient Medical Services").

22. Routine eye examinations and eyeglasses (except after cataract surgery), radial keratotomy, LASIK surgery, vision therapy and other low vision aids and services.

23. 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.)

24. Acupuncture.

25. Naturopath services.

26. Services provided to veterans in Veteran's Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost sharing is more than the cost sharing required under this Plan, we will reimburse veterans for the difference. Members are still responsible for the Health Net Life cost-sharing amount.

Section 6: Hospital care, skilled nursing facility care, and other services

(This section gives additional information about some of the covered services that are listed in the Benefits Chart in Section 4)

Hospital care

If you need hospital care, you can obtain care from any hospital in the U.S. that is eligible to be paid by Medicare and willing to accept the plan's terms and conditions. Covered services are listed in the Benefits Chart in Section 4 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.

What happens if you join or drop out of Health Net's PPFS Plan during a hospital stay?

If you either join or leave Health Net Life during an inpatient hospital stay, 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 Life, if anything, for the periods of your stay when you were and were not a plan member.

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

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

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

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

Health Net will not prepay for travel, lodging or meal expenses. Reimbursement will be provided with submission of the Claims Reimbursement form along with receipts for pre-approved

expenses; authorization needs to be indicated on the form. For use of personal car, the Member must provide: purpose of trip, date, location, receipts for tolls and parking (mileage will be reimbursed at federal mileage allowance rates).

Skilled nursing facility care (SNF care)

Covered services are listed in the Benefits Chart in Section 4 under the heading "Skilled nursing facility care." 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 skilled rehabilitation services** It can be a separate facility, or part of a hospital or other health care facility. A **S**killed **N**ursing **F**acility is called a "SNF" for short. The term "skilled nursing facility" does not include places 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.)

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. If you have any questions whether Health Net Life will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding Advance Coverage Determination made for the service. Call Health Net Life at 1-800-539-4072 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, and tell us you would like a determination if the service will be covered.

Stays that provide custodial care only are not covered

"Custodial care" is care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who do not have 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 this Plan unless it is provided as other care you are getting *in addition to* daily skilled nursing care and/or skilled rehabilitation services.

There are benefit period limitations on coverage of skilled nursing facility care

Inpatient skilled nursing facility coverage is limited to 100 days each benefit period. A "**benefit period**" begins on the first day you go to a Medicare-covered inpatient hospital or a 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.

Please note that after your SNF day limits are used up, Original Medicare will still pay for covered physician services and other medical services will still be covered. These services are listed in the Benefits Chart in Section 4 under the heading, "Inpatient services (when the hospital or SNF days are not or are no longer covered)."

Please also note that if you are receiving SNF services out of plan, and paying Original Medicare out-of-pocket amounts for the SNF services, you will have to pay Original Medicare out-of-pocket amounts for other services you get while you are in the SNF.

What happens if you join or drop out of Health Net's PPFS Plan during a SNF stay?

If you either join or leave Health Net Life during a SNF stay, 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 Life, if anything, for the periods of your stay when you were and were not a plan member.

Home health agency care

Home health care is skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Benefits Chart in Section 4 under the heading "Home health care." If you need home health care services, we will arrange these services for you if the requirements described below are met.

What are the requirements for getting home health agency services?

To get home health agency care benefits, you must meet all of these conditions:

You must be **home-bound**. This means that you are normally unable to leave your home and that leaving home is a major effort. When you leave home, it must be to get medical treatment or be infrequent, for a short time. You may attend religious services. You can also get care in an adult day care program that is licensed or certified by a state or accredited to furnish adult day care services in a state.

Occasional absences from the home for non-medical purposes, such as an occasional trip to the barber or a walk around the block or a drive, would not mean that you are not homebound if the absences are infrequent or are of relatively short duration. The absences cannot indicate that you have the capacity to obtain the health care provided outside of your home.

Generally speaking, you will be considered to be homebound if you have a condition due to an illness or injury that restricts your ability to leave your home except with the aid of supportive devices or if leaving home is medically contraindicated. "Supportive devices" include crutches, canes, wheelchairs, and walkers, the use of special transportation, or the assistance of another person.

Your doctor must decide that you need medical care in your home, and must make a plan for your care at home. Your **plan of care** describes the services you need, how often you need them, and what type of health care worker should give you these services.

1. The home health agency caring for you must be approved by the Medicare program.
2. You must need *at least one* of the following types of skilled care:
    - Skilled nursing care on an "intermittent" (not full time) basis. Generally, this means that you must need at least one skilled nursing visit every 60 days and not require daily skilled nursing care for more than 21 days. Skilled nursing care includes services that can only be performed by or under the supervision of a licensed nurse.
    - Physical therapy, which includes exercise to regain movement and strength to an area of the body, and training on how to use special equipment or do daily activities such as how to use a walker or get in and out of a wheel chair or bathtub.
    - Speech therapy, which includes exercise to regain and strengthen speech skills or to treat a swallowing problem.
    - Continuing occupational therapy, which helps you learn how to do usual daily activities by yourself. For example, you might learn new ways to eat or new ways to get dressed.

Home health care can include services from a home health aide, as long as you are <u>also</u> getting skilled care

As long as some qualifying skilled services are *also* included, the home health care you get can include services from a home health aide. A home health aide does not have a nursing license. The home health aide provides services that do not need the skills of a licensed nurse or therapist, such as help with personal care such as bathing, using the toilet, dressing, or carrying out the prescribed exercises. The services from a home health aide must be part of the home care of your illness or injury, and they are not covered unless you are *also* getting a covered skilled service. Home health services do not include the costs of housekeepers, food service arrangements, or full-time nursing care at home.

What are "part time" and "intermittent" home health care services?

If you meet the requirements given above for getting covered home health services, you may be eligible for "part time" or "intermittent" skilled nursing services 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.

If you have any questions whether Health Net Life will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding Advance Coverage Determination made for the service. Call Health Net Life at 1-800-539-4072 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, and tell us you would like a determination if the service will be covered.

Hospice care for people who are terminally ill

"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 Health Net's PPFS Plan, 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 1-800-Medicare for help in obtaining the list.

If you enroll in a Medicare-certified hospice, Original Medicare (rather than Health Net Life) 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 Health Net Life. If you use non-plan providers for your routine care, Original Medicare (rather than Health Net Life) 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), which is the national Medicare help line, or visit the Medicare Web site at www.medicare.gov. Section 1 tells more about how to contact the Medicare program and about the Web site.

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) The 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, liver, heart, lung, heart-lung, bone marrow, intestinal/multivisceral, and stem cell. Please be aware that the following transplants are covered only if they are performed in a Medicare-approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

Participating in a clinical trial

A "clinical trial" is a way of testing new types of medical care, like how well a new cancer drug works. 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.

Medicare pays for routine costs if you take part in a clinical trial that meets Medicare requirements. Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if you weren't in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial. There are certain requirements for Medicare coverage of clinical trials. Original Medicare (and not Health Net Life) pays the clinical trial doctors and other providers for the covered services you receive that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in this Plan and continue to get the rest of your care that is unrelated to the clinical trial through Health Net Life.

You will have to pay Original Medicare co-insurance for the services you receive when participating in a qualifying clinical trial. You do not have to pay the Original Medicare Part A or Part B deductibles, because you are enrolled in Health Net's PPFS Plan. For instance, you will be responsible for Part B co-insurance -- generally 20% of the Medicare-approved amount for most doctor services and most other outpatient services. However, there is no co-insurance for Medicare-covered clinical laboratory services related to the clinical trial. The Medicare program has written a booklet that includes information on Original Medicare co-insurance rules, called "Medicare & You." To get a free copy, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the web.

The Medicare program has written a booklet about "Medicare and Clinical Trials." To get a free copy, call 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the Web. Section 1 tells you more about how to contact the Medicare program and about Medicare's Web site.

You do *not* need to get a referral from a plan provider to join a clinical trial, and the clinical trial providers do *not* need to be plan providers. However, please be sure to **tell us before you start a clinical trial,** so that we can keep track of your health care services. When you tell us about starting a clinical trial, we can let you know what services you will get from clinical trial providers and what your costs for those services will be.

Care in Religious Non-medical Health Care Institutions

Care in a Medicare-certified **R**eligious **N**on-medical **H**ealth **C**are **I**nstitution (RNHCI) is covered by this Plan under certain conditions. Covered services in a RNHCI are limited to non-religious aspects of care. To be eligible for covered services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital care or extended care services. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "non-excepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state, or local law. "Non-excepted" medical treatment is any other medical care or treatment.) You must also get authorization (approval) in advance from Health Net Life, or your stay in the RNHCI may not be covered.

Note: To verify coverage and your cost sharing responsibility in a religious non-medical health care institution you or your provider should contact Health Net Life for an advance determination of coverage.

Section 7: Coverage for Part D Outpatient Prescription Drugs

This section describes your Part D outpatient prescription drug coverage as a member of our Plan. We will explain what a formulary is and how to use it, our drug management programs, how much you will pay when you fill a prescription for a covered drug, and what an Explanation of Benefits is and how to get additional copies.

What drugs are covered by this Plan?

What is a formulary?

We have a formulary that lists all drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy or through our network mail order pharmacy service and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage.

The drugs on the formulary are selected by our Plan with the help of a team of health care providers. We select the prescription therapies believed to be a necessary part of a quality treatment program and both brand-name drugs and generic drugs are included on the formulary. A generic drug has the same active-ingredient formula as the brand-name drug. Generic drugs usually cost less than brand-name drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as brand-name drugs.

Not all drugs are included on the formulary. In some cases, the law prohibits coverage of certain types of drugs. (See "Drug Exclusions," later in this section, for more information about the types of drugs that cannot be covered under a Medicare Prescription Drug Plan.) In other cases, we have decided not to include a particular drug.

Using plan pharmacies to get your prescription drugs covered by us

What are network pharmacies?

With few exceptions, **you must use network pharmacies to get your prescription drugs covered.**

- What is a "network pharmacy"? A network pharmacy is a pharmacy at which you can get your prescription drug benefits. We call them "network pharmacies" because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. Once you go to one, you are not required to continue going to the same pharmacy to fill your prescription; you can go to any of our network pharmacies. However, if you switch to a different network pharmacy, you must either have a new prescription written by a physician or have the previous pharmacy transfer the existing prescription to the new pharmacy if any refills remain.

- What are "covered drugs"? "Covered drugs" is the general term we use to mean all of the outpatient prescription drugs that are covered by our Plan. Covered drugs are listed in the formulary.

How do I fill a prescription at a network pharmacy?

To fill your prescription, you must show your Plan ID Card at one of our network pharmacies. If you do not have your ID Card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your co-payment). If this happens, you can ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described at the end of this section.

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

As a member of our Plan we will send you a Pharmacy Directory , which gives you a list of our network pharmacies. You can use it to find the network pharmacy closest to you. If you don't have the Pharmacy Directory, you can get a copy from Member Services. They can also give you the most up-to-date information about changes in this Plan's pharmacy network. In addition, you can find this information on our Web site, www.healthnet.com/uc.

What if a pharmacy is no longer a "network pharmacy"?

Sometimes a pharmacy might leave the plan's network. If this happens, you will have to get your prescriptions filled at another Plan network pharmacy. Please refer to your Pharmacy Directory or call Member Services to find another network pharmacy in your area.

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

You can use our network mail order pharmacy service to fill prescriptions for what we call "maintenance drugs.". These are drugs that you take on a regular basis, for a chronic or long-term medical condition. These are the only drugs available through our mail order service. Specialty Drugs are not available through mail order.

When you order prescription drugs through our network mail order pharmacy service, you must order at least a 35-day supply, and no more than a 90-day supply of the drug.

Generally, it takes us 14 days to process your order and ship it to you. However, sometimes your mail order may be delayed. If your order is delayed, call our mail order pharmacy at 1-800-265-9457, 24 hours a day, 7 days a week. TTY/TDD users should call 1-800-972-4348.

You are not required to use our mail order services to get an extended supply of maintenance medications. You can also get an extended supply through some retail network pharmacies. Some retail pharmacies may agree to accept the mail order co-payment for an extended supply of medications, which may result in no out-of-pocket payment difference to you. Other retail pharmacies may provide an extended supply, but charge a higher co-payment than our mail order service. Please call Member Services to find out which retail pharmacies offer an extended supply.

UC Walk-Up Service through UC Medical Center Pharmacies

Health Net and the UC Medical Center Pharmacies have partnered to offer UC members with the ability to fill up to a 90-day prescription for maintenance medications at any of the UC designated Medical Center Pharmacies. Just like Health Net's current Mail Order Program, members can now obtain up to a 90-day supply for only two copays, at one of the UC-designated Medical Center pharmacies.

Filling prescriptions outside the network

We have network pharmacies outside of the service area where you can get your drugs covered as a member of our plan. Generally, we only cover drugs filled at an out-of-network pharmacy in limited circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. **Before you fill your prescription in these situations, call Member Services to see if there is a network pharmacy in your area where you can fill your prescription**. If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just your co-payment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy as any amount you pay will help you qualify for catastrophic coverage (see Catastrophic Coverage later in this section).

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

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

- If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail-order pharmacy (including high costs and unique drugs).
- If you are getting a vaccine that is medically necessary, but not covered by Medicare Part B and some covered drugs that are administered in your doctor's office.

How do I submit a paper claim?

When you go to a network pharmacy, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy for one of the reasons listed above, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. To submit a claim:

- Complete a claim form. If you need a claim form, call Member Services. You may also print a claim for from our website at www.healthnet.com/uc.
- Attach your prescription receipt(s) to the claim form. You must attach the actual prescription receipt, a duplicate may be obtained from the dispensing pharmacy. Cash register receipts cannot be used when submitting a claim.

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

If you submit a paper claim to us, the claim is treated as a request for a coverage determination. If you are asking us to reimburse you for a prescription drug that is not on our formulary or is subject to coverage requirements or limits, your doctor may need to submit additional documentation supporting your request. See Section 12 to learn more about requesting coverage determinations.

