EVIDENCE OF COVERAGE AND PLAN DOCUMENT

A complete explanation of your plan

Health Net Seniority Plus (Plan 2H1) EOCID: 193559

For University of California Medicare Retirees
Effective 1/1/2008

Important benefit information – please read

Health Net®
Medicare Programs

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

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

For help or information, please call Member Services, 8:00 am to 8:00 p.m., 7 days a week. Calls to these numbers are free:

1-800-539-4072

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

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 Seniority Plus!

We are pleased that you've chosen Seniority Plus. Seniority Plus is a **H**ealth **M**aintenance **O**rganization "HMO" for people with Medicare. Now that you are enrolled in Seniority Plus, you're getting your care through Health Net of California, Inc. (Health Net). Seniority Plus, an HMO, is offered by Health Net. (**Seniority Plus is not a "Medigap" or supplemental Medicare insurance policy.**) Your Member Contract for Seniority Plus consists of this Evidence of Coverage, your election form, any current or future riders and amendments. It explains your rights, benefits, and responsibilities as a Member of Seniority Plus. It also explains our responsibilities to you.

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

- What is covered by Seniority Plus and what is not.
- What you will have to pay for when you get care.
- How to get the care you need, including some rules you must follow.
- What to do if you are unhappy about something related to your Covered Services.
- How to leave Seniority Plus, and other Medicare options that are available.

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

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

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

ELIGIBILITY

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

Subscriber

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

* Lecturers - see your benefits office for eligibility.

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

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

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

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

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

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

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

Eligible Dependents (Family Members)

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

Spouse: Your legal spouse.

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

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

- the incapacity began before age 23, the child was enrolled in a group medical plan before age 23 and coverage is continuous;

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

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

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

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

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

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

No Dual Coverage

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

More Information

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

Enrollment

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

During a Period of Initial Eligibility (PIE)

A PIE ends 31 days after it begins.

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

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

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

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

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

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

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

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

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

At Other Times For Employees And Retirees

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

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

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

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

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

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

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

Members before the effective date of retirement (or the date disability or survivor benefits begin).

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

Effective Date

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

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

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

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

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

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

(a) the date the Child becomes eligible, or

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

Change in Coverage

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

Effect of Medicare on Retiree Enrollment

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

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

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

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

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

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

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

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

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

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

Medicare Secondary Payer Law (MSP)

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

Medicare Private Contracting Provision and Providers Who do Not Accept Medicare

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

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

If you are classified as a Retiree by the University (or otherwise have Medicare as a primary coverage), are enrolled in Medicare Part B, and choose to enter into such a "private contract"

arrangement as described above with one or more physicians or practitioners, or if you choose to obtain services from a provider who does not participate in Medicare, under the law you have in effect "opted out" of Medicare for the services provided by these physicians or other practitioners. In either case, no benefits will be paid by this Plan for services rendered by these physicians or practitioners with whom you have so contracted, even if you submit a claim. You will be fully liable for the payment of the services rendered. Therefore, it is important that you confirm that your provider takes Medicare prior to obtaining services for which you wish the Plan to pay.

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

TERMINATION OF COVERAGE

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

Deenrollment Due to Loss of Eligible Status

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

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

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

Deenrollment Due to Fraud

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

fraud or deception, the Subscriber and any Family Members will be deenrolled for 12 months.

Leave of Absence, Layoff or Retirement

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

Optional Continuation of Coverage

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

PLAN ADMINISTRATION

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

Sponsorship and Administration of the Plan

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

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

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

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

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

Group Contract Number

The Group Contract number for this Plan is: 5522SM, 5047RB, 5047RL, 5047SH, 5047UL, 5047US, 5047VG, 5047TA, 5047TG, 5047TR, 5047TW

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 105 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. Our business hours are 8:00 a.m. to 8:00 p.m., 7 days a week.

CALL	**1-800-539-4072**. This number is also on the first page of this booklet for easy reference. Calls to this number are free.
TTY	**1-800-929-9955**. This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. It is also on the first page this booklet for easy reference. Calls to this number are free.
FAX	**1-818-676-8179.**
WRITE	Health Net Seniority Plus, Post office Box 10198, Van Nuys, California, 91410-0198.
VISIT	21281 Burbank Blvd, Woodland Hills, CA 91367
WEBSITE	www.healthnet.com/uc

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).

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 call **1-877-486-2048**.
- Use a computer to look at www.medicare.gov, the official **government website for Medicare information**. This website 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 website using their computer.

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

HICAP is a state organization paid by the federal government to give free health insurance information and help to people with Medicare. HICAP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. HICAP has information about Medicare 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 have tried a Medicare Advantage Plan (like Seniority Plus) for the first time. (Medicare Advantage is the new name for Medicare+Choice.) Section 11 has more information about your Medigap guaranteed issue rights.

You can contact HICAP at:

ALAMEDA COUNTY
HICAP Legal Assistance for Seniors
464 7th Street
Oakland, CA 94607

1-510-839-0393 or **1-800-434-0222**
Southern & Eastern Alameda County **1-800-393-0363** or **1-800-434-0222**
TTY/TDD **1-877-486-2048**

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

1-925-335-8720 or **1-800-434-0222**
TTY/TDD **1-925-335-8730**

PLACER, SACRAMENTO & YOLO COUNTY
HICAP
HICAP Services of Northern California
3950 Industrial Blvd., Suite 500
West Sacramento, CA 95691

1-916-376-8915 or **1-800-434-0222**

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

1-661-868-1000 or **1-800-434-0222**

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

1-213-383-4519 or **1-800-434-0222**

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

1-714-560-0424 or **1-800-434-0222**

RIVERSIDE & SAN BERNARDINO COUNTY
HICAP
Inland Agency
6296 River Crest Drive, Suite L
Riverside, CA 92507

1-951-697-6560 or **1-800-434-0222**

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

1-858-565-8772 or **1-800-434-0222**

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

1-415-538-3333 or **1-800-434-0222**

SAN JOAQUIN COUNTY
HICAP
Services of Northern California
3950 Industrial Blvd., Suite 500
West Sacramento, CA 95825

1-916-376-8915 or **1-800-434-0222**

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

1-650-627-9350 or **1-800-200-0268**

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

1-805-928-5663 or **1-800-434-0222**

SANTA CLARA COUNTY
HICAP
Council on Aging of Silicon Valley
2115 The Alameda
San Jose, CA 95126

1-408-296-8290 or **1-800-434-0222**

SANTA CRUZ COUNTY
HICAP
Senior Network Services, Inc.
1777 A-Capitola Road
Santa Cruz, California 95062

1-831-462-5510 or **1-800-434-0222**

STANISLAUS COUNTY
HICAP
Senior Citizens Law Project
801-15th Street, Suite D
Modesto, CA 95354

1-209-567-3262 or **1-800-434-0222**

SOLANO & SONOMA COUNTY
HICAP
Senior Advocacy Services
3262 Airway Drive, Suite C
Santa Rosa, CA 95403-2004

1-707-526-4108 or **1-800-434-0222**

TTY/TDD users should call the California Relay Service at **711** or **1-800-735-2929**. Calls to these numbers are free.

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

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

"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. In California, the QIO is called Lumetra. The doctors and other health experts in Lumetra review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage

for their Hospital, Skilled Nursing Facility, Home Health Agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Section 10 for more information about complaints.

You can contact Lumetra at:

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

1-415-677-2000 or 1-800-841-1602 (TDD/TTY at **1-800-881-5980)**

Other organizations (including Medicaid, Social Security Administration)

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

In the State of California, Medicaid is also known as Medi-Cal. 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:

The contact information for this agency is:

Alameda County – Social Services Agency	**1-510-383-8523**
Contra Costa County – Social Services Department	**1-925-313-7987**
Kern County – Department of Human Services	**1-661-631-6807**
Los Angeles – Department of Public Social Services	**1-213-639-6300**
Orange County – Social Service Agency:	
Anaheim	**1-714-575-2400**
Santa Ana	**1-714-435-5900**
Laguna Hills	**1-949-587-8543**
Garden Groves	**1-714-741-7100**
Placer County (Auburn) – Health and Human Services	**1-530-889-7610**
Placer County (Roseville) – Health and Human Services	**1-916-784-6000**
Riverside County – Department of Public Social Services	**1-951-358-3000**
Sacramento County – Department of Human Assistance	**1-916-874-2215** or **1-916-874-2072**
San Bernardino County – Department of Public Social Services	**1-909-388-0245**
San Diego County – Department of Health and Human Services	**1-858-514-6885**
San Francisco County – Department of Human Services	**1-415-863-9892**
San Joaquin County **–** Human Services Agency	**1-209-468-1000**
San Mateo County – Human Services Agency	**1-650-802-6470**
Santa Barbara County – Department of Social Services	**1-805-681-4528**

Santa Clara County – Social Services Agency	**1-408-271-5600**
Santa Cruz County – Human Resources Agency	**1-831-454-4131**
Watsonville – Human Resources Agency	**1-831-763-8500**
Solano County – Health and Social Services	**1-707-553-5311**
Sonoma County – Human Services Department	**1-707-565-5200**
Stanislaus County – Community Services Agency	**1-209-558-2777**
Yolo County – Department of Employment & Social Services	**1-530-661-2750**

TTY/TDD users should call the California Relay Service at **711** or **1-800-325-0778**. Calls to these numbers are free.

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 at **1-800-772-1213**. TTY users should call **1-800-325-0778**. Calls to these numbers are free. You can also visit www.ssa.gov on the web.

Genetically Handicapped Persons Program

Genetically Handicapped Persons Program is a state organization that provide limited-income and medically needy senior citizens and individuals with disabilities financial help for prescription drugs. You may contact Genetically Handicapped Persons Program at P.O Box 997413, MS 8105, Sacramento, CA 95899-7413, **1-800-639-0597** or **1-916-327-0470**. You can also find the Web site for Genetically Handicapped Persons Program at www.dhcs.ca.gov/services/ghpp.

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 **1-312-751-4701**. You can also visit www.rrb.gov on the web.