Specialty pharmacies

Home infusion pharmacies

This Plan will cover home infusion therapy if:

Your prescription drug is on our Plan's formulary or a formulary exception has been granted for your prescription drug,

- Your prescription drug is not otherwise covered under our Plan's medical benefit,

Our plan has approved your prescription for home infusion therapy,

Your prescription is written by an authorized prescriber, and.

You get you home infusion services from a Plan network pharmacy.

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

Long-term care pharmacies

In some cases, residents of a long-term care facility may access their prescription drugs through the facility's long-term care pharmacy or another network long-term care pharmacy. Please refer to your Pharmacy Directory to find out if your long-term care pharmacy is part of our network. If it is not, or for more information, please contact Member Services.

Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies

Only Native Americans and Alaska Natives have access to Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies through Health Net Life's pharmacy network. Those other than Native Americans and Alaskan Natives may be able to access these pharmacies under limited circumstances (e.g. emergencies).

Please refer to your Pharmacy Directory to find an I/T/U pharmacy in your area. For more information, please contact Member Services.

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

You may call Member Services to find out if your drug is on the formulary or to request a copy of our formulary. You can also get updated information about the drugs covered by us by visiting our Web site.

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your co-insurance/co-payment depends on which drug tier your drug is in. The table below (under "Initial Coverage Period") shows the co-insurance/co-payment amount you pay for each tier when you are in your initial coverage period. You can ask us to make an exception (which is a type of coverage determination) to your drug's tier placement in certain circumstances. (See "Can the formulary change?" below).

Can the formulary change?

We may add or remove drugs from the formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. If we remove drugs from the formulary, or add prior authorizations, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier, and you are taking the drug affected by the change, we will notify you of the change at least 60 days before the date that the change becomes effective. If we don't notify you of the change in advance, we will give you a 60 day supply of the drug when you request a refill of the drug. However, if a drug is removed from our formulary because the drug has been recalled from the market, we will not give 60-days notice before removing the drug from the formulary or give you a 60 day supply of the drug when you request a refill. Instead, we will remove the drug from our formulary immediately and notify members about the change as soon as possible.

Immediately after receiving the 60-day notice or 60-day supply, you should work with your physician to either switch to a drug we cover or request an exception (which is a type of coverage determination). If your physician determines that you need the drug that is being removed from our formulary and none of the drugs we cover are medically appropriate for you, you or your physician may request an exception. Similarly, if your physician determines that you are not able to meet a prior authorization, quantity limit, step therapy restriction, or other utilization management requirement for medical necessity reasons, you or your physician may request an exception. (See Section 12 for more information about how to request an exception.)

What if your drug is not on the formulary?

If your prescription is not listed on the formulary, you should first contact Member Services to be sure it is not covered.

If Member Services confirms that we do not cover your drug, you have three options:

- You can ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact Member Services.
- You can ask us to make an exception (which is a type of coverage determination) to cover your drug. (See "What Is An Exception" in Section 12).
- You can pay out-of-pocket for the drug and request that the plan reimburse you by requesting an exception (which is a type of coverage determination). If the exception request is not approve the plan is not obligated to reimburse you. If the exception is not approved, you may appeal the plan's denial. (See Section 12 for more information on how to request an exception or appeal.)

If you recently joined this plan, you may be able to get a temporary supply of a drug you were taking when you joined our plan if it is not on our formulary. The next section tells the rules governing obtaining temporary supplies of drugs.

Transition Policy

New members in our plan may be taking drugs that are not on our formulary, or that are subject to certain restrictions, such as prior authorization or step therapy. Members should talk to their doctors to decide if they should switch to an appropriate drug that we cover or request a formulary exception (which is a type of coverage determination) in order to get coverage for the drug. See Section 12 to learn more about how to request an exception. While these new members might talk to their doctors to determine the right course of action, we may cover the non-formulary drug in certain cases during the first 90 days of new membership.

For each of the drugs that is not on our formulary or that have coverage restrictions or limits, we will cover a temporary 30 to 60-day supply (unless the prescription is written for fewer days) when the new member goes to a network pharmacy (and the drug is otherwise a "Part D drug"). After we cover the temporary supply, we generally will not pay for these drugs as part of our transition policy again. We will provide you with a written notice after we cover your temporary supply. This notice will explain the steps you can take to request an exception and how to work with your doctor to decide if you should switch to an appropriate drug that we cover.
If the new member is a resident of a long-term care facility, we will cover a temporary 102-day transition supply (unless you have a prescription written for fewer days). We will cover more than one refill of these drugs for the first 90 days for a new member of our plan. If a new member needs a drug that is not on our formulary or subject to other restrictions, such as step therapy or dosage limits, but the new member is past the first 90 days of new membership in our plan, we will cover a 34-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.

If a member is a resident of a long-term care facility but is moving to a non-long-term care facility (e.g., home), we will cover a temporary 30-day supply. If a member is not a resident of a long-term care facility (e.g., living at home) but is moving to a long-term care setting, we will cover a temporary 34-day supply.

Please note that our transition policy applies only to those drugs that are "Part D drugs" and that are purchased at a network pharmacy. The transition policy cannot be used to purchase a non-Part D drug or drug out-of-network.

In some cases, we will contact you if you are taking a drug that is not on our formulary. We can give you the names of covered drugs that also are used to treat your condition so you can ask your doctor if any of these drugs are an option for your treatment.

How can you request an exception to the Plan's Formulary?

You can ask us to make an exception to our coverage rules. There are several types of exceptions that you can ask us to make.

- You can ask us to cover your drug even if it is not on our Formulary.

- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- If your drug is contained in our non-preferred tier or our injectable tier, you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier instead. This would lower the amount you must pay for your drug. This is a tier exception. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for drugs in the Specialty Tier.

Generally, we will only approve your request for an exception if the alternative drugs included on the Plan's Formulary or the low-tiered drug would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

Please go to Appendix E, subsection "Detailed information about how to request a Coverage Determination and an Appeal below", to learn more about requesting an exception. In order to help us make a decision more quickly, you should include supporting medical information from your doctor when you submit your exception request.

If we approve your exception request, our approval is valid for the remainder of the plan year, so long as your doctor continues to prescribe the drug for you and it continues to be safe and effective for treating your condition. If we deny your exception request, you can Appeal our decision. Please see Appendix E for more information about how to request an Appeal.

Drug exclusions

- Medications on the formulary are specifically excluded by Medicare will not count towards your yearly out-of-pocket costs. In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for these drugs. These include some prescription medications in the following categories:
  - Agents used for the symptomatic relief of cough and cold;
  - Prescription vitamin and mineral products;
  - Barbiturates; and
  - Benzodiazepines
  - Sexual dysfunction drugs
- Please refer to the formulary to find out which drugs we are offering additional coverage for or call Customer Service if you have any questions.
- Dispensing may be limited to less than a one-month (30 days) supply due to manufacturer packaging and/or appropriate length of treatment.
- Quantity and daily dosing limits may apply to specific drugs. Please refer to the formulary.
- Smoking cessation drugs are covered up to a 12-week course of therapy per calendar year if you are currently enrolled in a comprehensive smoking cessation program. Prior authorization from Health Net Life is required.
- By law, certain types of drugs or categories of drugs are not covered by Medicare Prescription Drug Plans, including:
  - Drugs used to treat infertility;

- Anorexiants, appetite suppressants, diet aids, weight loss medications, and drugs medications used to treat obesity or weight gain;
- Smoking cessation medications that do not require a prescription;
- Experimental or investigational medications;
- Agents when used for cosmetic purposes or hair growth;
- Non-prescription medications; and
- Outpatient drugs for which the manufacturer seeks to require associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale.

In addition, a Medicare Prescription Drug Plan cannot cover a drug that would be covered under Medicare Part A or Part B. (See "How does your enrollment in this Plan affect coverage for drugs covered under Medicare Part A or Part B?" below.)

Also, while a Medicare Prescription Drug Plan can cover off-label uses of a prescription drug, we cover the off-label use only in cases where the use is supported by certain reference book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted.[1] If the use is not supported by one of these reference books (known as compendia), then the drug would be considered a non-Part D drug and would not be covered by our plan.

We offer additional coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for catastrophic coverage). In addition, if you are receiving extra help from Medicare to pay for your prescriptions, the extra help will not pay for these drugs. Please refer to your formulary to find out which drugs we are offering additional coverage for or call Member Services if you have any questions.

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

Drug Management Programs

Utilization management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and pharmacists developed the following requirements and limits for our Plan to help us to provide quality coverage to our members:

Prior Authorization: We require you to get prior authorization for certain drugs. This means that will need to get approval from us before you fill your prescription. If they don't get approval, we may not cover the drug.

1 These compendia are: (1) American Hospital Formulary Service Drug Information; United States Pharmacopoeia-Drug Information; and (3) the DRUGDEX Information System.

Quantity Limits: For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. For example, we will provide up to 6 per prescription for Zithromax

Step Therapy: In some cases, we require you to first try one drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.

Generic Substitution: When there is a generic version of a brand-name drug available, our network pharmacies will automatically give you the generic version, unless your doctor has told us that you must take the brand-name drug.

You can find out if the drug you take is subject to these additional requirements or limits by looking in the formulary. If your drug is subject to one of these additional restrictions or limits and your physician determines that you are not able to meet the additional restriction or limit for medical necessity reasons, you or your physician can request an exception (which is a type of coverage determination). (See Section 12 for more information about how to request an exception.).

Drug utilization review

We conduct drug utilization reviews for all of our members to make sure that they are receiving safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribe their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

Possible medication errors;

Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition;

Drugs that are inappropriate because of your age or gender;

Possible harmful interactions between drugs you are taking;

Drug allergies; or

Drug dosage errors

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

How does your enrollment in this Plan affect coverage for the drugs covered under Medicare Part A or Part B?

Your enrollment in this Plan does not affect Medicare coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B even though you are enrolled in this Plan.

See your *Medicare & You* Handbook for more information about drugs that are covered by Medicare Part A and Part B.

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

If you qualify for extra help with your drug costs, your costs for your drugs may be different than those described below. (See "What extra help is available?" later in this section and the "Evidence of Coverage Rider for those who get extra help paying for their prescription drugs" for more information.)

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., initial coverage period, after you reach your initial coverage limit, and catastrophic level), the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Each phase of the benefit and your drug costs for each coverage level are described below.

Initial Coverage Period

During the **initial coverage period**, we will pay part of the costs for your covered drugs and you will pay the other part. The amount you pay when you fill a covered prescription is called the **co-insurance/co-payment**. Your **co-insurance/co-payment** will vary depending on the drug and where the prescription is filled.

Co-insurance/Co-payment in the Initial Coverage Period

You will have to pay the following for your prescription drugs*:

Drug Tier	Retail Copayment/ Coinsurance (30 day supply)	Retail Copayment/ Coinsurance (90 day supply)	Mail-Order Copayment/ Coinsurance (90-day supply)	Out of Network/ Copayment/ Coinsurance
Tier 1* Preferred Generic Drug	$10	$30	$20	$10
Tier 2* Preferred Brand Name Drug	$20	$60	$40	$20
Tier 3* Non-preferred Generic or Brand Name Drug	$35	$105	$70	$35
Specialty Tier I & S*	25%	25%	N/A	25%

*Amounts in this chart may vary according to your individual out-of-network cost sharing responsibility. After your yearly out-of-pocket drug costs reach $2,000, excluding any generic substitution costs, Copayments and coinsurances will not be required for the remainder of the calendar year until you qualify for Catastrophic Coverage.

See "Catastrophic Coverage" below for more information

Notes and Exceptions

- If the pharmacy's usual and customary charge is less than the applicable Copayment or coinsurance, you will pay the pharmacy's usual and customary charge.
- Generic Drugs will be dispensed when a Generic Drug equivalent is available. If you request a Brand Name Drug when a Generic Drug equivalent is commercially available, you must pay the cost difference between the equivalent Generic Drug and the Brand

Name Drug, in addition to the Brand Name Drug Copayment. However, if your physician indicates in writing that you must have the brand name medication over the generic medication, you will only have to pay the Brand Name Drug Copayment.

- Except for insulin, diabetic supplies (blood glucose testing strips, lancets, specific brands of needles & syringes) are packaged in 50, 100 or 200 unit packages. Packages cannot be "broken" (i.e., opened in order to dispense the product in quantities other than those packaged).
- When a prescription is dispensed, you will receive the size of package and/or number of packages required for you to test the number of times your physician has prescribed for a 30-day period. The Copayment or coinsurance will be applicable for each prescription dispensed for insulin and diabetic supplies.

Once your total drug costs reach $2,510, you will reach your **initial coverage limit**. Your initial coverage limit is calculated by adding payments made by this Plan and you. If other individuals, organizations, current or former employer/union, and another insurance plan or policy help pay for your drugs under this plan, the amount they spend may count towards your initial coverage limit.

We offer additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count towards your initial coverage limit. To find out which drugs are not generally covered under a Medicare prescription drug plan, refer to your formulary.

Catastrophic Coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend $4,050 out-of-pocket for the year. When the total amount you have paid toward co-payments, and the cost for covered Part D drugs after you reach the initial coverage limit reaches $4,050, you will qualify for catastrophic coverage.

During catastrophic coverage you will pay the greater of $2.25 for generics or drugs that are treated like generics and $5.60 for all other drugs, or 5% coinsurance. We will pay the rest

Note: As mentioned earlier we offer additional coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards your initial coverage limit, or total out of pocket costs (that is, the amount you pay does not help you move through the benefit or qualify for catastrophic coverage).

Vaccines (including administration)

Our Plan's prescription drug benefit covers a number of vaccines (including vaccine administration). The amount you will be responsible for will depend on how the vaccine is dispensed and who administers it. Also, please note that in some situations, the vaccine and its administration will be billed separately. When this happens, you may pay separate cost-sharing amounts for the vaccine and for the vaccine administration.

The following chart describes some of these scenarios. Note that in some cases, you will be receiving the vaccine from someone who is not part of our pharmacy network and that you may have to pay for the entire cost of the vaccine and its administration in advance. You will then need to mail us the receipts, and then you will be reimbursed. The following chart provides examples of how much it might cost to obtain a vaccine (including its administration) under our Plan. Actual vaccine costs will vary by vaccine type and by whether your vaccine is administered by a pharmacist or by another provider.

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

If you obtain the vaccine at:	And get it administered by:	You pay (and are reimbursed)
The Pharmacy	The Pharmacy (not possible in all States)	You pay co-payment/coinsurance
Your Doctor	Your Doctor	You pay up-front for the entire cost of the vaccine and its administration. You are reimbursed this amount less co-payment/coinsurance plus any difference between the amount the Doctor charges and what we normally pay. Or, if your doctor agrees to submit your claim on your behalf, you pay co-payment/coinsurance plus any difference between the amount the Doctor charges and what we normally pay.*
The Pharmacy	Your Doctor	You pay co-payment/coinsurance at the pharmacy and the full amount charged by the doctor for administering the vaccine. You are reimbursed the latter amount less co-payment/coinsurance plus any difference between what the Doctor charges for administering the vaccine and what we normally pay.*

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

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

What extra help is available?

Medicare provides "extra help" to pay prescription drug costs for people who meet specific income and resources limits. Resources include your savings and stocks, but not your home or car. If you qualify, you will get help paying for your Medicare drug plan's monthly premium, and prescription co-payments.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help one of two ways. The amount of extra help you get will depend on your income and resources.

- You automatically qualify for extra help and don't need to apply. If you have full coverage from a state Medicaid program, get help from Medicaid paying your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare mails letters monthly to people who automatically qualify for extra help.

You apply and qualify. You may qualify if your yearly income is less than $15,315 (single with no dependents) or $20,535 (married and living with your spouse with no dependents), and your resources are less than $11,710 (single) or $23,410 (married and living with your spouse). Resources include your savings and stocks but not your home or car. If you think you may qualify, call Social Security at 1-800-772-1213, visit www.socialsecurity.gov on the web, or apply at your State Medical Assistance (Medicaid) office. TTY users should call 1-800-325-0778. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next.

The above income amounts are for 2007 and will change in 2008. If you live in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

How do my costs change when I qualify for extra help?

The extra help you get from Medicare will help you pay for your Medicare drug plan's monthly premium, and prescription co-payments. The amount of extra help you get is based on your income and resources.

If you qualify for extra help, we will send you by mail an "Evidence of Coverage Rider for those who receive extra help from Medicare for their prescription drugs" that explains your costs as a member of our Plan. If the amount of your extra help changes during the year, we will also mail you an updated "Evidence of Coverage Rider for those who receive extra help from Medicare for their prescription drugs".

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

If you believe you have qualified for extra help and you believe that you are paying an incorrect co-payment amount when you get your prescription at a pharmacy our Plan has established a process that will allow you to provide evidence of your proper co-payment level.

Contact the customer service number on your membership card and advise the representative that you believe you qualify for extra help and are paying an incorrect co-payment. You may be required to provide one of the following:

- A copy of your Medicaid card which includes your name and an eligibility date during the discrepant period;
- A copy of a state document that confirms active Medicaid status during the discrepant period;
- A print out from the State electronic enrollment file showing Medicaid status during the discrepant period;
- A screen print from the State's Medicaid systems showing Medicaid status during the discrepant period;
- A letter from the State Medicaid agency showing Medicaid status during the discrepant period;
- Other documentation provided by the State showing Medicaid status during the discrepant period.
- Supporting documentation must be submitted within 60 days of when you paid the co-payment.

Please be assured that if you overpay your co-payment, we will generally reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future co-payments. Of course, if the pharmacy hasn't collected a co-payment from you and is carrying your co-payment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Member Services if you have questions.

How do you get more information?

For more information on who can get extra help with prescription drug costs and how to apply, call the Social Security Administration at 1-800-772-1213, or visit www.socialsecurity.gov on the Web. TTY/TDD users should call 1-800-325-0778.

In addition, you can look at the 2008 *Medicare & You* Handbook, visit www.medicare.gov on the Web, or call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

If you have any questions about our Plan, please refer to our Member Services numbers listed on the cover and in the Benefits at a Glance section. Or, visit our website.

How is your out-of-pocket cost calculated?

Your $2,000 plan-specific out-of-pocket maximum for outpatient drugs will be automatically calculated by Health Net. However, you will be responsible for tracking all expenses to be applied to your $4,050 out-of-pocket maximum for Medicare Part D. Every month you purchase covered Prescription Drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket costs amount to date or you can obtain this information on-line at www.healthnet.com/uc. Please submit appropriate documentation of such purchases to Health Net's PPFS.

What type of prescription drug payments count toward your out-of-pocket costs?

The following types of payments for prescription drugs can count toward your out-of-pocket costs and help you qualify for catastrophic coverage so long as the drug you are paying for is a Part D drug, on the formulary (or if you get a favorable decision on a coverage determination, exception request or appeal), obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy); and otherwise meets our coverage requirements:

Your co-insurance or co-payments; payments you make after the initial coverage limit.

When you have spent a total of $4,050 for these items, you will reach the catastrophic coverage level. The amount you pay for your monthly premium (if any) does not count toward reaching the catastrophic coverage level.

Purchases that will **not** count toward your out-of-pocket costs include:

- Prescription drugs purchased outside the United States and its territories;
- Prescription drugs not covered by the Plan
- Prescription drugs obtained at an out-of-network pharmacy when that purchase does not meet our requirements for out-of-network coverage.
- Prescription drugs covered by Part A or Part B.
- We offer additional coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for catastrophic coverage. In addition, if you are receiving extra help from Medicare to pay for your prescriptions, the extra help will not pay for these drugs. Please refer to your formulary to find out which drugs we are offering additional coverage for or call Member Services if you have any questions.

Who can pay for your prescription drugs, and how do these payments apply to your out-of-pocket costs?

Except for your premium payments, any payments you make for Part D drugs covered by us count toward your out-of-pocket costs and will help you qualify for catastrophic coverage. In addition, when the following individuals or organizations pay your costs for such drugs, these payments will count toward your out-of-pocket costs (and will help you qualify for catastrophic coverage):

- Family members or other individuals;
- Qualified State Pharmacy Assistance Programs (SPAPs);
- Medicare programs that provide extra help with prescription drug coverage; and
- Most charities or charitable organizations. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

Payments made by the following do **not** count toward your out-of-pocket costs:

- Group Health Plans;
- Insurance Plans and government funded health programs (e.g. TRICARE, the VA, the Indian Health Service); and
- Third party arrangements with a legal obligation to pay for prescription costs (e.g., Workers Compensation).

If you have coverage from a third party such as those listed above that pays a part of or all of your out-of-pocket costs, you must disclose this information to us.

We will be responsible for keeping track of your out-of-pocket cost amount and will let you know when you have qualified for catastrophic coverage. If you or another party on your behalf have purchased drugs outside of our plan benefit, you will be responsible for submitting appropriate documentation of such purchases to us. In addition, every month you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits is a document you will get each month you use your prescription drug coverage. It will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your drugs. You will get your Explanation of Benefits in the mail each month that you use the benefits provided by us. You will not get an Explanation of Benefits if you don't use any benefits that month.

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

A list of prescriptions you filled during the month, as well as the amount paid for each prescription;

Information about how to request an exception and appeal our coverage decisions;

A description of changes to the formulary affecting the prescriptions you filled that will occur at least 60 days in the future;

A summary of your coverage this year, including information about:

Annual Deductible -the amount you pay, and/or others, before you start receiving prescription coverage.

Amount Paid For Prescriptions -the amounts paid that count towards your initial coverage limit.

Total Out-Of-Pocket Costs That Count Towards Catastrophic Coverage -The total amount you and/or others have spent on prescription drugs that count towards you qualifying for catastrophic coverage. This total includes the amounts spent for your co-payments and co-insurance, and payments made on covered Part D drugs after you reach the initial coverage limit. (This amount does not include payments made by your current or former employer/union, another insurance plan or policy, government funded health program or other excluded parties.)

What should you do if you did not get an Explanation of Benefits or if you wish to request one?

An Explanation of Benefits is also available upon request. To get a copy, please contact Member Services.

How does your prescription drug coverage work if you go to a hospital or skilled nursing facility?

If you are admitted to a hospital for a Medicare-covered stay, Medicare Part A will cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, we will cover your prescription drugs as long as all coverage requirements are met (such as the drugs being on our formulary, filled at a network pharmacy, etc.), they are not covered by Medicare Part A or Part B, are part of the formulary and are purchased at one of our network pharmacies. We will also cover your prescription drugs if they are approved under the coverage determination, exceptions, or appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay, after Medicare Part A stops paying for your prescription drug costs, we will cover your prescriptions as long as the drug meets all of our coverage requirements (including the requirement that the skilled nursing facility pharmacy be in our pharmacy network, unless you meet standards for out-of – network care, and that the drug would not otherwise be covered by Medicare Part B coverage). When you enter, live in, or leave a skilled nursing facility you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a new Medicare Prescription Drug Plan. (Please see Section 11 of this document for more information about leaving this Plan and joining a new Medicare Prescription Drug Plan.)

Section 8: What you must pay for your Medicare health plan coverage and for the care you receive

Paying the plan premium for your coverage as a member of Health Net's PPFS Plan

To be a member of this Plan, you must continue to pay your Medicare Part B premium and your monthly Medicare Part A premium, if necessary (most people don't have to pay this premium).

Paying the plan premium for your coverage as a member of our Plan

Please call the employer's benefits administrator for information about your Plan premium.

Note: If you are getting extra help with paying for your drug coverage, the premium amount that you pay as a member of this Plan is listed in your "Evidence of Coverage Rider for those who Receive Extra Help for their Prescription Drugs".

Can your premiums change during the year?

In certain cases, your Plan premium may change during the calendar year. If you aren't currently getting extra help, but you qualify for it during the year, your monthly premium amount would go down. Or, if you currently get extra help paying your Plan premium, the amount of help you qualify for may change during the year. Your eligibility for extra help might change if there is a change in your income or resources or if you get married or become single during the year. If the amount of extra help you get changes, your monthly premium would also change. For example, if you qualify for more extra help, your monthly premium amount would be lower. Social Security or State Medical Assistance Office can tell you if there is a change in your eligibility for extra help (see contact information in Section 1).

What is the Medicare Prescription Drug Plan late enrollment penalty?

If you don't join a Medicare drug plan when you are first eligible, and you go without creditable prescription drug coverage (as good as Medicare's) for 63 continuous days or more, you may have to pay a late enrollment penalty to join a plan later. This penalty amount changes every year, and you will have to pay it as long as you have Medicare prescription drug coverage. However, if you qualified for extra help in 2006 and/or 2007, you may not have to pay a penalty.

If you must pay a late enrollment penalty, your penalty is calculated when you first join a Medicare drug plan. To estimate your penalty, take 1% of the national base beneficiary premium for the year you join (in 2007, the national base beneficiary premium is $27.35). Multiply it by the number of full months you were eligible to join a Medicare drug plan but didn't, and then round that amount to the nearest ten cents. This is your estimated penalty amount, which is added each month to your Medicare drug plan's premium for as long as you are in that plan.

If you disagree with your late enrollment penalty, you may be eligible to have it reconsidered (reviewed). Call Member Service to find out more about the reconsideration process and how to ask for such a review.

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

- You had creditable prescription drug coverage (as good as Medicare's)
- The period of time that you didn't have creditable prescription drug coverage was less than 63 continuous days
- You prove that you were not informed that your prescription drug coverage was not creditable
- You lived in an area affected by Hurricane Katrina AND you signed up for a Medicare prescription drug plan by December 31, 2006, AND you stay in a Medicare prescription drug plan
- You received or are receiving extra help AND you join a Medicare prescription drug plan by December 31, 2007, AND you stay in a Medicare prescription drug plan

Your late enrollment penalty may be reduced or eliminated if you receive extra help in 2008 or after.

Paying your share of the cost when you get covered services

What are "deductible," "co-payments" and "co-insurance"?

The **"deductible"** is the amount you must pay for the health care services OR drugs you receive before our Plan begins to pay its share of your covered services OR drugs. Please refer to the Benefits Chart in Section 4 for a list of services or drug benefits that may include a deductible.

A **"co-payment"** is a payment you make for your share of the cost of certain covered services you receive. A co-payment is **a set amount per service**. You pay it when you get the service. The Benefits Chart in Section 4 gives your co-payments for covered services.

"Co-insurance" is a payment you make for your share of the cost of certain covered services you receive. Co-insurance is a percentage of the cost of the service. You pay your co-insurance when you get the service. The Benefits Chart in Section 4 gives your co-insurance for covered services.

You must pay the full cost of services that are not covered

If you received services from a certified provider that does not have an actual written contract with Health Net Life, but informed this provider that you are enrolled in Health Net's PPFS Plan -- for example, you showed the provider your ID Card -- then this provider is deemed to have a contract with the plan and is bound by the plan's terms and conditions of payments. A provider is deemed to have a contract even if they didn't verbally acknowledge that they were accepting the plan's terms and conditions of payments, and even if they didn't even look up (but had access to) the details of these terms and conditions of payments.

However if you receive services from a certified provider that does not have an actual written contract with Health Net Life and this provider was not informed, and did not know, that you are enrolled in Health Net's PPFS Plan, then you must pay original Medicare out-of-pocket amounts if you receive Medicare-covered services that are not for the care of a medical emergency, urgently needed care, or services that are found upon appeal to be services that we should have paid or covered. (Sections 2 and 3 explain about using plan providers and the exceptions that apply.)

If you have any question whether Health Net Life will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding Advance Coverage Determination made for the service. Call Health Net Life at 1-800-539-4072 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, and tell us you would like a determination if the service will be covered.