Employer (or "Group") Coverage

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

Genetically Handicapped Persons Program - a State Pharmaceutical Assistance Program (SPAP)

If you receive financial assistance from Genetically Handicapped Persons Program to help pay for your medications, you may call them at **1-800-639-0597**. TTY/TDD users should call the California Relay Service at **711** or **1-800-735-2929**. Calls to these numbers are free.

SECTION 2. GETTING STARTED AS A MEMBER OF SENIORITY PLUS

Section 6 describes our coverage rules associated with our outpatient Prescription Drug coverage.

What is Seniority Plus?

Now that you are enrolled in Seniority Plus, you are getting your Medicare benefits through Health Net. Seniority Plus is offered by Health Net, and is an HMO for people with Medicare. The Medicare program pays us to manage health services for people with Medicare who are Members of Seniority Plus. (Seniority Plus is not a Medicare supplement policy. See Appendix A for a definition of Medicare supplement policy. Medicare supplement policies are sometimes called “Medigap” insurance policies.) Health Net provides medical services through Medicare-certified health care facilities. In addition, our health care professionals are in compliance with Medicare credentialing standards.

This booklet explains your benefits and services, what you have to pay, and the rules you must follow to get your care. Seniority Plus gives you all of the usual Medicare benefits and services that Medicare covers for everyone.

Since Seniority Plus is a Medicare HMO, this means that you will be getting most or all of your health services from the doctors, Hospitals, and other health Providers that are part of Seniority Plus. These doctors, Hospitals, and other Providers are the ones we are paying to provide your care, so they are the ones you must use (except in special situations such as emergencies).

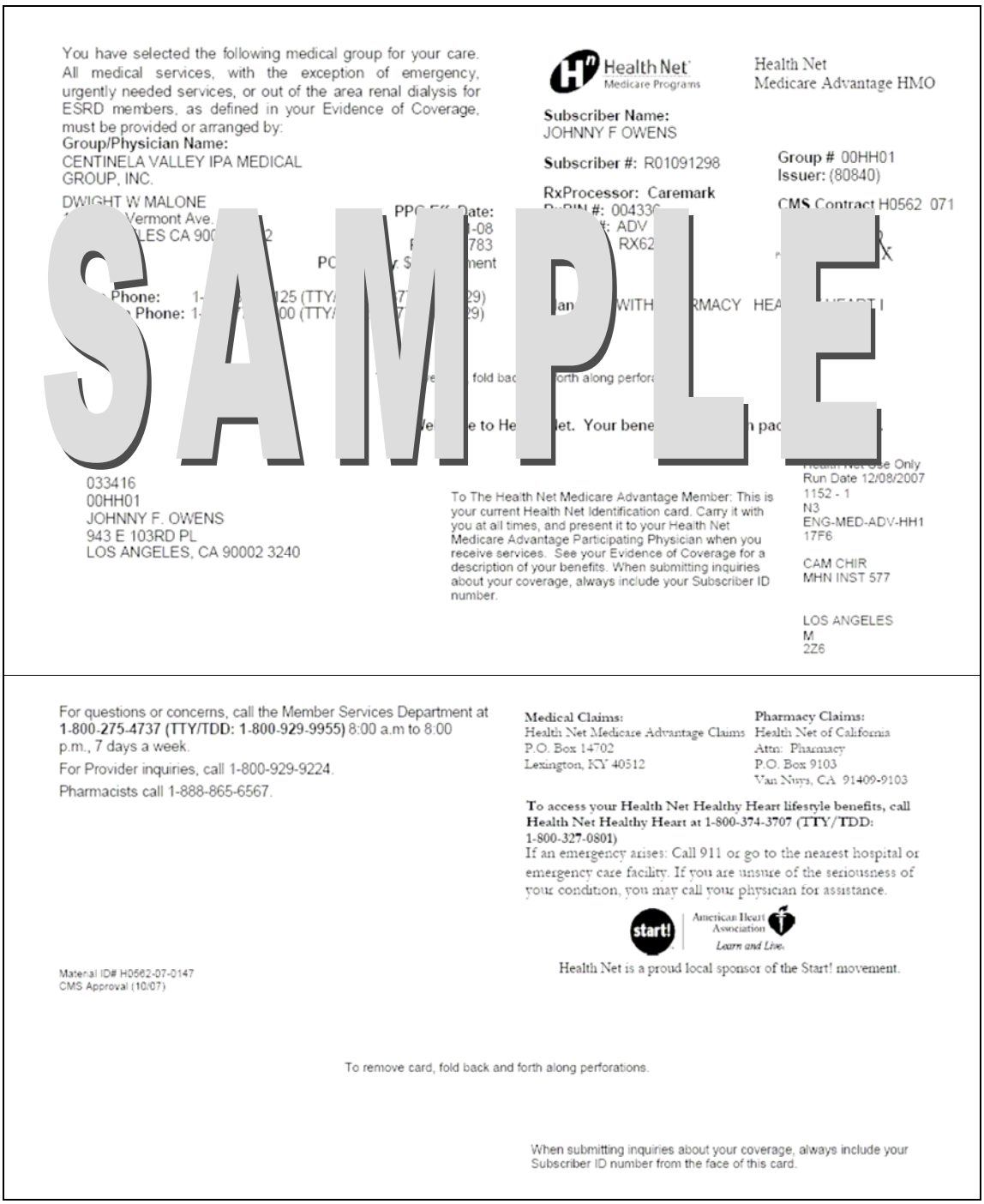
Who Is Eligible For Coverage

Coverage under 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;
  - Is presently, and will continue to be covered under Part A and/or Part B of Medicare; and
  - Is not enrolled in Medicare Part D through another Health Care Service Plan.
- Spouse, who must be listed on the enrollment form completed by the principal member and meets the same qualifications as the principal member. (The term "spouse" also includes the member’s Domestic Partner as defined.)

Using your membership card instead of your red, white, and blue Medicare card

Now that you are a Member of Seniority Plus, you have a Seniority Plus membership card. Here is a sample card to show what it looks like:



During the time you are a Plan Member and using plan services, **you *must* use your Plan membership card instead of your red, white, and blue Medicare card** to receive Covered Services. (See Section 3 for a definition and list of Covered Services.) Keep your red, white, and blue Medicare card in a safe place in case you need it later. If you get Covered Services using your red, white, and blue Medicare card instead of your Seniority Plus membership 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 Seniority Plus membership card with you at all times. You will need to show your card when you get Covered Services. You will also need it to get your prescriptions at the pharmacy. If your membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Help us keep your Member records up to date

Health Net has a file of information about you as a Plan Member. Doctors, Hospitals, pharmacists, and other Plan Providers 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 Seniority Plus coverage, the PCP you chose when you enrolled and other information. Below, we tell you how we protect the privacy of your personal health information.

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

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

The counties in our Service Area are listed below:

Alameda County

Contra Costa County

Kern County

Los Angeles County

Orange County

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

Riverside County

Sacramento County

San Bernardino County

San Diego County

San Francisco County

San Joaquin County

San Mateo County

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

Santa Clara County

Santa Cruz County

Solano County

Sonoma County

Stanislaus County

Yolo County

Your rights and responsibilities as a Member of Seniority Plus

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 Seniority Plus 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.

Your right to be treated with respect and fairness

You have the right to be treated with dignity, respect, and fairness at all times. Health Net 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 of Civil rights at **1-800-368-1019** or TTY/TDD **1-800-537-7697**, or, call the Office of Civil Rights in your area.

Your right to have 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 Plan Providers to make additions or corrections to your medical records (if you ask Plan Providers to do this, they 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 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. 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 Seniority Plus. 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 decision. See Sections 10 and Appendix B for more information about filing an Appeal.

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 that involve your Medicare health benefits under Seniority Plus are discussed in Sections 10 and Appendix B, Appeals and Grievances that involve the Seniority Plus drug benefits are discussed in Appendix E.

If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the Appeals and Grievances that Members have filed against Health Net in the past. To get this information, call Member Services at the phone number shown in Section 1.

Your right to see Plan Providers get Covered Services, and get your prescriptions filled within a reasonable period of time

As explained in this booklet, you will get most or all of your care from Plan Providers, that is, from doctors and other Providers who are part of Seniority Plus. You have the right to choose a Plan Provider (we will tell you which doctors are not accepting new patients). You have the right to go to a women's health Specialist (such as a gynecologist) without a Referral. You have the right to timely access to your Providers and to see Specialists when care from a Specialist is needed. You also have the right to timely access to your prescriptions at any Network Pharmacy. "Timely access" means that you can get appointments and services within a reasonable amount of time. Section 3 explains how to use Plan Providers to get the care and services you need. Section 4 explains your rights to get care for a Medical Emergency and Urgently Needed Care.

Your right to 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 Seniority Plus. This includes the right to know about the different Medication Management Treatment Programs we offer and which you may participate. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment, and be given the choice of refusing experimental treatments.

You have the right to receive a detailed explanation from us if you believe that a Plan Provider has denied care that you believe you are entitled to receive or care you believe you should continue to receive. In these cases, you must request an Initial Decision. "Initial decisions" are discussed in Sections 10 and Appendix B.

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. This includes the right to know about the different Medication Management Treatment Programs we offer and in which you may participate.

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 HICAP. Section 1 of this booklet tells how to contact HICAP. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it. It is important to sign this form and keep a copy at home. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well.

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

Remember, it is *your choice* whether you want to fill out an advance directive (including whether you want to sign one if you are in the Hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you have signed an advance directive, and you believe that a doctor or Hospital has not followed the instructions in it, you may file a complaint with the California Department of Health Services, P.O. Box 997413, M.S. 3200, Sacramento, California 95899-7413. The telephone number for the California Department of Health Services is **1-916-636-1980**

Your right to get information about Health Net, Seniority Plus, Plan Providers, your drug coverage, and costs

You have the right to get information from us about Health Net and Seniority Plus. This includes information about our financial condition, about our health care Providers and their qualifications, and about how Seniority Plus compares to other health plans. You have the right to find out from us how we pay our doctors. To get any of 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 and Part D. This includes information about our financial condition and about our Network Pharmacies. To get any of this information, call Member Service at the phone number listed in Section 1.

Involuntary Transfer to Another PCP or Contracting Physician Group

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

- Refusal to Follow Treatment: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you continually refuse to follow recommended treatment or established procedures of Health Net, the PCP, the contracting Physician Group.