For covered services that have a benefit limitation, **you must pay the full cost of any services you get after you have used up your benefit for that type of covered service.** For example, you have to pay the full cost of any skilled nursing facility stay beyond the 100th day during each benefit period. You can call Members Services when you want to know how much of your benefit limit you have already used.

Please keep us up-to-date on any other health insurance coverage you have

Using *all* of your insurance coverage

If you have other health insurance coverage besides Health Net Life, it is important to use this other coverage *in combination with* your coverage as a member 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.

Let us know if you have additional insurance

You must tell us if you have any other health insurance coverage besides Health Net Life, and let us know whenever there are any *changes* in your additional insurance coverage. The 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.
- Coverage you have through the "TRICARE for Life" program (veteran's benefits).
- Coverage you have for dental insurance or prescription drugs.

- "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).

Who pays first when you have additional insurance?

How we coordinate your benefits as a member of Health Net's PPFS Plan with your benefits from other insurance depends on your situation. If you have other coverage, you will often get your care as usual through Health Net Life, 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 Health Net Life, you may get your care outside of Health Net Life.

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 us and you will not have to be involved. However, if payment owed to us is sent directly to you, you are required under Medicare law to give this payment to us. 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 shown in Section 1 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." You can get a copy by calling 1-800-MEDICARE (1-800-633-4227; TTY 1-877-486-2048), or by visiting the www.medicare.gov Web site.

For Bills: What do we pay? What does the Plan Pay?

You should never pay the provider more than the cost sharing allowed by Health Net Life. You should ask your provider to bill us for the rest of his or her fee and we will pay him or her according to the Health Net Life's Terms and Conditions of payment. If the provider asks you to pay the remainder of the bill and have you directly re-imbursed from the plan, tell him or her that you only have to pay the cost-sharing amount. Your enrollment card will indicate how the provider can contact us for information on our Terms and Conditions of payment. If the provider wants further information on payment for covered services, please have him or her contact us at: Health Net Member Services 1-800-539-4072 (TTY 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, or

Health Net Medicare Programs
PO Box 1728
Augusta, GA 30903-1728.

If you receive a bill for the services, you can send the bill to us for payment. However, if you have already paid for the covered services we will reimburse you for our share of the cost. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay.

Section 9: Your rights and responsibilities as a member of Health Net's PPFS Plan

Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this Section, we explain your Medicare rights and protections as a member of Health Net's PPFS Plan and, we explain what you can do if you think you are being treated unfairly or your rights are not being respected. If you want to receive Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

If you have any question whether Health Net Life will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding advance coverage determination made for the service. Call Health Net Life at 1-800-539-4072 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, and tell us you would like a decision if the service will be covered.

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. Health Net Life must obey laws that protect you from discrimination or unfair treatment. These laws do not allow us to discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability. If you need help with communication, such as help from a language interpreter, please call Member Services at the number shown in Section 1. Member Services can also help if you need to file a complaint about access (such as wheel chair access). You can also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or, call the Office for Civil Rights in your area.

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who is not providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. For example, you have the right to look at your medical records, and to get a copy of the records (there may be a fee charged for making copies). You also have the right to ask us to make additions or corrections to your medical records (if you ask us to do this, we will review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Member Services at the phone number in Section 1.

Your right to see plan providers, get covered services within a reasonable period of time

As explained in this booklet, you will get most or all of your care from providers who have agreed to treat you under Health Net Life's Terms and Conditions of payment. You have the right to seek care from any provider in the U.S. who is eligible to be paid by Medicare and accepts Health Net Life's Terms and Conditions of payment. "Timely access" means that you can get appointments and services within a reasonable amount of time. Section 2 explains how to use plan providers to get the care and services you need. Section 3 explains your rights to get care for a medical emergency and urgently needed care.

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

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

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

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

You have the right to ask someone, such as a family member or friend, to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "**advance directives.**" There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you decide that you 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, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as your SHIP (which stands for State Health Insurance Assistance Program. Section 1 of this booklet tells how to contact your SHIP. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

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

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

Address	**Contact Number**
California Department of Health Post Office Box 997413 Sacramento, California 95899-7413	(916) 636-1980

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can

make. The complaint is called an appeal or grievance depending on the situation. Appeals and grievances that involve your Medicare health benefits under Health Net's PPFS Plan are discussed in Sections 9 and 10.

Your right to get information about your health care coverage and costs

This booklet tells you what medical services are covered for you as a plan member and what you have to pay. You have the right under law to have a written / binding Advance Coverage Determination made for the service. If you need more information, please call Member Services at the number shown in Section 1. You have the right to an explanation from us about any bills you may get for services not covered by this Plan. We must tell you in writing why we will not pay for or allow you to get a service, and how you can file an appeal to ask us to change this determination. See Sections 9 and 10 for more information about filing an appeal.

Your right to get information about Health Net Life, Health Net's PPFS Plan, and plan providers

You have the right to find out from us how we pay our doctors. To get this information, call Member Services at the phone number shown in Section 1. You have the right to get information from us about Health Net Life. This includes information about our financial condition. To get any of this information, call Member Services at the phone number listed on the cover.

If you have any question whether Health Net Life will pay for a service, including inpatient hospital services, call Health Net Life at 1-800-539-4072 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, and tell us you would like a decision if the service will be covered.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call Member Services at the number shown in Section 1. You can also get free help and information from your State Health Insurance Assistance Program, or SHIP (Section 1 tells how to contact the SHIP in your state). In addition, the Medicare program has written a booklet called "Your Medicare Rights and Protections." To get a free copy, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, you can visit www.medicare.gov on the Web to order this booklet or print it directly from your computer.

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

- If you think you have been treated unfairly or your rights have not been respected, what you should do depends on your situation. If you think you have been treated unfairly due to your

race, color, national origin, disability, age, or religion, please let us know. Or, you can call the Office for Civil Rights in your area at:

Address	Contact Number
Office for Civil Rights U.S. Department of Health and Human Services 50 United Nations Plaza - Room 322 San Francisco, CA 94102	(415)437-8310 TDD:(415) 437-8311

- For any other kind of concern or problem related to your Medicare rights and protections described in this section, you can call Member Services at the number shown in Section 1. You can also get help from your State Health Insurance Assistance Program, or SHIP (Section 1 tells how to contact the SHIP in your state.)

What are your responsibilities as a member of Health Net's PPFS Plan?

Along with the rights you have as a member of Health Net Life, you also have some responsibilities. Your responsibilities include the following:

- To get familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet and other information we give you to learn about your coverage, what you have to pay, and the rules you need to follow. Please call Member Services at the phone number shown in Section 1 if you have any questions.
- When seeking care you must notify providers (unless it is an emergency) that you are enrolled in Health Net's PPFS Plan.
- To give your doctor and other providers the information they need to care for you, and to follow the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and to explain your treatment in a way you can understand.
- 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 pay your plan premiums and any co-payments you owe for the covered services you get. You must also meet your other financial responsibilities that are described in Section 8 of this booklet.
- To let us know if you have any questions, concerns, problems, or suggestions. If you do, please call Member Services at the phone number shown in Section 1.

Section 10: How to file a grievance

What is a Grievance?

A grievance is different from a request for an organization determination, a request for a coverage determination, or a request for an appeal as described in Section 11 of this Evidence of Coverage because grievances do not involve problems related to coverage or payment of care, problems about being discharged from the hospital too soon, and problems about coverage for Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending to soon.

For problems about 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 too soon, you must follow the rules outlined in Section 11.

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

- Problems with the quality of the medical care you receive, including quality of care during a hospital stay.
- If you feel that you are being encouraged to leave (disenroll from) Health Net Life.
- Problems with the Member Services 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.
- Cleanliness or condition of doctor's offices, clinics, or hospitals.
- If you disagree with our decision not to expedite your request for an expedited coverage determination, organization determination, redetermination, or reconsideration.
- You believe our notices and other written materials are difficult to understand.
- Failure to give you a decision within the required timeframe.
- Failure to forward your case to the independent review entity if we do not give you a decision within the required timeframe.
- Failure by the Plan to provide required notices.
- Failure to provide required notices that comply with CMS standards.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance." In certain cases, you have the right to ask for a "fast grievance," meaning your grievance will be decided within 24 hours. We discuss these fast grievances in more detail in Section 11 and Section 12.

Filing a grievance with Health Net Life.

If you have a complaint, we encourage you to first call Member Services at the number shown in Section 1**. We will try to resolve any complaint that you might have over the phone.** If you request a written response to your phone complaint, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this** the Grievance procedure.

To make a complaint – or if you have questions about this procedure – please call the Health Net Life Member Services at **1-800-539-4072** (TTY/TDD **1-800-929-9955**), 8:00 a.m. to 8:00 p.m., 7 days a week. You may also submit your complaint in writing or via facsimile to Health Net Life at:

Health Net's PPFS Plan
Appeals and Grievance Dept.
PO Box 10450
Van Nuys, Ca 91410-0450
Fax: 1-800-977-1959

Upon receipt of your complaint we will initiate the Grievance procedure and acknowledge receipt of your complaint 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 complaint.

We must notify you of our decision about your grievance as quickly as your complaint requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the timeframe by up to 14 days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

How soon must you file your complaint?

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

Expedited Grievance Procedure

You are now entitled to a quick review of your complaint if you disagree with our decision in the following circumstances:

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

Requests for Expedited Grievances may be submitted by phone at 1-800-539-4072 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week. You may also submit your complaint in writing or via facsimile to Health Net Life at:

Health Net's PPFS Plan
Appeals and Grievance Dept.
PO Box 10450
Van Nuys, Ca 91410-0450
Fax: 1-800-977-1959

Once the Expedited Grievance is received by Health Net Life, a Clinical Practitioner will review the complaint to determine the circumstances surrounding the denial of your request for expedited review or if the complaint extension was appropriate.

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

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

Complaints concerning the quality of care received under Medicare, including care during a hospital stay may be acted upon by the plan sponsor under the grievance process, by an independent organization called the QIO, or by both. For any complaint filed with the QIO, the plan sponsor must cooperate with the QIO in resolving the complaint. See Section 1 for more information about the QIO.

How to file a quality of care complaint with the QIO

Quality of care complaints filed with the QIO must be made in writing. An enrollee who files a quality of care grievance with a QIO is not required to file the grievance within a specific time period. See page 2 of the introduction for more information about how to file a quality of care complaint with the QIO.

Section 11: Information on how to make a complaint about your health benefits

Introduction

This section gives the rules for making complaints about your health benefits, services and payments 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 plan member. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from this Plan or penalized in any way if you make a complaint.

Note that this section does not apply to Part D Drug benefits. The rules that apply to Appeals and Grievances of Part D drug coverage are different than the rules that apply to your health benefits. Be sure to read Section 12 for detailed information about how to make an Appeal or Grievance that involves a request for Part D Drug benefits.

Please refer to Original Medicare in Section 7 of your 2008 *Medicare and You Handbook* for additional guidance on your appeal rights under Original Medicare. If you do not have a *Medicare and You Handbook,* please call *1-800 Medicare* to get a copy.

How to make complaints in different situations

This section tells you how to complain about services or payment in each of the following situations:

Part 1. Complaints about what benefit or service we will provide you or what we will pay for (cover).

Part 2. Complaints if you think you are being discharged from the hospital too soon.

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

If you want to make a complaint about any type of problem other than those that are listed above, a grievance is the type of complaint you would make. For more information about grievances, including how to file a grievance, see Section 10.

PART 1. COMPLAINTS ABOUT WHAT BENEFIT OR SERVICE HEALTH NET LIFE WILL PROVIDE YOU OR WHAT HEALTH NET LIFE WILL PAY FOR (COVER)

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

If you are not getting the care you want, and you believe that this care is covered by Health Net Life

- If you are being told that a treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
- If you have received care that you believe should be covered by Health Net Life, but we have refused to pay for this care because we say it is not covered.

If you have any question whether Health Net Life will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding advance coverage determination made for the service. Call Health Net Life at 1-800-539-4072 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, and tell us you would like a decision

What is an organization determination?

An organization determination is our initial decision about whether we will provide the medical care or service you request, or pay for a service you have already received. If our initial decision is to deny your request, you can **appeal** the decision by going on to Appeal Level 1 (see below). You may also appeal if we fail to make a timely initial decision on your request.

When we make an "initial decision," we are giving our interpretation of how the benefits and services that are covered for members of Health Net's PPFS Plan apply to your specific situation. This booklet and any amendments you may receive describe the benefits and services covered by Health Net Life, including any limitations that may apply to these services. This booklet also lists exclusions (services that are "not covered" by Health Net Life).

Who may ask for an "initial decision" about your medical care or payment?

Depending on the situation, your doctor or other medical provider may ask us whether we will authorize the treatment. Otherwise, you can ask us for an initial decision yourself, or you can name (appoint) someone to do it for you. The person you name would be your 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 the person you want to act for you must sign and date a statement that gives this person legal permission to act as your representative. This statement must be sent to us at:

Health Net Life
Attn: Prior Authorizations, Advance Coverage Determination
21281 Burbank Boulevard
Woodland Hills, CA 91367

You can call us at 1-800-539-4072 (for TTY, call 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, to learn how to name your representative.

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. You may want to contact your local SHIP.

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), or it can be a "fast decision" that is

made more quickly (typically within 72 hours). A fast decision is sometimes called 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.

Asking for a standard decision

To ask for a standard decision about providing medical care or payment for care, you or your representative should mail or deliver a request in writing to the following address:

For decision about medical care,

Health Net Life
Attn: Prior Authorizations, Advance Coverage Determination
21281 Burbank Boulevard
Woodland Hills, CA 91367

For decision about payment for care,

Health Net Life Medicare Program
PO Box 870502
Surfside Beach, South Carolina 29587-8713

Asking for a fast decision

You, any doctor, or your representative can ask us to give a "fast" decision (rather than a "standard" decision) about medical care by calling us at 1-800-539-4072 (for TTY, call 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week. Or, you can deliver a written request to

Health Net Life
Attn: Prior Authorizations, Advance Coverage Determination
21281 Burbank Boulevard
Woodland Hills, CA 91367

Or fax it to 1-800-672-2135. Requests that are made outside of regular weekday business hours will be handled on the next business day. To reach us after our regular business hours, please fax your request to 1-800-672-2135. 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 give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor's support for a "fast" decision, 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. It will also tell you about your right to ask for a "fast grievance." If we deny your request for a fast decision, we will give you a standard decision. For more information about grievances, see Section 10.