- Health Net will offer you the opportunity to develop an acceptable relationship with another PCP at the contracting Physician Group, or at another contracting Physician Group, if available. A transfer to another Physician Group will be at Health Net's discretion.

- Disruptive or Threatening Behavior: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you repeatedly disrupt the operations of the Physician Group or Health Net to the extent that the normal operations of either the Physician's office, the contracting Physician Group or Health Net are adversely impacted.

- Abusive Behavior: You may be involuntarily transferred to an alternate Primary Care Physician or Physician Group if you exhibit behavior that is abusive or threatening in nature toward the health care provider, his or her staff, the contracting Physician Group or Health Net personnel.

- Inadequate Geographic Access to Care: You may be involuntarily transferred to an alternate Primary Care Physician or contracting Physician Group if it is determined that neither your residence nor place of work are within reasonable access to your Primary Care Physician.

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

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

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 HICAP (Section 1 tells how to contact HICAP). 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 of Civil Rights in your area at **1-415-437-8310** or TTY **1-415-437-8311**.
- 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 HICAP (Section 1 tells how to contact HICAP).

What are your responsibilities as a Member of Seniority Plus

Along with the rights you have as a Member of Seniority Plus, 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 question.
- 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 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 understand your health problems and to participate with your Provider to develop mutually agreed-upon treatment plans.
- To pay any applicable Plan Premiums and any Copayments you owe for Covered Services you get. You must also meet your other financial responsibilities that are described earlier in this section.
- 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 3. GETTING THE CARE YOU NEED

Using Plan Providers to get services covered by Seniority Plus

Now that you are a Member of Seniority Plus, with few exceptions, you must use Plan Providers to get your Covered Services.

- **What are "Plan Providers?"** "Providers" is the general term we use for doctors, Hospitals, other health care professionals, and other health care facilities that are licensed and/or certified by Medicare and by the state to provide health care services. We call them "Plan Providers" when they participate in Seniority Plus. When we say that Plan Providers "participate in Seniority Plus," this means that we have arranged with them to coordinate or provide Covered Services to Members of Seniority Plus.
- **What are "Covered Services?"** "Covered Services" is the general term we use in this booklet to mean all of the health care services and supplies that are covered by Seniority Plus. Covered Services are listed in the Benefits Chart in Section 5.

As we explain below, you will have to choose one of our Plan Providers to be your PCP, which stands for Primary Care Physician. Your PCP will provide or arrange for most or all of your Covered Services. Care or services you get from Non-Plan Providers will not be covered, with few exceptions such as emergencies. (When we say "Non-Plan Providers," we mean Providers that are not part of Seniority Plus.)

Rules about using non-plan providers to get your covered services

We list the providers that participate with our Plan in our provider directory. These providers are called network providers. Except in limited cases such as emergency care, urgently needed care when our network is not available, or out of service area dialysis, you must obtain covered services from network providers for the services to be covered. If you get non-emergency care from non-network providers without prior authorization, you must pay the entire cost yourself.

The Provider Directory gives you a list of Plan Providers

Every year as long as you are a Member of Seniority Plus, we will send you either a Provider Directory or an update to your Provider Directory, which gives you a list of Plan Providers. If you don't have the Provider Directory, you can get a copy from Member Services (see Section 1 for how to contact Member Services). You can ask Member Services for more information about Plan Providers, including their qualifications and experience. Member Services can give you the most up-to-date information about changes in Plan Providers and about which ones are accepting new patients.

Access to care and information from Plan Providers

You have the right to get timely access to Plan Providers and to all services covered by the Plan. ("Timely access" means that you can get appointments and services within a reasonable period of time.) You have the right to get full information from your doctors when you go for medical care. You have the right to participate fully in decisions about your health care, which includes the right to refuse care. Please see Section 2 for more information about these and other rights you have, and what you can do if you think your rights have not been respected.

Choosing your PCP (Primary Care Provider)

What is a "PCP?"

When you become a Member of Seniority Plus, you must choose a Plan Provider to be your PCP. Your PCP is a health care professional who meets state requirements and is trained to give you basic care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the Covered Services you get as a Plan Member. For example, in order to see a Specialist, you usually need to get your PCP's approval first (this is called getting a "Referral" to a Specialist). Example: Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as a member of our Plan. This includes:

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

"Coordinating" your services includes checking or consulting with other plan providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your PCP (such as giving you a referral to see a specialist). In some cases, your PCP will need to get prior authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Section 2 tells you how we will protect the privacy of your medical records and personal health information..

How do you choose a "PCP?"

When you enroll in Health Net Seniority Plus, you will select a contracting Medical Group from our network. You'll also choose a PCP from this contracting Medical Group, which you will need to indicate on your enrollment form and submit to Health Net. You can find a list of all contracting Medical Groups (and their affiliated PCP's and Hospital affiliations) from the Health Net Seniority Plus Medical Group directory. To confirm the availability of a Provider, or to ask about a specific PCP, please contact our Member Services Department at **1-800-539-4072** (or

use the Seniority Plus Telecommunication Device for the Deaf at **1-800-929-9955**). Business hours are 8:00 a.m. to 8:00 p.m., 7 days a week.

Once Health Net receives your enrollment form with the PCP you have chosen, we will send you a letter confirming your effective date of enrollment. A New Member Kit with your ID card reflecting your choice of PCP will also be sent.

If there is a particular Seniority Plus Specialist or Hospital that you want to use, check first to be sure your PCP makes Referrals to that Specialist, or uses that Hospital. The name and office telephone number of your PCP is printed on your membership card.

For information on how to change your PCP, please see the "How to change your PCP" portion of this section.

Getting care from your PCP

You will usually see your PCP first for most of your routine health care needs. As we explain below and in Section 5, there are only a few types of Covered Services you can get on your own, without contacting your PCP first.

Besides providing much of your care, your PCP will help arrange or coordinate the rest of the Covered Services you get as a Plan Member. This includes your x-rays, laboratory tests, therapies, care from doctors who are Specialists, Hospital admissions, and follow-up care. "Coordinating" your services includes checking or consulting with other Plan Providers about your care and how it is going. If you need certain types of Covered Services or supplies, your PCP must give approval in advance (such as giving you a Referral to see a Specialist). In some cases, your PCP will also need to get Prior Authorization (prior approval). Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your new PCP's office. Section 2 tells how we will protect the privacy of your medical records and personal health information.

What if you need medical care when your PCP's office is closed?

What to do if you have a Medical Emergency or urgent need for care

In an emergency, you should get care immediately. You do not have to contact your PCP or get permission in an emergency. You can dial **911** for immediate help by phone, or go directly to the nearest emergency room, Hospital, or urgent care center. Section 4 tells what to do if you have a Medical Emergency or urgent need for care.

What to do if it is not a Medical Emergency

If you need to talk with your PCP or get medical care when the PCP's office is closed, and it is not a Medical Emergency, call the "Physician Phone" number on your membership ID card. (TTY/TDD users should call the California Relay Service at **711** or **1-800-735-2929**). There will always be a physician on call to help you. This physician will call you back and tell you what to do. You can also call Health Net's Decision Power Health Coaches anytime, 24 hour a day, seven days a week. Health Net's Decision Power Health Coaches' phone number is **1-800-893-5597**, (TTY **1-800-276-3821**). There will always be a health professional on call to help you.

See Section 4 for more information about what to do if you have an urgent need for care.

Getting care from Specialists

When your PCP thinks you need specialized treatment, he or she will give you a Referral (approval in advance) to see a plan Specialist. A Specialist is a doctor who provides health care services for a specific disease or part of the body. Examples include oncologists (who care for patients with cancer), cardiologists (who care for patients with heart conditions), and orthopedists (who care for patients with certain bone, joint, or muscle conditions). For some types of Referrals to plan Specialists, your PCP may need to get approval in advance from the Medical Management Department (this is called getting "Prior Authorization").

- It is very important to get a Referral from your PCP before seeing a plan Specialist (there are a few exceptions, including routine women's health care that we explain later in this section). **If you don't have a Referral before you receive the services from a Specialist, you may have to pay for these services yourself**. If the Specialist wants you to come back for more care, check first to be sure that the Referral you got from your PCP covers more visits to the Specialist.
- If there are specific Specialists you want to use, find out whether your PCP sends patients to these Specialists. Each plan PCP has certain Specialists they use for Referrals. This means that **the Seniority Plus Specialists you can use may depend on which person you chose to be your PCP.** You can change your PCP at any time if you want to see a plan Specialist that your current PCP cannot refer you to. Later in this section, under "How to change your PCP," we tell you how to change your PCP. If there are specific Hospitals you want to use, find out whether your PCP uses these Hospitals.

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

As explained above, you will get most of your routine or basic care from your PCP, and your PCP will coordinate the rest of the Covered Services you get as a Plan Member. If you get services from any doctor, Hospital, or other health care Provider without getting a Referral in advance from your PCP, you may have to pay for these services yourself – even if you get the services from a Plan Provider. But there are a few exceptions: you can get the following services on your own, without a Referral or approval in advance from your PCP. This is called "**self-refer**" when you get these services on your own. You still have to pay your Copayment for these services.

- Routine women's health care which includes breast exams, mammograms (x-rays of the breast), pap tests and pelvic exams. This care is covered without a Referral from your PCP *only* if you get it from a Plan Provider.
- Flu shots and pneumonia vaccinations (as long as you get them from a Plan Provider).
- Emergency services, whether you get these services from Plan Providers or Non-Plan Providers (see Section 3 for more information).
- Urgently Needed Care that you get from Non-Plan Providers when you are temporarily outside the Plan's Service Area. Also, Urgently Needed Care that you get from Non-Plan Providers when you are in the Service Area but, because of unusual or extraordinary circumstances, the Plan Providers are temporarily unavailable or inaccessible. (See Section 4 for more information about Urgently Needed Care. Earlier in this section, we explain the Plan's Service Area.)
- Dialysis (kidney) services that you get when you are temporarily outside the Plan's service area. If possible, please let us know before you leave the Service Area where you are going to be so we can help arrange for you to have maintenance dialysis while outside the Service Area.