What happens next when you request an initial decision?

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

   We have 30 days to make a decision after we have received your request. However, if we need more information, we can take up to 30 more days. You will be told in writing if we extend the timeframe for making 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 days of your request, you can **appeal** this decision. (An appeal is also called a "reconsideration.")

2. **For a <u>standard</u> initial decision about medical care.**

   We have 14 days to make a decision after we have received your request. However, we can take up to 14 more days if you request the additional time, or if we need more time to gather information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a "fast grievance" (see Section 11).

   If we do not approve your request, we must explain why in writing, and tell you of your right to appeal our decision.

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

3. **For a <u>fast</u> initial decision about medical care.**

   If you receive a "fast" decision, we will give you our decision about your medical care within 72 hours after you or your doctor ask for it – sooner if your health requires. However, we can take up to 14 more 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 believe that we should not take any additional days, you can file a fast grievance.

   We will tell you our decision by phone as soon as we make the decision. If we deny any part of your request, we will send you a letter that explains the decision within 3 days of contacting you by phone. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), you have the right to appeal. If we deny your request for a fast decision, you may file a fast grievance.

Appeal Level 1: If we deny any part of your request for coverage or payment of a service, you may ask us to reconsider our decision. This is called an "appeal" or a "request for reconsideration."

Please call us at 1-800-539-4072 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, if you need help in filing your appeal. 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.

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* are the same as those described for a "standard" or "fast" *initial decision*. While the process for deciding on a standard or fast appeal are the same as the process for a standard or fast decision, the place where the appeal is sent is different, please refer to "What if you want a 'fast' appeal" later in this section for more information.

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you. You have the right to 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's PPFS Plan
Appeals and Grievance Dept.
PO Box 10450
Van Nuys, Ca 91410-0450

- By fax, at 1-800-977-1959.
- By telephone – if it is a "fast appeal" – at 1-800-539-4072 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week.
- In person, at 21281 Burbank Boulevard, Woodland Hills, California 91367. (Business hours are 8:00 a.m. to 5:00 p.m., Monday to Friday, except holidays.

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at 1-800-539-4072 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, Health Net PPFS Plan, Appeals and Grievance Department, Post Office Box 10450, Van Nuys, California 91410-0450.

How do you file your appeal of the initial decision?

The rules about who may file an appeal are the same as the rules about who may ask for an initial decision. Follow the instructions under "Who may ask for an 'initial decision' about medical care or payment?" However, providers who do not have a contract with Health Net Life must sign a "waiver of payment" statement that 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?

You need to file your appeal within 60 days after we notify you of the initial decision. We can give you more time if you have a good reason for missing the deadline. To file your appeal you can call us at the telephone number shown in Section 1 or send the appeal to us in writing at:

Health Net's PPFS Plan
Appeals and Grievance Dept.
PO Box 10450
Van Nuys, Ca 91410-0450

What if you want a "fast" appeal?

The rules about asking for a "fast" appeal are the same as the rules about asking for a "fast" initial decision. While the process for deciding on a standard or fast appeal are the same as the process for a standard or fast decision, the place where you send the appeal is different. You can file an appeal by calling us at 1-800-539-4072 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, or write to Health Net's PPFS Plan, Appeals and Grievance Department, Post Office Box 10450, Van Nuys, California 91410-0450. You can also fax your appeal to 1-800-977-1959, 24 hours a day, 7 days a week. Be sure to ask for a "fast," "expedited," or "72-hour" review.

How soon must we decide on your appeal?

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

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

2. **For a standard decision about medical care.**

   After we receive your appeal, we have up to 30 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 days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will *automatically* go to Appeal Level 2.

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 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 Appeal Level 2.

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.

2. **For a standard decision about medical care.**

   We must authorize or provide you with the care you have asked for no later than 30 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 <u>fast</u> decision about <u>medical care.</u>**

   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, your appeal *automatically* goes on to Appeal Level 2 where an independent review organization will review your case. This independent review organization contracts with the federal government and is not part of Health Net Life. We will tell you in writing that your appeal has been sent to this independent review organization for review. How quickly we must forward your appeal to the independent review organization depends on the type of appeal:

1. **For a decision about <u>payment</u> for care you already received.**

   We must send all the information about your appeal to the independent review organization within 60 days from the date we received your Level 1 appeal.

2. **For a <u>standard</u> decision about <u>medical care</u>.**

   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 days after we received your Level 1 appeal.

3. **For a <u>fast</u> decision about <u>medical care.</u>**

   We must send all of the information about your appeal to the independent review organization within 24 hours of our decision.

Appeal Level 2: If we deny any part of your Level 1 appeal, your appeal will automatically be reviewed by a government-contracted independent review organization

At the second level of appeal, your case is given a new review by an outside, independent review organization that has a contract with CMS (**C**enters for **M**edicare & Medicaid **S**ervices), the government agency that runs the Medicare program. This independent review organization has no connection to us. We will tell you when we have sent your appeal to this independent review organization. You have the right to get a copy from us of your case file that we sent to this independent review organization.

How soon must the independent review organization decide?

For an appeal about <u>payment</u> for care, the independent review organization has up to 60 days to make a decision.

For a standard appeal about medical care, the independent review organization has up to 30 days to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.

For a *fast* appeal about *medical care*, the independent review organization has up to 72 hours to make a decision. However, it can take up to 14 more 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.

1. **For an appeal about payment for care,**

   We must pay within 30 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, or *provide* the care no later than 14 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.

   If you continue to be dissatisfied after the independent review process has been completed, you may then initiate binding arbitration as described at the end of this section. Binding arbitration is generally the final process to resolve disputes.

Appeal Level 3: If the independent review organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

You must make a request for review by an Administrative Law Judge in writing within 60 days after the date you were notified of the decision made at Appeal Level 2. The deadline may be extended for good cause. You must send your written request to the ALJ Field Office that is listed in the decision you receive from the independent review organization. The Administrative Law Judge will not review the appeal if the dollar value of the medical care does not meet the minimum requirement provided in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further. During this review, you may present evidence, review the record, and be represented by counsel.

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 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 (Appeal Level 4).

If the Judge rules against you

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

Appeal Level 4: Your case may be reviewed by the Medicare Appeals Council

This Council will first decide whether to review your case

The Medicare Appeals Council does not review every case it receives. If they decide not to review your case, then either you or Health Net Life may request a review by a Federal Court Judge (Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

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

If the Council decides in your favor

We must pay for, authorize, or provide the medical service you have asked for within 60 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 (Appeal Level 5), so long as the dollar value of the contested benefit meets the minimum requirement provided in the Medicare Appeals Council's decision. If the dollar value is less than the minimum requirement,, the Council’s decision is final.

If the Council decides against you

If the amount involved meets the minimum requirement provided in the Medicare Appeals Council's decision, you or we have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). If the value is less than the minimum requirement, the Council’s decision is final and you may not take the appeal any further.

Appeal Level 5: Your case may go to a Federal Court

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell

you how to request this review. The Federal Court Judge will first decide whether to review your case.

If the contested amount meets the minimum requirement provided in the Medicare Appeals Council's decision, you or we may ask a Federal Court Judge to review the case.

How soon will the judge make a decision?

The Federal judiciary controls the timing of any decision. The judge's decision is final and you may not take the appeal any further.

PART 2. COMPLAINTS (APPEALS) IF YOU THINK YOU ARE BEING DISCHARGED FROM THE HOSPITAL TOO SOON

When you are hospitalized, you have the right to get all the hospital care covered by this Plan that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your "discharge date") is based on when your stay in the hospital is no longer medically necessary. This part of Section 11 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 give you a notice called the *Important Message from Medicare*. 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, 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 your representative) 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, 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 **Q**uality **I**mprovement **O**rganization. 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 Life or your hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and 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 quickly contact the QIO. The *Notice of Discharge & Medicare Appeal Rights* gives the name and telephone number of the 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 an "immediate review."
- 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 first look at your medical information. Then it will 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 full working day after it has received your request and all of the medical information it needs to make a decision.

What happens if the QIO decides in your favor?

- If the QIO agrees with you, we will continue to cover your hospital stay for as long as it is medically necessary.

What happens if the QIO denies your request?

- If the QIO decides that your discharge date was medically appropriate, you will not be responsible for paying the hospital charges until noon of the day after the QIO gives you its decision.

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

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

If you do not ask the QIO for a fast review 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 in Part 1 of this section.

If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care for as long as it is medically necessary.
- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received after the discharge date (unless the independent review organization overturns our decision).

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

When you are a patient in a SNF, **H**ome **H**ealth **A**gency (HHA), or **C**omprehensive **O**utpatient **R**ehabilitation **F**acility (CORF), you have the right to get all the SNF, HHA or CORF care covered by this Plan that is necessary to diagnose and treat your illness or injury. The day we end your SNF, HHA, or CORF coverage is based on when your stay is no longer medically necessary. This part explains what to do if you believe that your coverage is ending too soon.

Information you will 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 your representative) 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 get a review of your coverage by 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 **Q**uality **I**mprovement **O**rganization (the "QIO") to do an independent review of whether it is medically appropriate to terminate your coverage.

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

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

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

What will happen during the review?

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 we believe that your services should end.

After reviewing all the information, the QIO will decide whether it is medically appropriate to terminate your coverage 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 Life 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 by the deadline?

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

If you do not ask the QIO for a fast appeal of your coverage termination by the deadline, you can ask us for a fast appeal. How to ask us for a fast appeal is covered in Part 1 of this section.

If you ask us for a fast appeal of your termination and you continue getting services from the SNF, HHA, or CORF, you may have 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, we will continue to cover your care for as long as medically necessary.
- If we decide that you should not have continued getting your services covered, we will not cover any care you received after the termination date.

Binding Arbitration

Sometimes disputes or disagreements may arise between you (including your enrolled Family Members, heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of this Evidence of Coverage or regarding other matters

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

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

Health Net's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitration's under this process. In the event that the total amount of damages claimed is $200,000 or less, the parties shall, within 30 days of submission of the demand for Arbitration to Health Net, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $200,000. In the event that total amount of damages is over $200,000, the parties shall, within 30 days of submission of the demand for Arbitration to Health Net, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

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

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

Health Net of California
Attention: Litigation Administrator
PO Box 4504
Woodland Hills, CA 91365-4505

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

and binding on all parties except to the extent that State or Federal law provide for judicial review of arbitration proceedings.

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

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

Additionally, binding arbitration does not apply to disputes that are subject to the Medicare Appeals process. Please refer to Original Medicare in Section 7 of your 2008 Medicare and You Handbook for additional guidance on your appeal rights under Original Medicare. If you do not have a Medicare and You Handbook, please call 1-800-Medicare to get a copy.

Section 12: What to do if you have complaints about your Part D prescription drug benefits

What to do if you have complaints

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage. Please call Member Services at the number listed in Section 1.

(Please note that Section 12 addresses complaints about your Part D prescription drug benefits. If you have complaints about your MA benefits, you must follow the rules outlined in Section 11.)

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint, and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be disenrolled from this Plan or penalized in any way if you make a complaint.

A complaint will be handled as a grievance, coverage determination, or an appeal, depending on the subject of the complaint.

What is a Grievance?

A grievance is any complaint other than one that involves a coverage determination. You would file a grievance if you have any type of problem with Health Net Life or one of our network pharmacies that does not relate to coverage for a prescription drug. For example, you would file a grievance if you have a problem with things such as waiting times when you fill a prescription, the way your network pharmacist or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of a network pharmacy. For more information about grievances, including how to file a grievance, see Section 10.

What is a coverage determination?

Whenever you ask for a Part D prescription drug benefit, the first step is called "requesting a coverage determination." If your doctor or pharmacist tells you that a certain prescription drug is not covered, **you must contact us if you want to request a coverage determination.** When we make a coverage determination, we are making a decision whether or not to provide or pay for a Part D drug and what your share of the cost is for the drug. You have the right to ask us for an "exception," which is a type of coverage determination, if you believe you need a drug that is not on our list of covered drugs (formulary) or believe you should get a drug at a lower co-payment.

If you request an exception, your physician must provide a statement to support your request.

For more information about coverage determinations and exceptions, see the section, "How to request a coverage determination" below.

What is an appeal?

An appeal is any of the procedures that deal with the review of an unfavorable coverage determination. **You cannot request an appeal if we have not issued a coverage determination.** If we issue an unfavorable coverage determination, you may file an appeal called a "redetermination" if you want us to reconsider and change our decision. If our redetermination decision is unfavorable, you have additional appeal rights. For more information about appeals, see the section, "How to request an appeal" below.

How to request a coverage determination

What is the purpose of this section?

This part of Section 12 explains what you can do if you have problems getting the prescription drugs you believe we should provide and you want to request a coverage determination. We use the word "provide" in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting.

What is a coverage determination?

The coverage determination made by Health Net Life is the starting point for dealing with requests you may have about covering or paying for a Part D prescription drug. If your doctor or pharmacist tells you that a certain prescription drug is not covered, you should contact Health Net Life and ask us for a coverage determination. With this decision, we explain whether we will provide the prescription drug you are requesting or pay for a prescription drug you have already received. If we deny your request (this is sometimes called an "adverse coverage determination"), you can "appeal" the decision by going on to Appeal Level 1 (see below). If we fail to make a timely coverage determination on your request, it will be automatically forwarded to the independent review entity for review (see Appeal Level 2 below).