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

How to change your PCP (Primary Care Physician)

You may change your PCP for any reason if we receive your request for a transfer on or before the 15th day of the month, the transfer will occur on the first day of the following month. (Example: Request received March 12, transfer effective April 1.) If we receive your request for a transfer on or after the 16th day of the month, the transfer will occur on the first day of the second following month. (Example: Request received March 17, transfer effective May 1.) To change your PCP, call Member Services at the number shown in Section 1. When you call, be sure to tell Member Services if you are seeing Specialists or getting other Covered Services that needed your PCP's approval (such as home health services and Durable Medical Equipment). Member Services will help make sure that you can continue with the specialty care and other

services you have been getting when you change to a new PCP. They will check to be sure the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP, and will tell you when the change to your new PCP will go into effect. They will also send you a new membership card that shows the name and phone number of your new PCP.

What if your doctor leaves Seniority Plus?

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

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

If you need care when you are outside the Service Area, your coverage is limited. The only services we cover when you are outside our Service Area are care for a Medical Emergency, Urgently Needed Care, renal dialysis, and care that Health Net or a Plan Provider has approved in advance. See Section 4 for more information about care for a Medical Emergency and Urgently Needed Care. If you have questions about what medical care is covered when you travel, please call Member Services at the telephone number in Section 1. See Section 6 for more information about how to fill your outpatient prescriptions when you travel or are away from the Plan Service Area.

SECTION 4. GETTING CARE IF YOU HAVE AN 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 <u>not</u> need approval or a referral first from your PCP or other Plan Provider.** (See Section 3 tells about your PCP and Plan Providers.)

- Make sure that your Medical Group knows about your emergency, because your Medical Group will need to be involved in following up on your Emergency Care. You or someone else should call to tell your PCP about your Emergency Care as soon as possible, preferably within 48 hours. This number is located on your Health Net Seniority Plus ID card.

Your Medical Group will help manage and follow up on your Emergency Care

Health Net or your Medical Group will talk with the doctors who are giving you Emergency Care to help manage and follow up on your care. When the doctors who are giving you Emergency Care say that your condition is stable and the Medical Emergency is over, what happens next is called "post-stabilization care." Your follow-up care (post-stabilization care) will be covered according to Medicare guidelines. In general, your Medical Group will try to arrange for Plan Providers to take over your care as soon as your medical condition and the circumstances allow.

What is covered if you have a Medical Emergency?

- You can get covered emergency medical care whenever you need it, anywhere in the world. See Section 6 for more information on how we cover outpatient Prescription Drugs in an emergency situation while you are outside the Service Area.

- Ambulance services are covered in situations where other means of transportation in the United States would endanger your health. Generally, the Medicare ambulance benefit is a transportation benefit, and without a transport, there is no payable service.

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 this happens to you, you are still covered for the care you got to determine what was wrong (as long as you thought your health was in serious danger, as explained in "What is a 'Medical Emergency" above). However, please note that:

- If you get any additional care after the doctor says it was not a Medical Emergency, we will pay our portion of the covered additional care **only if you get it from a Plan Provider**.
- If you get any additional care from a Non-Plan Provider after the doctor says it was not a Medical Emergency, we will usually not cover the additional care. There is an exception: we will pay our portion of the covered additional care from a Non-Plan Provider if you are out of our Service Area, as long as the additional care you get meets the definition of "Urgently Needed Care" that is given below.

What is "Urgently Needed Care?" (This is different from a Medical Emergency)

"Urgently needed care" is when you need medical attention right away for an unforeseen illness, injury, and it is not reasonable given the situation for you to get medical care from your PCP or other Plan Providers. In these cases, your health is *not* in serious danger. As we explain below, how you get "Urgently Needed Care" depends on whether you need it when you are in the Plan's Service Area, or outside the Plan's Service Area. Section 3 tells about the Plan's Service Area.

What is the difference between a "Medical Emergency" and "Urgently Needed Care?"

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

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

Seniority Plus covers Urgently Needed Care that you get from Non-Plan Providers when you are outside the Plan's Service Area. If you need urgent care while you are outside the Plan's Service Area, we prefer that you call your PCP first, whenever possible. If you are treated for an urgent care condition while out of the Service Area, we prefer that you return to the Service Area to get follow-up care through your PCP. However, we will cover follow-up care that you get from Non-Plan Providers outside the Plan's Service Area as long as the care you are getting still meets the definition of "Urgently Needed Care."

We cover renal (kidney) dialysis services that you get when you are temporarily outside the Plan's Service Area. See Section 6 for more information on filling your Prescription Drugs when you are getting Urgently Needed Care and when you are outside the Plans Service Area.

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

If you have a sudden illness or injury that is not a Medical Emergency, and you are in the Plan's Service Area, please call "Physician Phone" number on your membership card. (TTY/TDD users should call the California Relay Service at **711** or **1-800-735-2929**.) There will always be a physician on call to help you. This physician will call you back and tell you what to do. You can also call Health Net's Decision Power Health Coaches anytime, 24 hours a day, seven days a week. Health Net's Decision Power Health Coaches' phone number is **1-800-893-5597**, (TTY **1-800-276-3821**).

Keep in mind that if you have an urgent need for care while you are in the Plan's Service Area, we expect you to get this care from Plan Providers. In most cases, we will not pay for Urgently Needed Care that you get from a Non-Plan Provider while you are in the Plan's Service Area.

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

What are "Covered Services?"

This section describes the medical benefits and coverage you get as a Member of Health Net. **Covered Services** means the medical care, services, supplies and equipment that are covered by Seniority Plus. This section has a Benefits Chart that gives a list of your Covered Services and tells what you must pay for each covered service. Section 8 tells about **services that are *not* covered** (these are called "Exclusions"). Section 8 also tells about **limitations** on certain services.

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 "Schedule of Medical Benefits" in this section are covered only when *all* requirements listed below are met:

- Except for Employer-Sponsored benefits, services must be provided according to the Medicare coverage guidelines established by the Medicare program.
- The medical care, services, supplies, and equipment that are listed as Covered Services must be Medically Necessary. Certain preventive care and screening tests are also covered. (See Appendix A for a definition of "Medically Necessary.")
- With few exceptions, Covered Services must be provided by Plan Providers, be approved in advance by Plan Providers, or be authorized by Health Net. The exceptions are care for a Medical Emergency, Urgently Needed Care outside the Service Area, and renal (kidney) dialysis you get when you are outside the Plan's Service Area.

In addition, some covered services require "prior authorization" by the Plan in order to be covered. Some of the covered services listed in the Benefits Chart in this section are covered only if your doctor or other plan provider gets "prior authorization" (approval in advance) from our Plan. Covered services that need prior authorization (approval ahead of time) are marked in the Benefits Chart with an asterisk ("*").

Your Schedule of Medical Benefits

Covered Services	What You Pay for Covered Services
INPATIENT SERVICES	
Inpatient Hospital Care* - *For more information, see Section 7.* 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; • Rehabilitation services, such as physical or 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 7 for more information about transplants; • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used; and • Physician Services.	You pay a $250 Copayment for the Medicare-covered service(s) listed. 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.

Covered Services	What You Pay for 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 for services in a network Hospital. Hospital Copayments are required for the first three admissions in each calendar year for covered services. Once the requirement is met, no Copayment is required for further admissions in the same calendar-year.

Covered Services	What You Pay for Covered Services
Inpatient Substance Abuse Care* • Residential care in a Hospital or substance abuse facility	You pay a $250 Copayment for services in a network Hospital. Hospital Copayment are required for the first three admissions per Calendar Year. Once the Copayment is met, no Copayment is required for further admissions in the same Calendar Year.
Inpatient Services (when the inpatient stay itself is not or is no longer covered)*: *For more information, please see Section 7.* • Physician services; • Diagnostic tests (like X-ray or lab tests); • X-ray, radium, and isotope therapy including technician materials and services; • Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations; • Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices; • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition; • Physical therapy, speech therapy, and occupational therapy.	There is no Copayment for the Medicare-covered service(s) listed.

Covered Services	What You Pay for Covered Services
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.
Skilled Nursing Facility Care* *For more information, please see Section 7.* *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, occupational 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 begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used • Medical and surgical supplies; • 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. No Hospital stay is required.
Home Health Care* *For more information, please see Section 7.* **Home Health Agency Care:** • Part-time or intermittent skilled nursing and home health aide services; • Physical therapy, occupational therapy and speech therapy; • Medical social services; • Medical equipment and supplies.	There is no Copayment for Medicare-covered home health visits.

Covered Services	What You Pay for Covered Services
Hospice Care *For more information, please see Section 7.* • Drugs for symptom control and pain relief, short-term respite care, and services not otherwise covered by Medicare; • Home care; • Hospice consultation services (one time only) for a terminally ill individual who has not yet elected the Hospice benefit.	When you enroll in a Medicare-certified Hospice, your hospice services are paid by Medicare.

Covered Services	What You Pay for Covered 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;	You pay $15 for each primary care doctor Office Visit for Medicare-covered services.
• Physician visit to Member's home (at discretion of the Physician in accordance with the rules and criteria established by Health Net).	You pay $15 for each Physician visit to your home.
**The following require prior authorization (approval in advance) to be covered, except in an emergency* • Consultation, diagnosis and treatment by a Specialist;	You pay $15 for each Specialist visit for Medicare-covered services.
• Consultation, diagnosis and treatment by a Specialist; • Second opinion by another Plan Provider prior to surgery; • Outpatient Hospital services; • Non-routine-dental care (Covered Services is limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of the teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor).	
Chiropractic Services*	
• Manual manipulation of the spine to correct subluxation (Medicare-covered). • Routine Chiropractic care (non Medicare-covered).	You pay $15 for each Medicare-covered visit (manual manipulation of the spine to correct subluxation). Medicare-covered chiropractic services require Prior Authorization based on medical necessity and must conform to the PCP's treatment plan. You pay $15 per visit when using our Chiropractic Network (20 visits per Calendar Year).

Covered Services	What You Pay for Covered Services
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 (Medically Necessary foot care). You pay $15 for each routine (non Medicare-covered) visit. Care is limited to one visit per calendar month. Additional visits or Referrals must be arranged and approved by your PCP.
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 Copayment are required for the first three admissions per Calendar Year. Once the Copayment is met, no Copayment is required for further admissions in the same Calendar Year.