The following are examples of coverage determinations:

- You ask us to pay for a prescription drug you have already received. This is a request for a coverage determination about payment. You can call us at 1-800-539-4072 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, to get help in making this request.
- You ask for a Part D drug that is not on your plan sponsor's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." You can call us at 1-800-539-4072 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, to ask for this type of decision. **See "What is an exception" below for more information about the exceptions process.**

- You ask for an exception to our utilization management tools - such as prior authorization, dosage limits, quantity limits, or step therapy requirements Requesting an exception to a utilization management tool is a type of formulary exception. You can call us at 1-800-539-4072 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, to ask for this type of decision. **See "What is an exception" below for more information about the exceptions process.**
- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering exception." You can call us at 1-800-539-4072 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, to ask for this type of decision. **See "What is an exception" below for more information about the exceptions process.**
- You ask us to reimburse you for a drug you bought at an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician's office, will be covered by the plan. See reference heading for a description of these circumstances. You can call us at 1-800-539-4072 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, to make a request for payment or coverage for drugs provided by an out-of-network pharmacy or in a physician's office.

When we make a coverage determination, we are giving our interpretation of how the Part D prescription drug benefits that are covered for members of Health Net's PPFS Plan apply to your specific situation. This booklet and any amendments you may receive describe the Part D prescription drug benefits covered by Health Net, including any limitations that may apply to these benefits. This booklet also lists exclusions (benefits that are "not covered" by Health Net's PPFS Plan).

What is an exception?

An exception is a type of coverage determination. You can ask us to make an exception to our coverage rules in a number of situations.

- You can ask us to cover your drug even if it is not on our formulary. Excluded drugs cannot be covered by a Part D plan unless coverage is through an enhanced plan.
- You can ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you can ask us to waive the limit and cover more.
- You can ask us to provide a higher level of coverage for your drug. If your drug is contained in our highest tier subject to the tiering exceptions process, you can ask us to cover it at the cost-sharing amount that applies to drugs in the preferred tier instead. This would lower the amount you must pay for your drug. Please note, if we grant your request to cover a drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for drugs that are in the specialty drug tier.

Generally, we will only approve your request for an exception if the alternative drugs included on the plan formulary or the drug in the highest tier subject to the tiering exceptions process would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

Your physician must submit a statement supporting your exception request. In order to help us make a decision more quickly, you should include supporting medical information from your doctor when you submit your exception request.

If we approve your exception request, our approval is valid for the remainder of the plan year, so long as your doctor continues to prescribe the drug for you and it continues to be safe and effective for treating your condition. If we deny your exception request, you can appeal our decision.

Note: If we approve your exception request for a non-formulary drug, you cannot request an exception to the co-payment or co-insurance amount we require you to pay for the drug.

Who may ask for a coverage determination?

You can ask us for a coverage determination yourself, or your prescribing physician or someone you name may do it for you. The person you name would be your *appointed representative*. You can name a relative, friend, advocate, doctor, or anyone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to act as your appointed representative. This statement must be sent to us at:

Health Net Life Pharmacy Services
10540 White Rock Road Suite 280
Rancho Cordova, CA 95670

You can call us at 1-800-539-4072, TTY: 1-800-929-9955, 8:00 a.m. to 8:00 p.m., 7 days a week to learn how to name your appointed representative.

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

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

Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard time frame?

A decision about whether we will cover a Part D prescription drug can be a "standard" coverage determination that is made within the standard time frame (typically within 72 hours; see below), or it can be a "fast" coverage determination that is made more quickly (typically within 24 hours; see below). A fast decision is sometimes called an "expedited coverage determination."

You can ask for a fast decision **only** if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for Part D drugs that you have not received yet. You cannot get a fast decision if you are requesting payment for a Part D drug that you already received.)

Asking for a standard decision

To ask for a standard decision, you, your doctor, or your appointed representative should call us at 1-800-539-4072, (for TTY, call 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week. Or, you can deliver a written request to:

Health Net Life Pharmacy Services
10540 White Rock Road Suite 280
Rancho Cordova, CA 95670.
Or fax it to 1-916-463-9754

Requests made after regular weekday business hours can be faxed to the fax number above.

Asking for a fast decision

You, your doctor, or your appointed representative can ask us to give a fast decision (rather than a standard decision) by calling us at 1-800-539-4072, (for TTY, call 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week. Or, you can deliver a written request to:

Health Net Life Pharmacy Services
10540 White Rock Road Suite 280
Rancho Cordova, CA 95670.
Or fax it to 1-916-463-9754

Requests made after regular business hours can be faxed to the fax number above. Be sure to ask for a "fast," "expedited," or "24-hour" review.

- If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.
- If you ask for a fast coverage determination without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast coverage determination, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast coverage determination, we will give you our decision within the 72-hour standard time frame.

What happens when you request a coverage determination?

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

1. **For a <u>standard</u> coverage determination about a Part D drug, which includes a request about payment for a Part D drug that you already received.**

   Generally, we must give you our decision no later than 72 hours after we have received your request, but we will make it sooner if your health condition requires. However, if your request involves a request for an exception (including a formulary exception, tiering

exception, or an exception from utilization management rules - such as dosage or quantity limits or step therapy requirements), we must give you our decision no later than 72 hours after we have received your physician's "supporting statement," which explains why the drug you are asking for is medically necessary. **If you are requesting an exception, you should submit your prescribing physician's supporting statement with the request, if possible.**

We will give you a decision in writing about the prescription drug you have requested. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section, "Appeal Level 1" explains how to file this appeal.

If you have not received an answer from us within 72 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

2. **For a <u>fast</u> coverage determination about a Part D drug that you have not received.**

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

   We will give you a decision in writing about the prescription drug you have requested. If we do not approve your request, we must explain why, and tell you of your right to appeal our decision. The section, "Appeal Level 1" explains how to file this appeal.

   If we decide you are eligible for a fast review, and you have not received an answer from us within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

   If we do not grant your or your physician's request for a fast review, we will give you our decision within the standard 72- hour time frame discussed above. If we tell you about our decision not to provide a fast review by phone, we will send you a letter explaining our decision within three calendar days after we call you. The letter will also tell you how to file a "grievance" if you disagree with our decision to deny your request for a fast review, and will explain that we will automatically give you a fast decision if you get a doctor's support for a fast review.

What happens if we decide completely in your favor?

If we make a coverage determination that is completely in your favor, what happens next depends on the situation.

1. **For a <u>standard</u> decision about a Part D drug, which includes a request about payment for a Part D drug that you already received.**

   We must authorize or provide the benefit you have requested as quickly as your health requires, but no later than 72 hours after we received the request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 72 hours after we have received your physician's "supporting statement." If you are

requesting reimbursement for a drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

2. **For a <u>fast</u> decision about a Part D drug that you have not received.**

   We must authorize or provide you with the benefit you have requested no later than 24 hours of receiving your request. If your request involves a request for an exception, we must authorize or provide the benefit no later than 24 hours after we have received your physician's "supporting statement."

What happens if we deny your request?

If we deny your request, we will send you a written decision explaining the reason why your request was denied. We may decide *completely* or only *partly* against you. For example, if we deny your request for payment for a Part D drug that you have already received, we may say that we will pay nothing or only part of the amount you requested. If a coverage determination does not give you *all* that you requested, you have the right to appeal the decision. (See Appeal Level 1.)

How to request an appeal

This part of Section 12 explains what you can do if you disagree with our coverage determination decision.

What kinds of decisions can be appealed?

If you are unhappy with our coverage determination decision, you can ask for an appeal called a "redetermination." You can generally appeal our decision not to cover a Part D drug, vaccine, or other Part D benefit. You may also appeal our decision not to reimburse you for a Part D drug that you paid for, if you think we should have reimbursed you more than you received, or if you are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription. Finally, if we deny your exceptions request, you can appeal.

How does the appeals process work?

There are five levels to the appeals process. Here are a few things to keep in mind as you read the description of these steps in the appeals process:

- **Moving from one level to the next.** At each level, your request for Part D prescription drug benefits or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the requested drug or on other factors.

- **Who makes the decision at each level?** You make your request for coverage or payment of a Part D prescription drug directly to us. We review this request and make a coverage determination. If our coverage determination is to deny any part of your request, you can go on to the first level of appeal by asking us to review our coverage determination. If you are still dissatisfied with the outcome, you can ask for further review. If you ask for further review, your appeal is sent outside of Health Net Life, where people who are not connected to us review your case and make the decision. After the first level of appeal, all subsequent levels of appeal will be decided by someone who is connected to the Medicare program or the federal court system. This will help ensure a fair, impartial decision.

Each appeal level is discussed in greater detail below.

Appeal Level 1: If we deny any part of your request in our coverage determination, you may ask us to reconsider our decision. This is called an "appeal" or "request for redetermination."

Please call us at 1-800-539-4072 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, if you need help with filing your appeal. You may ask us to reconsider our coverage determination, even if only part of our decision is not what you requested. When we receive your request to reconsider the coverage determination, we give the request to people at our organization who were not involved in making the coverage determination. This helps ensure that we will give your request a fresh look.

How you make your appeal depends on whether you are requesting reimbursement for a Part D drug you already received and paid for, or authorization of a Part D benefit (that is, a Part D drug that you have not yet received). If your appeal concerns a decision we made about authorizing a Part D benefit that you have not received yet, then you and/or your doctor will first need to decide whether you need a fast appeal. The procedures for deciding on a standard or a fast *appeal* are the same as those described for a standard or fast *coverage determination*. Please see the discussion under "Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard time frame?" and "Asking for a fast decision."

While the process for deciding on a standard or fast appeal is the same as in the case of a coverage determination, the place where the appeal is sent is different. See "What if you want a 'fast' appeal" later in this section for more information.

Getting information to support your appeal

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

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

In writing, to:

Health Net's PPFS Plan
Appeals and Grievances Department
Post Office Box 10450
Van Nuys, California 91410-0450.

By fax, at818-676-5505.

By telephone —if it is a fast appeal—at 1-800-539-4072 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week.

In person, at 21281 Burbank Boulevard, Woodland Hills, California, 91367. (Business hours are 8:00 a.m. to 5:00 p.m., Monday to Friday, except holidays.)

You also have the right to ask us for a copy of information regarding your appeal. You can call or write us at 1-800-539-4072 (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, Health Net's PPFS Plan, Appeals and Grievances Department, Post Office Box 10450, Van Nuys, California 91410-0450.

Who may file your appeal of the coverage determination?

The rules about who may file an appeal are almost the same as the rules about who may ask for a coverage determination. For a standard request, you or your appointed representative may file the request. A fast appeal may be filed by you, your appointed representative, or your prescribing physician.

How soon must you file your appeal?

You need to file your appeal within 60 calendar days from the date included on the notice of our coverage determination. We can give you more time if you have a good reason for missing the deadline.

To file a standard appeal, you can send the appeal to us in writing at

Health Net's PPFS Plan
Appeals and Grievances Department
Post Office Box 10450
Van Nuys, California 91410-0450.

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination. You, your doctor, or your appointed representative can ask us to give a fast appeal (rather than a standard appeal) by calling us at 1-800-539-4072 (for TTY, call 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week. Or, you can deliver a written request to:

Health Net's PPFS Plan
Appeals and Grievances Department
Post Office Box 10450
Van Nuys, California 91410-0450.
Or fax it to 1-800-977-1959

Requests after business hours can be faxed to the fax number above. Be sure to ask for a "fast," "expedited," or "72-hour" review. Remember, that if your prescribing physician provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically treat you as eligible for a fast appeal. While the process for deciding on a standard or fast appeal is the same as the process at the coverage determination level, the place where the appeal is sent to is the same as the contact information above.

How soon must we decide on your appeal?

How quickly we decide on your appeal depends on the type of appeal:

1. **For a <u>standard</u> decision about a <u>Part D drug</u>, which includes a request for reimbursement for a Part D drug you already paid for and received.**

   After we receive your appeal, we have up to 7 calendar days to give you a decision, but will make it sooner if your health condition requires us to. If we do not give you our decision within 7 calendar days, your request will *automatically* go to the second level of appeal, where an independent organization will review your case.

2. **For a fast decision about a Part D drug that you have not received.**

   After we receive your appeal, we have up to 72 hours to give you a decision, but will make it sooner if your health requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. **For a decision about reimbursement for a Part D drug you already paid for and received.**

   We must send payment to you no later than 30 calendar days after we receive your request to reconsider our coverage determination.

2. **For a standard decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 7 calendar days after we received your appeal.

3. **For a fast decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 72 hours after we received your appeal.

What happens next if we deny your appeal?

If we deny any part of your appeal, you or your appointed representative have the right to ask an independent organization to review your case. This independent review organization contracts with the federal government and is not part of Health Net Life.

Appeal Level 2: If we deny any part of your first appeal, you may ask for a review by a government-contracted independent review organization.

What independent review organization does this review?

At the second level of appeal, your appeal is reviewed by an outside, independent review organization that has a contract with the **C**enters for **M**edicare & Medicaid **S**ervices (CMS), the government agency that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this independent review organization.

How soon must you file your appeal?

You or your appointed representative must make a request for review by the independent review organization in writing within 60 calendar days after the date you were notified of the decision on your first appeal. You must send your written request to the independent review organization whose name and address is included in the redetermination notice you receive from Health Net Life.

What if you want a fast appeal?

The rules about asking for a fast appeal are the same as the rules about asking for a fast coverage determination, except your prescribing physician cannot file the request for you – only you or your appointed representative may file the request. If you want to ask for a fast appeal, please follow the instructions under "Asking for a fast decision." Remember, if your prescribing physician provides a written or oral statement supporting your request for a fast appeal, the independent review organization will automatically treat you as eligible FOR A FAST APPEAL.

How soon must the independent review organization decide?

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

For a standard request about a Part D drug, which includes a request about reimbursement for a Part D drug that you already paid for and received, the independent review organization has up to 7 calendar days from the date it received your request to give you a decision.

For a fast decision about a Part D drug that you have not received, the independent review organization has up to 72 hours from the time it receives the request to give you a decision.