Covered Services	What You Pay for Covered Services
Outpatient Substance Abuse Services* *For more information, please see Section 7.*	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). **(Behavioral Health Care Telephonic clinical consultation services are provided by a licensed counselor - 1-800-663-9355.)**	There is no Copayment for Telephonic clinical consultations
Outpatient Surgery*	There is no Copayment for Medicare-covered visits to an ambulatory surgical center. There is no Copayment for Medicare-covered visits to an outpatient Hospital facility.

Covered Services	What You Pay for Covered Services
Outpatient Transgender Surgery/Services** (including hysterectomy, oophorectomy and mastectomy) • Travel, lodging and meals included. The transgender surgery must be performed by a Health Net qualified provider in conjunction with gender transformation treatment. The treatment plan must conform to Harry Benjamin International Gender Dysphoria Association (HBIGDA) standards. Psychotherapy and hormonal treatment are excluded from the lifetime maximum.	There is no Copayment for transgender surgery Transgender surgery and related services (including travel, lodging and meal expenses) approved by the plan are subject to a combined inpatient and outpatient lifetime benefit maximum of $75,000 for each Member.
Ambulance Services 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. Health Net coverage for ambulance transportation is the same as Original Medicare. Generally, the Medicare ambulance benefit is a transportation benefit, and without a transport, there is no payable service.	There is no Copayment for Medicare-covered ambulance services.
Emergency Services *For more information, please see Section 4.* Mariana Islands, and American Samoa. • Coverage in the United States* * United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern World Wide Coverage	You pay $50 for each Medicare-covered emergency room visit; you do not pay this amount if you are directly admitted to the Hospital. There is no Copayment for World Wide Coverage.

Covered Services	What You Pay for Covered Services
Urgently needed services *For more information, please see Section 4.* • Coverage in the United States* ** United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.*	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. If you receive care from an urgent care center owned and operated by your Physician Group, the urgent care Copayment will not apply. However, a visit to one of its facilities will be considered an office visit, and any Copayment required for office visits will apply. There is no Copayment for World Wide Coverage.
World Wide Coverage	
Outpatient Rehabilitation Services (physical and 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 Medicare-covered outpatient rehabilitation service visits.
Durable Medical Equipment and Related Supplies* – Such as wheelchairs, crutches, Hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker. (See definition of "Durable Medical Equipment" in Appendix A)	There is no Copayment for Medicare-covered items.

Covered Services	What You Pay for Covered Services
Prosthetic devices and relates supplies*- which replace a body part or function. These include colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair/or replacement of prosthetic devices.	There is no Copayment for Medicare-covered items.
One pair of Eyeglasses or Contact Lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective Lenses/frames (and replacements) needed after a cataract removal without a lens implant.	There is no Copayment for Medicare-covered eyewear (one pair of Eyeglasses or Contact Lenses after each cataract surgery).
Diabetes self-monitoring, training and supplies*	
For all people who have diabetes (insulin and non-insulin users) • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose control solutions for checking the accuracy of test strips and monitors;	There is no Copayment for Diabetes supplies.
• One pair per Calendar Year of therapeutic shoes for people with diabetes who have severe diabetic foot disease, including fitting of shoes or inserts;	There is no Copayment for therapeutic shoes for people with diabetes who have severe diabetic foot disease.
Self-management training is covered under certain conditions.	There is no Copayment for Diabetes self-monitoring training.
For persons at risk of diabetes: Fasting plasma glucose tests. Please call the Member Services Department at the number shown in Section 1 for information on how often we will cover these tests.	There is no Copayment for fasting plasma glucose tests for persons at risk of diabetes.
Allergy testing	You pay $15 copayment for each Medicare-covered allergy testing service.
Allergy desensitizing serum	There is no copayment for each Medicare-covered service.

Covered Services	What You Pay for Covered Services
Medical nutrition therapy - for people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.	You pay $15 for each Medicare-covered medical nutrition therapy visit.
Allergy Testing	You pay $15 for each Medicare covered allergy testing service.
Allergy Serum	There is no Copayment for the Medicare-covered allergy serum service
Outpatient diagnostic tests and therapeutic services and supplies* • X-rays. • Radiation therapy. • Complex diagnostic radiology (PET Scan, CT Scan, MRI) • Surgical supplies, such as dressings. • Supplies, such as splints and casts. • Laboratory tests. Blood - Coverage begins with the first pint of blood that you need. Coverage of storage and administration begins with the first pint of blood that you need.	There is no Copayment for the Medicare-covered service(s) listed.
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 Medicare-covered bone mass measurements.

Covered Services	What You Pay for Covered Services
Colorectal screening * *For people 50 and older, the following are covered:* • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • Fecal occult blood test, every 12 months. *For people at high risk of colorectal cancer, the following are covered:* • Screening colonoscopy (or screening barium enema as an alternative) every 24 months. *For people not at high risk 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.

Covered Services	What You Pay for Covered Services
Preventive Care Services	
Mammography Screening: (As explained in Section 3, you can get this service on your own, without a Referral from your PCP as long as you get it from a Plan Provider): • One screening for women age 40 and over every 12 months. • One baseline exam for women age 35 to 39 years of age.	There is no Copayment for Medicare-covered Screening Mammograms.
Pap tests, pelvic exams, and clinical breast exam (As explained in Section 3, you can get these routine women's health services on your own, without a Referral from your PCP as long as you get the services from an OB/GYN Specialist who is part of your contracting Medical Group): • For all woman, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months; • If you are at high risk of cervical cancer or have had abnormal Pap tests and are of childbearing age – one Pap test every 12 months.	There is no Copayment for Medicare-covered Pap Tests and Pelvic Exams.
Prostate cancer screening* *For men over age 50, 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.

Covered Services	What You Pay for Covered Services
Preventive care services (continued)	
Immunizations: • Pneumonia vaccine (as explained in Section 3, you can get this service on your own, without a Referral from your PCP as long as you get the service from a Plan Provider.); • Flu shots, once a year in the fall or winter. As explained in Section 3, you can get this service on your own, without a Referral from your PCP (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.	There is no Copayment for the pneumonia vaccine. There is no Copayment for the flu vaccine. There is no Copayment for the Hepatitis B vaccine. You may self refer for mammography screening, cervical cancer screening tests, flu shots and pneumococcal shots.
Cardiovascular disease testing*	
Blood tests for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). Please call the Member Services Department at the phone number shown in Section 1 for information on how often we will cover these tests.	There is no Copayment for Medicare-covered cardiovascular screening blood tests.
Physical exam*	
Welcome to Medicare physical exam • Routine annual physical exam.	There is no Copayment for Medicare-covered exam.

Covered Services	What You Pay for Covered Services
Other Services	
Renal Dialysis (Kidney) • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the Service Area, as explained in Sections 3 and 4); • Inpatient dialysis treatments (if you are admitted to a Hospital for special care); • Self-dialysis training (includes training for you and for the person helping you with your home dialysis treatments); • Home dialysis equipment and supplies; Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies when needed, and check your dialysis equipment and water supply).	There is no Copayment for Medicare-covered Renal Dialysis(kidney) services. There is no Copayment for Medicare-covered home dialysis services.

Covered Services	What You Pay for Covered Services
Prescription Drugs *For more information, see Section 6.* That are covered under Original Medicare (these Part B drugs are covered for everyone with Medicare) *Your Provider must get Prior Authorization from Health Net Seniority Plus for certain Prescription Drugs. Contact plan for details.* *Part B Drugs* "Drugs" includes substances that are naturally present in the body, such as blood clotting factors. • Drugs that are usually not self-administered by the patient and are injected while receiving physician services; • Drugs you take using durable medical equipment (such as nebulizers) that was authorized by Health Net; • Clotting factors you give yourself by injection if you have hemophilia; • Immunosuppressive if you have had an organ transplant that was covered by Medicare; • Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug; • Antigens; • Certain oral anti-cancer drugs and anti-nausea drugs; • Certain drugs for home dialysis, including heparin, the antidote for heparin when Medically Necessary, topical anesthetics, 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 coinsurances for Medicare-covered Drugs and Biologicals listed except for the Immunosuppressive drugs, certain oral anti-cancer drugs and anti-nausea drugs and injectable drugs for the treatment of osteoporosis for the home-bound who cannot self-administer and drugs used with Durable Medical Equipment: The applicable Brand Name, Generic, or Specialty Drug Copayment applies for Part B Drugs. There is no Copayment for injections or injectable substances obtained at a physician's office. Injections or injectable substances obtained through a retail pharmacy are subject to the applicable Specialty Tier I or S Coinsurance. **One-month (30-day) supply of Part D Drugs purchased at local pharmacies:** - $10 Copayment – Tier 1 - $20 Copayment – Tier 2 - $35 Copayment – Tier 3 - 25% Coinsurance - drugs on Specialty Tier I or S - 50% Coinsurance – Sexual Dysfunction drugs

Covered Services	What You Pay for Covered Services
Prescription Drugs (continued) Prescription drugs (Part D Drugs) that are covered if you are enrolled in Seniority Plus because you have enrolled for Medicare Prescription Drug coverage. Section 6 explains about the Prescription Drug benefit, including rules you must follow to have prescriptions covered. Section 6 also tells about drugs that are not covered by this benefit.	**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 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. After your yearly out-of-pocket drug costs 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.

Covered Services	What You Pay for Covered Services
Dental services Medicare-covered dental 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 disease, or services that would be covered when provided by a doctor.	In general, you pay 100% for dental services.
Hearing services* • Diagnostic hearing exams. • Routine 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. 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.

Covered Services	What You Pay for Covered Services
Vision care*	
• Outpatient physician services for eye care; • *For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older:* Glaucoma screening once per year; • Routine vision exams.	You pay $15 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye). Vision screenings, provided as part of a periodic health evaluation, are covered at no charge.
Eyeglasses or Contact Lenses after cataract surgery are covered under Prosthetic devices and related supplies. See "Prosthetic devices and related supplies" in this section for details	You pay $15 for each Routine eye exam, limited to 1 exam(s) every year. You pay no copayment for Medicare-covered eye wear (one pair of eyeglasses or contact lenses after each cataract surgery). Lenses are covered (in full or subject to an eyewear allowance) $100 allowance for frames every 2 years. No Referral necessary for eyewear for any Network Providers.
Periodic Health Evaluations	There is no Copayment.

Covered Services	What You Pay for 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 of California for details. No Referral necessary for Network Providers.
Health Promotion Programs* Programs designed to enrich the health and lifestyles of Members include weight management, smoking cessation, fitness & stress management.	There is no Copayment.

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

SECTION 6. USING YOUR COVERAGE FOR PRESCRIPTION MEDICINES

This section describes your outpatient Prescription Drug coverage you get as a Member of our Plan. There are some special rules that apply to your outpatient Prescription Drug coverage. This section contains:

- What a Formulary is and how to use it.
- Drug Management Programs.
- How much you will pay when you fill a prescription for a covered drug.
- What an Explanation of Benefits is and how to get additional copies.
- If you have limited income and resources, you may be able to get extra help from Medicare to pay your Medicare drug plan costs so that you get your outpatient Prescription Drugs for little or no cost.

Using plan pharmacies to get your outpatient Prescription Drugs covered by us

What are Network Pharmacies?

With few exceptions, **you must use Network Pharmacies to get your outpatient Prescription Drugs covered.**

- **What is a "Network Pharmacy?"** A Network Pharmacy is a pharmacy where you can get your outpatient Prescription Drug through your Prescription Drug coverage. 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.
- **What are "Covered Drugs?"** "Covered Drugs" is the general term we use to mean all of the outpatient Prescription Drugs that are covered by our Plan. Covered Drugs are listed in the Formulary.

How do I fill a prescription at a Network Pharmacy?

To fill your prescription, you must show your Plan membership card at one of our Network Pharmacies. If you do not have your membership card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your Copayment). 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.

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.

The Pharmacy Directory gives you a list of Plan Network Pharmacies.

As a Member of our Plan you will get a Pharmacy Directory, which gives you a list of our Network Pharmacies. You can use it to find a 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 website.

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 the 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.

When you order Prescription Drugs through our network mail-order pharmacy service, you must order at least a 60-day supply, and no more than a 90-day supply of the drug.

Generally, it takes us 14-days to process your order and ship it to you. However, sometimes your mail order may be delayed. To get a prescription if the mail order is delayed, please contact Express Script at **1-866-265-9455**, TTY/TDD **1-800-972-4348**.

You are not required to use our mail order services to get an extended supply of maintenance medications. You can also obtain an extended supply through some retail Network Pharmacies. Retail pharmacies may provide an extended supply, but charge a higher Copayment than our mail order service. Please call our Member Services Department, or look in your Pharmacy Directory, to find out which retail pharmacies offer an extended supply.

UC members can also obtain their mail order prescriptions at a designated UC Medical Center pharmacy. To locate a UC Medical Center pharmacy, a listing is provided on the HR/Benefits website or contact Health Net customer service.

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 a prescription at an out-of-Network Pharmacy, please call Member Services to see if there is a Network Pharmacy available.**

What if I need a prescription because of a Medical Emergency?

We will cover prescriptions that are filled at an out-of-Network Pharmacy if the prescriptions are related to care for a Medical Emergency or Urgently Needed Care. In this situation, you will have to pay the full cost (rather than paying just your Copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim form. To learn how to submit a paper claim, please refer to the paper claims process described below.

Getting coverage when you travel or are away from the Plan's Service Area

If you take a Prescription Drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your Prescription Drugs ahead of time through our network mail order pharmacy service or through a retail Network Pharmacy that offers an extended supply.

If you are traveling within the US, but outside of the Plan's Service Area, and you become ill, lose or run out of your Prescription Drugs, we will cover prescriptions that are filled at an out-of-Network Pharmacy if you follow all other coverage rules identified within this document and a Network Pharmacy is not available. In this situation, you will have to pay the full cost (rather than paying just your Copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. To learn how to submit a paper claim, please refer to the paper claims process described below.

Prior to filling your prescription at an out-of-Network Pharmacy, call our Member Services Department to find out if there is a Network Pharmacy in the area where you are traveling. If there are no network pharmacies in that area, our Member Services Department may be able to make arrangements for you to get your prescriptions from an out-of-Network Pharmacy.

We cannot pay for any prescriptions that are filled by pharmacies outside the United States, even for a Medical Emergency.

Other times you can get your prescription covered if you go to an out-of-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 covered Prescription Drug that is not regularly stocked at an eligible network retail or mail order pharmacy (these drugs include orphan drugs or other specialty pharmaceuticals).

Before you fill your prescription in either of 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 above, you will have to pay the full cost (rather than paying just your Copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. To learn how to submit a paper claim, please refer to the paper claims process described next.

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:

- Send us a letter or complete a claim form. If you need a claim form, call Member Services. You may also print a claim form from our website at www.healthnet.com/uc.

  Attach your prescription receipt(s) to the claim form or letter. You must attach the actual prescription receipt, which includes required information about the dispensing pharmacy and the Prescription Drug you purchased. If you do not have the actual prescription receipt, a duplicate may be obtained from the dispensing pharmacy. Cash register receipts cannot be used when submitting a claim.

- Mail the completed claim form or letter and actual prescription receipt(s) to:

  Health Net of California
  Attn: Pharmacy
  P.O. Box 9103
  Van Nuys, CA 91409-9103

We will mail you notification of our determination on your claim within 72 hours of receipt of your claim.

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

Specialty pharmacies

Home infusion pharmacies

Plan will cover home infusion therapy if:

- Your Prescription Drug is on our Plan's Formulary,
- You have followed all required coverage rules and our Plan has approved your prescription for home infusion therapy,
- Your prescription is written by a doctor, and
- You get your home infusion services from a Plan Network Pharmacy.

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

Long-term care pharmacies

Residents of a long-term care facility may get their Prescription Drugs through a long-term care pharmacy in the plan's network of long-term care pharmacies. In some cases this will be the long-term care pharmacy that contracts directly with the long-term care facility. If it is not, or for more information, please contact Member Services.

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

Native Americans and Alaska Natives have access to Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies through Plan's pharmacy network.

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

What drugs are covered by this Plan?

What is a Formulary?

A Formulary is a list of all the drugs we cover. We have a Formulary that lists all drugs that we cover. We will generally cover the drugs listed in our Formulary as long as the drug is Medically Necessary, the prescription is filled at a Network Pharmacy or through our network mail order pharmacy service and other coverage rules are followed. For certain Prescription Drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described in Section 8. As a person with Medicare you are also entitled to coverage of those

drugs that are covered under Medicare Part A and B (How does your enrollment in Seniority Plus affect coverage for the drugs covered under Medicare Part A or Part B?)

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 **F**ood and **D**rug **A**dministration (FDA) to be as safe and as effective as Brand Name Drugs.

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

In certain situations, prescriptions filled at an out-of-Network Pharmacy may also be covered.

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 website.

What are drug tiers?

Drugs on our Formulary are organized into different drug tiers, or groups of different drug types. Your Coinsurance/Copayment depends on which drug tier your drugs are in. The table below shows the Coinsurance/Copayment amount you pay for each tier when you are in your initial coverage level. (See "How much do you pay for drugs covered by this Plan?" later in this section for more information about the initial coverage level.)

You can ask us to make an exception to your drug's tier placement. See "How Do I Request an Exception to the Formulary?" described 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, 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, you will get 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.

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 for us to cover your drug. See the section, "How do you request an exception to the Plan's Formulary?" below for more information.
- You can pay out-of-pocket for the drug and request that the plan reimburse you by requesting an exception (which is a type of coverage determination). This does not obligate the plan to reimburse you if the exception request is not approved. If the exception is not approved, you may appeal the plan's denial. See Appendix E for more information on how to request an Appeal.

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 60 day supply (unless the prescription is written for fewer days) when the new member goes to a network pharmacy (and the drug is otherwise a "Part D drug"). After the temporary 60 day supply, we generally will not pay for these drugs as part of our transition policy again. 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 can not 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

The following Exclusions and limitations apply to any category or type of drugs described throughout this Evidence of Coverage:

Medications on the Formulary that are specifically excluded by Medicare will not count towards your yearly out-of-pocket costs. In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for these drugs. These include some prescription medications in the following categories:

- Prescription vitamins and mineral products, except as listed in the Formulary.
- 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.
- Drugs (including injectable medications) when Medically Necessary for treating sexual dysfunction are limited to two doses per week or eight tablets per month. Sexual Dysfunction drugs are not available through the mail order program.
- Smoking cessation drugs are covered up to a 12-week course of therapy per calendar year if you are currently enrolled in a comprehensive smoking cessation program. Prior authorization from Health Net is required.

By law, certain types of drugs or categories of drugs are not covered by Medicare Prescription Drug Plans. These drugs are not considered Part D drugs and may be referred to as "exclusions" or "non-Part D drugs." These drugs include:

Nonprescription drugs	Drugs when used for anorexia, weight loss, or weight gain
Drugs when used to promote fertility	Drugs when used for cosmetic purposes or hair growth
Drugs when used for the symptomatic relief of cough or colds	Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale	Barbiturates and Benzodiazepines

In addition, a Prescription Drug Plan cannot cover a drug that is 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.

For more information please refer to your Schedule of Benefits 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 these requirements and limits for our Plan to help us to provide quality coverage to our Members. Examples of utilization management tools are described below:

- **Prior Authorization:** We require you to get Prior Authorization for certain drugs. This means that you or your doctor will need to get approval from us before you fill your prescription. If they don't get approval, we may not cover the drug.
- **Quantity Limits:** For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. For example, we will provide up to 6 tablets per prescription for ZITHROMAX.
- **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. If you choose to fill your prescription with a Brand Name Drug when a generic equivalent is available, you may be responsible for a higher Copayment and/or the difference in cost between the brand and generic medications.
- **Age Limits:** Some drugs may require Prior Authorization if your age does not meet manufacturer, Food and Drug Administration, or clinical recommendations.
- **Gender Limit:** Some drugs are only covered for males or females based on manufacturer, Food and Drug Administration, or clinical recommendations.
- **Therapy Limit:** Some drugs are only covered for a specific length of time based on manufacturer, Food and Drug Administration, or clinical recommendations.