If the independent review organization decides completely in your favor

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

1. **For a decision about reimbursement for a Part D drug you already paid for and received.**

   We must pay within 30 calendar days from the date we receive notice reversing our coverage determination. We will also send the independent review organization a notice that we have given effect to their decision.

2. **For a standard decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination. We will also send the independent review organization a notice that we have given effect to their decision.

3. **For a fast decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination. We will also send the independent review organization a notice that we have given effect to their decision.

What happens next if the independent review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You or your appointed representative may continue your appeal by asking for a review by an Administrative Law Judge (see Appeal Level 3), so long as the dollar value of the contested Part D benefit meets the minimum requirement provided in the independent review organization's decision.

Appeal Level 3: If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

As stated above, if the independent review organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge. You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date of the decision made at Appeal Level 2. You may request that the Administrative Law Judge extend this deadline for good cause. You must send your written request to ALJ Field Office indicated in the Notice of Reconsideration letter sent by the IRE. The address and contact information for the ALJ Field Office is located in this notice. ALJ Field Office can also be found at http://www.hhs.gov/omha/offices.html.

During the Administrative Law Judge review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel. The Administrative Law Judge will not review the appeal if the dollar value of the Part D benefit does not meet the minimum requirement specified in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

How is the dollar value (the "amount remaining in controversy") calculated?

If we have refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes any costs you could incur based on what you would be charged for the drug and the number of refills prescribed for the requested drug during the plan year. Projected value includes your co-payments, all expenditures incurred after your expenditures exceed the initial coverage limit, and expenditures paid by other entities.

You may also combine multiple Part D claims to meet the dollar value if:

The claims involve the delivery of Part D prescription drugs to you;

All of the claims have received a determination by the independent review organization as described in Appeal Level 2;

Each of the combined requests for review are filed in writing within 60 calendar days after the date that each decision was made at Appeal Level 2; and

Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

How soon does the Judge make a decision?

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

If the Judge decides in your favor

The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it. What happens next depends on the type of appeal:

1. **For a decision about payment for a Part D drug you already received.**

   We must send payment to you no later than 30 calendar days from the date we receive notice reversing our coverage determination.

2. **For a standard decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination.

3. **For a fast decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination.

If the Judge rules against you

You have the right to appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

Appeal Level 4: Your case may be reviewed by the Medicare Appeals Council

The Medicare Appeals Council will first decide whether to review your case. There is no minimum dollar value for the Medicare Appeals Council to hear your case. If you got a denial at Appeal Level 3, you or your appointed representative can request review by filing a written request with the Council.

The Medicare Appeals Council does not review every case it receives. If they decide not to review your case, then you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to you request for review. The notice will tell you how to request a review by a Federal Court Judge. if the amount involved meets the minimum requirement specified in the Medicare Appeals Council's decision

How soon will the Council make a decision?

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

If the Council decides in your favor

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it. What happens next depends on the type of appeal:

1. **For a decision about payment for a Part D drug you already received.**

   We must send payment to you no later than 30 calendar days from the date we receive notice reversing our coverage determination.

2. **For a standard decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination.

3. **For a fast decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination.

If the Council decides against you

If the amount involved meets the minimum requirement provided in the Medicare Appeals Council's decision, you have the right to continue your appeal by asking a Federal Court Judge to review the case (Appeal Level 5). The letter you get from the Medicare Appeals Council will tell you how to request this review. If the value is less than the minimum requirement the Council's decision is final and you may not take the appeal any further.

Appeal Level 5: Your case may go to a Federal Court.

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case.

If the contested amount meets the minimum requirement provided in the Medicare Appeals Council's decision, you may ask a Federal Court Judge to review the case.

How soon will the Judge make a decision?

The Federal judiciary is in control of the timing of any decision.

If the Judge decides in your favor

Once we receive notice of a judicial decision in your favor, what happens next depends on the type of appeal:

1. **For a decision about payment for a Part D drug you already received.**

   We must send payment to you within 30 calendar days from the date we receive notice reversing our coverage determination.

2. **For a standard decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we receive notice reversing our coverage determination.

3. **For a fast decision about a Part D drug you have not received.**

   We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we receive notice reversing our coverage determination.

If the Judge decides against you

The Judge's decision is final and you may not take the appeal any further.

Section 13: Eligibility, enrollment and disenrollment from Health Net's PPFS Plan

Who is eligible for coverage?

This Plan is available to the following people as long as they live in the United States, either work or live in our service area and meet any additional eligibility requirements of the Group:

The principal member who:

- Is entitled to Medicare Part A and enrolled in Medicare Part B;
- Is not enrolled in Medicare Part D through another Health Care Service Plan.

Spouse, who must be listed on the enrollment form completed by the principal member and meets the same qualifications as the principal member. (The term "spouse" also includes the member's domestic partner as defined.)

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

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

Subscriber

Employee

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

*Lecturers - see your benefits office for eligibility.

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

Retiree

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

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

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

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

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

Survivor

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

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

Eligible Dependents (Family Members)

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

Spouse

Your legal spouse

Child

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

(a) your natural or legally adopted children;

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

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

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

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

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

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

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

Other Eligible Dependents (Family Members)

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

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

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

No Dual Coverage

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

More Information

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

How to enroll for coverage?

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

A Period of Initial Eligibility (PIE)

A PIE ends 31 days after it begins.

Employee

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

Newly Acquired Dependents

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

Spouse: On the date of Marriage.

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

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

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

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

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

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

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

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

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

Enrollment At Other Times For Employees And Retirees

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

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

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

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

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

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

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

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

Effective Date

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

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

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

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

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

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

(a) the date the Child becomes eligible, or

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

Change in Coverage

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

Effect of Medicare on Retiree Enrollment

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

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

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

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

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

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

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

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

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

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

Medicare Secondary Payer Law (MSP)

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

Medicare Private Contracting Provision and Providers Who do Not Accept Medicare

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

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

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

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

Special Reinstatement Rule For Reservists Returning From Active Duty

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

Special Reinstatement Rule Under USERRA

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

Changes made during the Open Enrollment Period would be effective on the following January.

However, any transfer which requires Health Net's approval of a health status questionnaire will not take effect until the first day of the calendar month following the date of such approval.

Effect of Medicare

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

Termination of Coverage

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

Deenrollment Due to Loss of Eligible Status

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

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

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

Deenrollment Due to Fraud

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

Leave of Absence, Layoff or Retirement

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

Individual Members that Establish Residency Outside the Health Net Service Area

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

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

Termination for Cause

Health Net has the right to terminate your coverage from this Plan under certain circumstances. The following are examples of circumstances that may result in a termination:

- Disruptive or Threatening Behavior: Your coverage may be terminated upon the date the notice of termination is mailed if you threaten the safety of the health care provider, his or her office staff, the contracting Physician Group or Health Net if such behavior does not arise from a diagnosed illness or condition. In addition, your coverage may be terminated upon 15 days prior written notice if you repeatedly or materially disrupt the operations of the Physician Group or Health Net to the extent that your behavior substantially impairs Health Net's ability to furnish or arrange services for you or other Health Net Members, or substantially impairs the Physician's office or contracting Physician Group's ability to provide services to other patients.

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

If coverage is terminated for any of the above reasons, you forfeit all rights to enroll in the Health Net conversion plan, COBRA plan or any plan that is owned or operated by Health Net's parent company or its subsidiaries and lose the right to re-enroll in Health Net in the future. The termination is effective immediately on the date Health Net mails the notice of termination, unless Health Net has specified a later date in that notice.

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

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

Optional Continuation of Coverage

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

Extension of Benefits

When Benefits May Be Extended

Benefits may be extended beyond the date coverage would ordinarily end if;

You lose your Health Net coverage because the UC Standardized Contract is discontinued, and you are ***totally disabled*** at that time; or

You lose your coverage for any reason other than discontinuance of the UC Standardized Contract and you are a ***registered bed patient*** in a Hospital or Skilled Nursing Facility when coverage ends, and the hospitalization was covered by this Plan.

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

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

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

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

For the Subscriber it means that because of an illness or injury, the Subscriber is unable to engage in employment or occupation for which he or she is or becomes qualified by reason of education, training, or experience; furthermore, the Subscriber must not be employed for wage or profit.

For a Family Member it means that because of an illness or injury, that person is prevented from performing substantially all regular and customary activities usual for a person of his or her age and family status.

How to Obtain an Extension

Member Is Confined to a Hospital

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

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

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

Member Is Not Confined to a Hospital

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

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

When the Extension Ends

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

1. **For extensions provided only because of Hospital confinement:** If the Agreement between Health Net and the Group **has not been** terminated, then the Extension of Benefits will end on the earliest of the following dates:
   a On the date the Member is discharged from the Hospital or Skilled Nursing Facility, even if the total disability continues;
   b On the date the Member becomes covered by another private or group health insurance policy or plan; or

c On the date that available benefits are exhausted.

2. For extensions provided because of total disability which may or may not involve hospitalization: If the Agreement between Health Net and the Group has been terminated, then the extension of benefits will end on the earliest of the following dates:
   a. On the date the Member is no longer totally disabled;
   b. On the date the Member becomes covered by a replacement health policy or plan obtained by the Group, and this coverage has no limitation for the disabling condition;
   c. On the date that available benefits are exhausted; or
   d. On the last day of the 12-month period following the date the extension began, unless the Member is confined in a Hospital or Skilled Nursing Facility on that date for the disabling condition.

Other Coverage Affects Extension of Benefits

Other Group Coverage

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

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

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

COBRA Continuation Coverage

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

Conversion Coverage

Conversion coverage affects extension of benefits when:

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

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

Conversion Privilege

Who Is Eligible for Conversion Coverage

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

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

Who Is Not Eligible for Conversion Coverage

The following people are not eligible for conversion coverage:

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

How to Apply for Conversion Coverage?

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

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

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

Eligible Dependents (Family Members)

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

How to enroll for coverage?

Notify the Group that you want to enroll an eligible person. The Group will send the request to Health Net Life according to current procedures. Call your Group's benefits administrator if you have any questions about how or when to enroll.

What is "disenrollment"?

"Disenrollment" from Health Net's PPFS Plan means **ending your membership** in this Plan. Disenrollment can be **voluntary** (your own choice) or **involuntary** (not your own choice):

You might leave Health Net Life because you have decided that you *want* to leave. You can do this for any reason. However, as we explain in this section, **there is a new law that limits <u>when</u> you may leave and <u>how often</u> you can make changes, <u>what your other choices are</u> for receiving Medicare services, and <u>how</u> you can make changes.**

There are also a few situations where you would be *required* to leave. For example, you would have to leave Health Net Life if you move out of our geographic service area or if Health Net Life leaves the Medicare program. We are not allowed to ask you to leave the plan because of your health.

Voluntarily ending your membership

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

Every year, from November 15 through December 31, during the Annual Coordinated Election Period (AEP), anyone with Medicare may switch from one way of getting Medicare to another for the following year. Your change will take effect on January 1.

There may be other limited times during which you may make changes. For more information about these times and the options available to you, please refer to the "Medicare & You" handbook you receive each fall. You may also call 1-800-MEDICARE (1-800-633-4227), or visit **www.medicare.gov** to learn more about your options.

Until your membership officially ends, you should keep getting your Medicare services through Health Net's PPFS Plan or you will have to pay more for your services.

If you leave Health Net Life, it takes some time for your membership to end and your new way of getting Medicare to take effect. While you are waiting for your membership to end, you are still a member and **should** continue to get your care as usual through Health Net Life.

What happens to you if Health Net Life leaves the Medicare program or the area where I 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 this happens, your membership in Health Net will end, and you will have to change to another way of getting your Medicare benefits. All of the benefits and rules described in this booklet will continue until your membership ends. This means that you must continue to get your medical care in the usual way through Health Net until your membership ends.

Your choices for how to get your Medicare will always include Original Medicare and joining a Prescription Drug Plan to complement your Original Medicare coverage. Your choices may also include joining another Health Net Life plan, another Medicare Advantage Plan, or a Private Fee-for-Service plan, if these plans are available in your area and are accepting new members. Once we have told you in writing that we are leaving the Medicare program or the area where you live, you will have a chance to change to another way of getting your Medicare benefits. If you decide to change from Health Net's PPFS Plan to Original Medicare, you will have the right to buy a Medigap policy regardless of your health. This is called a "guaranteed issue right" and it is explained earlier in this section under the heading, "Do you need to buy a Medigap (Medicare supplement insurance) policy?"

Health Net Life 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 Life 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 during the year, too. In these situations we will try to tell you 90 days in advance, but your advance notice may be as little as 30 or fewer days if CMS must end our contract in the middle of the year.

Whenever a Medicare health plan leaves the Medicare program or stops serving your area, you will be provided a special enrollment period to make choices about how you get Medicare, including choosing a Medicare Prescription Drug Plan and guaranteed issue rights to a Medigap policy.

Involuntarily ending your membership

Under certain conditions Health Net Life can end your membership and make you leave the plan.

We *cannot* ask you to leave the plan 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 Health Net Life because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

We *can* ask you to leave the plan under certain special conditions.

If any of the following situations occur, we will end your membership in Health Net Life.

1. You no longer meet the eligibility requirements established by the Group and Health Net Life. If the principal Member loses coverage for this reason, any enrolled dependent will also lose coverage at the same time.
2. The marriage or domestic partnership (between the principal Member & the enrolled dependent) ends by divorce, annulment or some other form of dissolution. Eligibility for the enrolled spouse or Domestic Partner (now former spouse or Domestic Partner) will end.
3. If you move out of the service area or are away from the 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 cover of this booklet to find out if the place you are moving to or traveling to is in Health Net Life's service area. If you move permanently out of our geographic service area, or if you are away from our service area for more than six months in a row you generally cannot remain a member of this Plan. In these situations, 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 Health Net Life and explains how to leave. Section 2 gives more information about getting care when you are away from the service area.
4. If you do not stay continuously enrolled in both Medicare Part A and Medicare Part B.
5. The Group Policy (between the Group and Health Net Life) is terminated, including termination due to nonpayment of premiums by the Group;
6. If you give us information on your enrollment request that you know is false or deliberately misleading, and it affects whether or not you can enroll in this Plan.
7. If you behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of Health Net Life. We cannot make you leave Health Net Life for this reason unless we get permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
8. If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.