You can find out if your drug is subject to these additional requirements or limits by looking in the Formulary. If your drug does have these additional restrictions or limits, you can ask us to make an exception to our coverage rules. See the section, "How do I request an exception to the Formulary?" described above for more information.

Drug utilization review

We conduct drug utilization reviews for all of our Members to make sure that they are getting safe and appropriate care. These reviews are especially important for Members who have more than one doctor who 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:

- Incorrect medication.
- 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.
- Inaccurate drug dosage.

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

Medication therapy management programs

We offer medication therapy management programs at no additional cost for Members who have multiple medical conditions, who are taking many Prescription Drugs, or who have high drug costs. These programs were developed for us by a team of pharmacists and doctors. We use these medication therapy management programs to help us provide better coverage for our Members. For example, these programs help us make sure that our Members are using appropriate drugs to treat their medical conditions and help us identify incorrect medication.

We offer several medication therapy management program(s) for Members that meet specific criteria. We may contact Members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you do not need to pay anything extra to participate.

If you are selected to join a medication therapy management program we will send you information about the specific program, including information about how to get the program.

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

As a person with Medicare, you are entitled to coverage of those drugs that are covered under Medicare Parts A and B, and the drugs that are covered in your Medicare drug plan.

Your enrollment in Seniority Plus does not affect Medicare coverage for drugs. You are entitled to all Medically Necessary A and B services including drugs that are covered under A and B. In addition, Seniority Plus also covers your Part D benefit.

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

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

We cover vaccines that are Medically Necessary but are not already covered by Medicare Part B. In addition we cover some drugs that may be administered in your doctor's office. ("How does your enrollment in Plan affect coverage for drugs covered under Medicare Part A or Part B?" for more information.)

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

If you qualify for extra help with your Medicare Prescription Drug coverage your costs for your drugs may be different than those described below. See "Extra Help with Drug Plan Costs for People with Limited Income and Resources" late in this section and the "Low Income Subsidy Rider" for those who get extra help paying for their Prescription Drugs."

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 level, 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. Your drug costs for each coverage level are described below.

Deductible

You, or others on your behalf, will pay a yearly deductible of $0. This is the amount that must be paid each year before we will begin paying for part of your drug costs. After you meet the deductible of $0, you will reach the initial coverage level.

Initial Coverage Level

During the **initial coverage level**, we will pay part of the costs for your covered drugs and you (or others on your behalf) will pay the other part. The amount you pay when you fill a covered prescription is called the Coinsurance/Copayment. Your Coinsurance/Copayment will vary depending on the drug.

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

***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:

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.

Plan Specific Out-of-Pocket Maximum for Outpatient Prescription drugs

Once you have spent $2,000, excluding any generic substitution costs (the difference in cost between a brand name and generic drug), your copayment/coinsurance will be waived for the remainder of the year. All expenses that apply to the $2000 out-of-pocket maximum will automatically be calculated by Health Net. Generic substitution costs for Part D drugs will apply towards the $4,050 Medicare Catastrophic Coverage limit, stated below.

Catastrophic Coverage

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 on Medicare Covered Drugs. When the total amount you have paid in Copayments/Coinsurance, and the cost for covered Part D Drugs after you reach the $4,050, you will qualify for catastrophic coverage. During catastrophic coverage a copayment/coinsurance will not apply.

- The greater of $2.25 for generics or preferred brand that is a multi-source drug; 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 total out of pocket costs (that is, the amount you pay does not help you qualify for catastrophic coverage).

Vaccines (including administration)

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

Note that in some cases, you will be receiving the vaccine from someone who is not part of our pharmacy network and that you may have to pay for the entire cost of the vaccine and its administration in advance. You will need to mail us the receipts, and then you will be reimbursed. Actual vaccine costs will vary by vaccine type and by whether your vaccine is administered by a pharmacist or by another provider.

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

How is your Out-of-Pocket Maximum for Outpatient Prescription 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 Seniority Plus.

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:

- Your Coinsurance or Copayments made on drugs that are normally covered in a Medicare Prescription Drug Plan that are:
  - Covered by the Plan during the initial coverage level.
  - Not on Seniority Plus's Formulary, but were determined to count towards your out-of-pocket costs through the Coverage Determination, exceptions, or Appeals process; and
  - Filled at an out-of-Network Pharmacy in accordance with our out-of-network access rules.
- Any payments you make for Prescription Drugs after the initial coverage limit that would otherwise be covered by the Plan.

When you have spent a total of $4,050 for these items, you will reach the catastrophic coverage level.

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

- Prescription drugs purchased outside the United States and its territories.
- Prescription drugs not covered by the Plan.
- Certain prescription drugs covered by us but not normally covered in a Medicare Prescription Drug Plan.

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

Except for your premium payments, any payments you make for covered Part D Drugs 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 Prescription Drug costs, 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); – the Genetically Handicapped Persons Program;
- 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; and
- Third party arrangements that obligate the third party to pay for prescription costs (e.g., TRICARE, Workers Compensation).

If you have coverage from a third party that pays part (or all) of your out-of-pocket costs, you must disclose this information to us. An example of third party coverage would be an employer-sponsored health plan that offers Prescription Drug 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 Seniority Plus. 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.

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of prescriptions you get during the month, as well as the amount paid for each prescription.
- Information about how to request an exception and Appeal our coverage decisions.
- A description of changes to the Formulary that will occur at least 60 days in the future.
- A summary of your coverage this year, including information about:

  - **Amount Paid For Prescriptions** - the amounts paid by the Plan.

  - **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 your qualifying for catastrophic coverage. This total includes the amounts spent for your Copayments and Coinsurance. (This amount does not include payments made by your current or former employer/union, another insurance plan or policy or other excluded parties.)

When will you get an Explanation of Benefits?

You will get an Explanation of Benefits in the mail each month that you use the coverage provided by us.

What should you do if you haven't received an Explanation of Benefits or if you wish to request one?

An Explanation of Benefits is also available upon request. To obtain 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, Seniority Plus will provide your Prescription Drugs under your medical benefit. Once you are released from the Hospital, we will provide your Prescription Drugs under your outpatient drug benefit.

If you are admitted to a Skilled Nursing Facility for a Medicare-covered stay, we will arrange for any Medically Necessary Part A Prescription Drugs for the first 100 days that you are in the facility. After the first 100 days, we will cover your prescriptions as long as the Skilled Nursing Facility's pharmacy is in our pharmacy network. Once you enter a Skilled Nursing Facility you are entitled to a Special Enrollment Period, during which time you will be able to leave this Plan and select another Medicare Advantage plan or original Medicare. Please see Section 11 of this document for more information about leaving this Plan.

If you are a Member of a the Genetically Handicapped Persons Program

If you are currently enrolled in the Genetically Handicapped Persons Program, you may get help paying your Copayments and/or coinsurance. Please contact your Genetically Handicapped Persons Program to determine what benefits are available to you. Please see the Introduction for more information.

If you have a Medigap policy with Prescription Drug coverage

If you currently have a Medicare Supplement (Medigap) policy that includes coverage for Prescription Drugs, you must contact your Medigap issuer and tell them you have enrolled in our Plan. You cannot use it for out-of-pocket costs under the plan. You cannot change to another Medigap policy while you are in our Plan, and if you decide to drop the policy you will not be able to get it back and in no case will you be able to get the Prescription Drug coverage under the policy. If you do, however, decide to keep your current Medigap policy, your Medigap issuer will remove the Prescription Drug coverage portion of your policy and adjust your premium. You should have received a letter in the fall of 2005 from your Medigap issuer explaining your options and how the removal of drug coverage from your Medigap policy will affect your premiums. If you do not receive this letter, please contact your Medigap issuer.

Extra help with drug plan costs for people with limited income and resources

What extra help is available?

If you have limited income and resources, you may qualify for extra help paying your Prescription Drug plan costs. If you qualify, you will get help paying for your premium, prescription Copayments and Coinsurances.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help. To qualify, your 2007 annual income must be below $15,315 (single with no dependents) or $20,535(married and living with your spouse and no dependents). In addition, your resources (including your savings and stocks, but not your home or car) must not exceed $11,710 (single) or $23,410 (married and living with your spouse). The amount of extra help you get will depend on your income and resources.

Note: Amounts shown above are for 2007 and will change in 2008. If you live in Alaska or Hawaii, or pay more than half of the living expenses of dependent family members, income limits are higher. Please call Member Service to find out what the income limits are.

Some people automatically qualify for extra help and do not have to apply for it. If you answer "yes" to any of the questions below, you automatically qualify for extra help:

- Do you have Medicare and full coverage from a state Medicaid program?
- Do you get Supplemental Security Income?
- Do you get help from your state Medicaid program paying your Medicare premiums? That is, do you belong to a Medicare Savings Program, such as the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualified Individual (QI) program?

How do you apply for extra help?

Medicare mailed letters to people who automatically qualify for extra help in May or June. If you did not automatically qualify, the Social Security Administration (SSA) sent people with certain incomes an application for this extra help. If you got this application, fill it out and send it back to SSA as soon as possible. If you did not get an application but think you may qualify, call **1-800-772-1213**, visit www.socialsecurity.gov on the web, or apply at your State Medical Assistance office. After you apply, you will receive a letter in the mail letting you know if you qualify or not and what you need to do next.

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 number listed in Section 1. Or, visit www.healthnet.com/uc.

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

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

Hospital care

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

See Appendix A for definition of Inpatient Care.

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

Note: If your Seniority Plus coverage began while you were an inpatient in a Hospital, Health Net may not be responsible for the inpatient services until the date after your discharge. If we are not responsible for the inpatient services, either Original Medicare or the previous Medicare managed care plan you were enrolled is responsible for the inpatient Hospital services. We have Member Services representatives available at **1-800- 275-4737** (or TDD **1-800-929-9955** for hearing impaired), 8:00 a.m. to 8:00 p.m., 7 days a week.