If your coverage for this Plan ends for reasons other than those listed in bullets 4 through 8 above, you may be eligible for additional coverage. Please see "COBRA continuation coverage" below.

COBRA continuation coverage

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

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

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

Section 14: 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 principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the **C**enters for **M**edicare & Medicaid **S**ervices, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the State of California may apply.

Notice about non-discrimination

When we make decisions about the provision of health care services, we do not discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Advantage Plans, like Health Net Life, 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.

Health Care Plan Fraud

Health care plan fraud is defined as a deception or misrepresentation by a provider, Member, employer or any person acting on their behalf. It is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care plan by filing a claim that contains a false or deceptive statement is guilty of insurance fraud.
If you are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if you know of or suspect any illegal activity, call Health Net Life's toll-free Fraud Hotline at 1-800-977-3565. The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

Circumstances Beyond Health Net Life's Control

Except as otherwise required by law or regulation, to the extent that a natural disaster, war, riot, civil insurrection, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, disability of significant medical group personnel, or other similar events, not within the control of Health Net Life, results in the facilities, or personnel, of Health Net Life not being available to provide or arrange for services or benefits under this Evidence of Coverage, Health Net Life's obligation to provide such services or benefits shall be limited to the requirement that Health Net Life 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 Life will provide benefits for all covered medications that you receive through this plan. However, if you receive money because of your injuries, you must reimburse Health Net Life or the pharmacy for the value of any medications provided to you through this plan.

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

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

Steps You Must Take

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

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

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

How The Amount Of your Reimbursement Is Determined

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

- The amount of the reimbursement that you owe Health Net Life or the pharmacy will be reduced by the percentage that your recovery is reduced if a judge, jury or arbitrator determines that you were responsible for some portion of your injuries.

- The amount of the reimbursement that you owe Health Net Life or the physician group will also be reduced by a pro rata share for any legal fees or costs that you paid from the money you received.
- The amount that you will be required to reimburse Health Net Life or the pharmacy for medications you receive under this plan will not exceed one-third of the money that you receive if you do engage a lawyer, or one-half of the money you receive if you do not engage a lawyer.
- Coordination of benefits protects you from higher plan premiums. The end result is more affordable health care.

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.

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 Life (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. In some cases, we may use or disclose the information for underwriting or determining premiums.
- Treatment. We may use and disclose your protected health information to assist your health care providers (doctors, dentists, 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 Life 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.
- Enrolled Dependents and Family Members. We will mail explanation of benefits forms and other mailings containing protected health information to the address we have on record for the member of the health plan.

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., state insurance departments) for activities authorized by law.
- Judicial and Administrative Proceedings. We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.
- Law Enforcement. We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- Coroners, Funeral Directors, Organ Donation. We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their

duties. We may also disclose protected health information in connection with organ or tissue donation.

- Research. Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.
- To Avert a Serious Threat to Health or Safety. We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.
- Special Government Functions. We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- Workers' Compensation. We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

Other Uses Or Disclosures With An Authorization

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

Your Rights Regarding Your Protected Health Information

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

- Right To Access Your Protected Health Information. You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.
- Right To Amend Your Protected Health Information. If you feel that protected health information maintained by the Plan is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by the Plan, as is often the case for health information in our records or you ask to amend a record that is already accurate and complete.
- If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.

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

Health Information Security

Health Net Life requires its employees to follow the Health Net Life 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 Life maintains physical, administrative and technical security measures to safeguard your protected health information.

Changes To This Notice

We reserve the right to change the terms of this notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the

future. We will provide you with a copy of the new notice whenever we make a material change to the privacy practices described in this notice. We also post a copy of our current notice on our website at www.healthnet.com/uc. Any time we make a material change to this notice, we will promptly revise and issue the new notice with the new effective date.

Complaints

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

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

Contact The Plan

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

Health Net Life Privacy Office
Attention: Director, Information Privacy
Post Office 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/uc

Binding Arbitration

Sometimes disputes or disagreements may arise between you (including your enrolled Family Members, heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of this EOC or regarding other matters relating to or arising out of your Health Net membership. Typically such disputes are handled and resolved through the Health Net grievance, appeal and independent medical review process. However, in the event that a dispute is not resolved in that process, Health Net uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, health care providers, or their agents or employees, are also involved. In addition, disputes with Health Net involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

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

Health Net's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitration's under this process. In the event that the total amount of damages claimed is $200,000 or less, the parties shall, within 30 days of submission of the demand for Arbitration to Health Net, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than $200,000. In the event that total amount of damages is over $200,000, the parties shall, within 30 days of submission of the demand for Arbitration to Health Net, appoint a mutually acceptable panel of three neutral arbitrators (unless the parties mutually agree to one arbitrator), who shall hear and decide the case.

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

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

Health Net Life Insurance Company
Attention: Litigation Administrator
PO Box 4504
Woodland Hills, CA 91365-4505

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

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

resolution organization for a determination. Such request for hardship should be submitted to the Litigation Administrator at the address provided above.

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

Please note that binding arbitration does not apply to disputes that are subject to the Medicare Appeals process as described in Section 9 and Section 10.

Section 15: Definitions of some words used in this booklet

For the terms listed below, this section either gives a definition or directs you to a place in this booklet that explains the term

Advance Coverage Determination – A written (binding) advance coverage decision from the Health Net's PPFS Plan to make sure the service, especially inpatient hospitalization, will be covered by the plan. If you ask for an advance coverage determination, you have the right to get a decision from Health Net Life about your Health Net Life coverage .

Appeal – A type of complaint you make when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service. Sections 10 and 11 explain about appeals, including the process involved in making an appeal.

Benefit period – For both Health Net's PPFS Plan and Original Medicare, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period *begins* on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period *ends* when you 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. The type of care you actually receive during the stay determines whether you are considered to be an inpatient for SNF stays, but not for hospital stays.

You are an inpatient in a SNF only if your care in the SNF meets certain skilled level of care standards. Specifically, in order to have been an inpatient while in a SNF, you must need daily skilled nursing or skilled rehabilitation care, or both. (Section 6 tells what is meant by skilled care.)

Generally, you are an inpatient of a hospital if you are receiving inpatient services in the hospital (the type of care you actually receive in the hospital does not determine whether you are considered to be an inpatient in the hospital).

Brand name drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are not available until after the patent on the brand name drug has expired.

Covered services – The general term we use in this booklet to mean all of the health care services and supplies that are covered by this Plan. Covered services are listed in the Benefits Chart in Section 4.

Creditable coverage – Coverage that is at least as good as the standard Medicare prescription drug coverage.

Deemed provider - A provider is a deemed provider and must follow a Health Net's PPFS plan's terms and conditions of payment if the following conditions are met: a) In advance of furnishing services the provider knows that a patient is enrolled in a Health Net's PPFS plan and b) the provider either possesses or has access to the plan's terms and conditions of payment.

It is important to note that a provider is not required to furnish health care services to enrollees of a Health Net's PPFS plan. However, when a provider chooses to furnish services to a Health Net's PPFS enrollee and the deeming conditions have been met the provider is automatically a deemed provider (for that enrollee) and must follow the Health Net's PPFS plan's terms and conditions of payment.

Disenroll or disenrollment – The process of ending your membership in this Plan. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 13 tells about disenrollment.

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

- Have a common residence. It is not necessary that the legal right to possess the common residence be in both names.
- Not be married or a member of another domestic partnership with someone else that has not been terminated, dissolved or judged a nullity.
- Not be related by blood in a way that would prevent them from being married to each other in this state.
- Be at least 18 years of age.
- Be capable of consenting to the domestic partnership.
- Be either of the following:
- Members of the same sex; or
- Members of the opposite sex and one or both be eligible for Social Security benefits and one or both be over the age of 62.

  Both file a Declaration of Domestic Partnership with the Secretary of State or an equivalent document with another recognized state or local agency, or both are persons of the same sex who have validly formed a legal union other than marriage in a jurisdiction outside of California which is substantially equivalent to a Domestic Partnership as defined under California law.

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

Durable medical equipment – Equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment include wheelchairs, hospital beds, or equipment that supplies a person with oxygen.

Emergency care – Covered services that are 1) furnished by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition. Section 3 tells about emergency services.

Evidence of coverage and disclosure information – This document along with your enrollment form, which explains your covered services, defines our obligations, and explains your rights and responsibilities as a member of Health Net Life.

Generic drug – A prescription drug that has the same active-ingredient formula as a brand name drug. Generic drugs usually cost less than brand name drugs and are rated by the **F**ood and **D**rug **A**dministration (FDA) to be as safe and effective as brand name drugs.

Grievance – A type of complaint you make about us or one of our plan providers, including a complaint concerning the quality of your care. This type of complaint does not involve payment or coverage disputes. See Section 10 for more information about grievances.

Group -- The business organization to which Health Net Life has issued the Group Service Policy 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 this Plan 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.

Group Service Policy -- The contract Health Net Life issues to the Group, in order to provide the benefits of this Plan.

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

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

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 **C**enters for **M**edicare & Medicaid **S**ervices (CMS) to provide covered services. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans. Health Net Life Insurance Company and Health Net Life Insurance of New York, Inc. are Medicare Advantage Organizations.

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 who live in the service area covered by the Plan. A Medicare Advantage Organization may offer more than one plan in the same service area. Health Net's PPFS Plan is a Medicare Advantage Plan.

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

"Medigap" (Medicare supplement insurance) policy – Many people who get their Medicare through Original Medicare buy "Medigap" or Medicare supplement insurance policies to fill "gaps" in Original Medicare coverage.

Member (member of Health Net Life l, or "plan member") – A person with Medicare who is eligible to get covered services, who has enrolled in Health Net Life, and whose enrollment has been confirmed by the **C**enters for **M**edicare & Medicaid **S**ervices (CMS).

Member services – A department within Health Net Life responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 1 for information about how to contact Member Services.

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

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

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

Part D drugs – Any drug that can be covered under a Medicare Prescription Drug Plan. Generally, any drug not specifically excluded under Medicare drug coverage is considered a Part D Drug. Part D Drugs that are listed on our formulary, and that we pay for based on an exception or an appeal, are called "Covered Part D Drugs."

Plan provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them "plan providers" when they are part of Health Net Life. When we say that plan providers are "part of Health Net Life," this means that they accept Medicare and agree to Health Net Life terms and conditions of payment.

Health Net's PPFS Plan – An MA private fee-for-service plan is an MA plan that pays providers of services at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk. An MA Organization wishing to offer a Health Net's PPFS plan must meet general requirements for MA Organizations required by law including:
Providing for all original Medicare covered services;
Providing for emergency and urgent care;
Allowing beneficiary appeals for services that are limited, not provided, not paid for, or not allowed and
Disclosing its terms and conditions of payment and a list of services it provides.

An MA Organization offering a Health Net's PPFS plan:
Does not vary the rates for a provider based on the utilization of that provider's services;
Does not restrict enrollees' choices among providers that (a) agree to accept the plan's terms and conditions of payment and (b) are lawfully authorized to provide services; and
Does not limit enrollees to a provider network (no "lock in").

Special access rules apply to Health Net's PPFS plans.

Members of a Health Net's PPFS plan may go to any doctor or hospital in the U.S. that is:
eligible to be paid by Medicare (that is (a) the provider is state licensed, (b)is eligible to receive, or has received, a Medicare billing number, and, (c) for Institutional providers, such as hospitals and skilled nursing facilities, is certified to treat Medicare beneficiaries); and
is willing to accept the plan's terms and conditions of payment.

Health Net's PPFS plans may offer supplemental benefits. Additionally a Health Net's PPFS plan offered by an MA Organization has the option of offering a Part D prescription drug benefit. Health Net's PPFS Plan does not include Part D prescription drug coverage.

Terms and conditions of participation (payment) – The Health Net's PPFS Terms and Conditions of participation establish the rules that providers must follow if they choose to furnish services to an enrollee of a Health Net's PPFS plan. At a minimum the Terms and Conditions will specify:

A list of all services that the plan provides;

The amount the Health Net's PPFS organization will pay for all plan-covered services;

Provider billing procedures;

The amount the provider is permitted to collect from the enrollee including balance billing; and

The Health Net's PPFS plan is not required to reimburse providers for services to Health Net's PPFS plan enrollees, if these services are not covered by the plan.

A Health Net's PPFS organization is required to make its Terms and Conditions of participation reasonably available--through phone, fax, email, or websites-- to providers in the U.S. from whom its enrollees seek 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 doctors in inpatient hospitals, hospital outpatient departments, hospital emergency rooms, skilled nursing facilities, home health agencies, Health Net's PPFS plans, and ambulatory surgical centers. See Section 1 for information about how to contact the QIO in your state and Section 11 for information about making complaints to the QIO.

Referral –. You do not need a referral to obtain care in a Health Net's PPFS plan. If you have any question whether Health Net Life will pay for a service, including inpatient hospital services, you have the right under law to have a written / binding Advance Coverage Determination made for the service. Call Health Net Life at 1-800-539-4072, (TTY/TDD 1-800-929-9955), 8:00 a.m. to 8:00 p.m., 7 days a week, and tell us you would like a determination if the service will be covered.

Rehabilitation services – These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a plan provider. See Section 4 for more information.

Service area – Section 2 tells about Health Net Life's service area. "Service area" is the geographic area approved by the **C**enters for **M**edicare & Medicaid **S**ervices (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Health Plan.

Urgently needed care – Section 3 explains about urgently needed services. These are different from emergency services.

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For more information, please contact us at:

Health Net's PPFS Plan
Post Office Box 870502
Surfside Beach, SC 29587-8713

Customer Service Department
1-800-539-4072

Telecommunications Device for the Deaf
1-800-929-9955

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

WWW.HEALTHNET.COM/UC