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

When your inpatient stay is not covered

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

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 (when performed with or after a Medicare covered kidney transplant), 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 preformed in a Medicare approved transplant center: heart, liver, lung, heart-lung, and intestinal/multivisceral transplants.

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)

If you need Skilled Nursing Facility care, we will arrange these services for you. Covered services are listed in the "Your Schedule of Medical Benefits" in Section 5 under the heading “Skilled nursing facility care.” Inpatient SNF coverage is limited to 100 days each Benefit Period. The purpose of this subsection is to tell you more about some rules that apply to your Covered Services.

Please note that after your SNF day limits are used up, physician services and other medical services will still be covered. These services are listed in the "Your Schedule of Medical Benefits" in Section 5 under the heading, "Inpatient services (when the Hospital or SNF days are not or are no longer covered)."

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 a convalescent nursing home or rest home. (By "Custodial Care," we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.)

What is Skilled Nursing Facility care?

"Skilled Nursing Facility care" means a level of care ordered by a physician that must be given or supervised by licensed health care professionals. It can be Skilled Nursing Care, or skilled rehabilitation services, or both. Skilled Nursing Care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services include physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the

movement and strength of an area of the body, and training on how to use special equipment such as how to use a walker or get in and out of a wheel chair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to do usual daily activities such as eating and dressing by yourself.

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

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

What is a "Benefit Period?"

Seniority Plus uses Benefit Periods to determine your coverage for inpatient services during a Hospital stay (generally, you are an inpatient of a Hospital if you are receiving inpatient services in the Hospital). A **Benefit Period** begins on the first day you go to a Medicare covered inpatient Hospital or Skilled Nursing Facility (SNF). The Benefit Period ends when you have not been an inpatient at any Hospital or SNF for 60 days in a row. If you go to the Hospital (or SNF) after one Benefit Period has ended, a new Benefit Period begins. There is no limit to the number of Benefit Periods you can have.

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

Stays to provide Custodial Care 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 Seniority Plus unless it is provided as other care you are getting *in addition* to daily Skilled Nursing Care and/or skilled rehabilitation services.

In some situations, you may be able to get care in a SNF that is not a Plan Provider

Generally, you will get your Skilled Nursing Facility care from SNFs that are Plan Providers for Seniority Plus. However, *if certain conditions are met*, you may be able to get your Skilled Nursing Facility care from a SNF that is not a Plan Provider. One of the conditions is that the SNF that is not a Plan Provider must be willing to accept Health Net's rates for payment. At your request, we may be able to arrange for you to get your Skilled Nursing Facility care from one of the facilities listed below (in these situations, the facility is called a "Home SNF"):

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as the place gives Skilled Nursing Facility care).

- A SNF where your spouse is living at the time you leave the Hospital.

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

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

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 "Your Schedule of Medical Benefits" in Section 5 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:

1. 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.

2. 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.

3. The Home Health Agency caring for you must be approved by the Medicare program.

4. 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.

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 Seniority Plus, you may receive care from any Medicare-certified Hospice. Your doctor can help you arrange for your care in a Hospice. If you are interested in using Hospice services, you can call Member Services at the number in Section 1 to get a list of the Medicare-certified Hospice Providers in your area, or you can call the Regional Home Health Intermediary at **1-414-226-6972**. (If you are enrolled in Medicare Part B only and not entitled to Part A, you should call Members Services at the telephone number in Section 1, to get information on your Hospice coverage.)

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

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

Participating in a clinical trials

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

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 were not in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, Original Medicare (and not Seniority Plus) 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 Seniority Plus and continue to get the rest of your care that is unrelated to the clinical trial through Seniority Plus. You will have to pay the Original Medicare Coinsurance for the clinical trial services.

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 more about how to contact the Medicare program and about Medicare's website.

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**nstitutions (RNHCIs) is covered by Seniority Plus 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, or care in a Home Health Agency. You may get services when furnished in the home, but only items and services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "non-excepted" medical treatment. ("Excepted" medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state or local law. "Non-excepted" medical treatment is any other medical care or treatment.) You must also get authorization (approval) in advance from Seniority Plus, or your stay in the RNHCI may not be covered.

Vision Care

Refractive Eye Examination

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

Eyewear

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

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

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

How To Use The Plan

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

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

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

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

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

Eyewear Benefits

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

Eyewear Schedule:

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

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

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

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

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

Eyewear Schedule (continued):

Cost Sharing:

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

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

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

Medically necessary** (one pair every 24 months*)

- Conventional or Disposable..... Health Net Vision pays the first $250, Member pays the remaining balance.

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

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

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

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

If the Member is diagnosed with a Medically Necessary condition, the Health Net Vision Provider will submit a request for pre-authorization to EyeMed. The EyeMed Medical Director reviews all requests for Medically Necessary Contact Lenses. If approved, the individual will be covered for Medically Necessary Contact Lenses up to the Plan allowance.

Chiropractic Services

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

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

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

- You may receive Emergency Chiropractic Services from any chiropractor, including a non-ASH Contracted Chiropractor; and

- If covered Chiropractic Services are not available and accessible, you may obtain covered Chiropractic Services from a non-ASH Contracted Chiropractor who is available and accessible to you upon Referral by ASH Plans.

All covered Chiropractic Services require Prior Authorization by ASH Plans except:

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

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

The following benefits are provided for Chiropractic Services:

Office Visits

- An initial examination is performed by a ASH Contracted Chiropractor to determine the nature of your problem, to provide or commence, in the initial examination, Medically Necessary Chiropractic Services that are Covered Services, to the extent consistent with professionally recognized standards of practice, and to prepare a treatment plan of services to be furnished. An initial examination will be provided to you if you seek services from a ASH Contracted Chiropractor for any injury, illness, disease, functional disorder, or condition with regard to which you are not, at that time, receiving services from the ASH Contracted Chiropractor. A $15 Copayment will be required.
- Subsequent Office Visits, as set forth in a treatment plan approved by ASH Plans, may involve an adjustment, a brief re-examination, and other services, in various combinations. A Copayment will be required for each visit to the office.
- Adjunctive therapies, as set forth in a treatment plan approved by ASH Plans, may involve therapies such as ultrasound, hot packs, cold packs, electrical muscle stimulation and other therapies.
- A re-examination may be performed by the ASH Contracted Chiropractor to assess the need to continue, extend or change a treatment plan approved by ASH Plans. A re-evaluation may be performed during a subsequent Office Visit or separately. If performed separately, a Copayment will be required.

Second Opinion

If you would like a second opinion with regard to Covered Services provided by a ASH Contracted Chiropractor, you will have direct access to any other ASH Contracted Chiropractor. Your visit to a ASH Contracted Chiropractor for purposes of obtaining a second opinion generally will count as one

visit, for purposes of any maximum benefit, and you must pay any Copayment that applies for that visit on the same terms and conditions as a visit to any other ASH Contracted Chiropractor.

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

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

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

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

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

SECTION 8. MEDICAL CARE AND SERVICES THAT ARE NOT COVERED (LIST OF EXCLUSIONS 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 Seniority Plus. 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. ("Your Schedule of Medical Benefits" chart in Section 5 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 10 and Appendix B).

What services are not covered by Seniority Plus

In addition to any Exclusions or limitations described in "Your Schedule of Medical Benefits" (in Section 5), **the following items and services are limited or <u>not</u> covered** by Seniority Plus:

- Charges imposed by immediate relatives or members of your household.
- Cosmetic surgery or procedures, *unless* it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery and all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast, is covered.
- Drugs prescribed for hormonal therapy for individuals who have been diagnosed with a covered Gender Identity Disorder (GID) may be covered.
- Cosmetic procedures, beyond surgery, that are related to transgender services are not covered.
- Custodial care is not covered by Seniority Plus *unless* it is provided in conjunction with Skilled Nursing Care and/or skilled rehabilitation services. "Custodial care" includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
- Emergency facility services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a Medical Emergency. (See Section 4 for more information about getting care for a medical emergency.)
- Elective or voluntary enhancement procedures, services, supplies and medications

including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance *unless* Medically Necessary.

- Experimental or investigational medical and surgical procedures, equipment and medications, unless covered by Original Medicare or under an approved clinical trial. Experimental procedures and items are those items and procedures determined by Health Net and Original Medicare to not be generally accepted by the medical community. See Section 7 for information about participation in clinical trials while you are a Member of Seniority Plus.
- Homemaker services.
- Hospice services in a Medicare-participating Hospice are not paid for by Health Net, but reimbursed directly by Original Medicare when you enroll in a Medicare-certified Hospice.
- Meals delivered to your home.
- Naturopaths' services.
- New procedures, services, supplies and medications are excluded until they are reviewed for safety, efficacy and cost-effectiveness and approved by Health Net Seniority Plus *unless* Medically Necessary and covered by Original Medicare.
- Non-emergency transportation *unless* ambulance transportation is determined to be Medically Necessary and other means of transportation would be inadvisable.
- Non-Medicare-covered organ transplants. Medical and Hospital services of a donor when the recipient of an organ transplant is not a Member of Health Net Seniority Plus.
- Nursing care on a full-time basis in your home.
- Orthopedic shoes, *unless* they are part of a leg brace and are included in the cost of the leg brace. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 5, under "Outpatient Medical Services").
- Personal convenience items, such as a telephone or television in your room at a Hospital or Skilled Nursing Facility.
- Physical examinations for the purpose of maintaining or obtaining employment, licenses, insurance, court hearing, travel or for premarital and pre-adoption purposes and/or other non-preventive reasons, *unless* otherwise Medically Necessary.
- Prenatal, maternity or post-partum care for a non-Health Net Seniority Plus Member acting as a surrogate.
- Private duty nurses.
- Private room in a Hospital, *unless* Medically Necessary.

- Procedures, services, supplies, and medications until they are reviewed for safety, efficacy, and cost effectiveness and approved by Health Net or Medicare.
- Radial keratotomy and low vision aids and services.
- Reversal of sterilization procedures; sex change operations; and non-prescription contraceptive supplies and devices. (Medically Necessary services for infertility are covered according to Original Medicare guidelines.)
- Routine dental care (such as cleanings, filling, or dentures) or other dental services. Certain dental services that you get when you are in the Hospital will be covered.
- Routine foot care is generally not covered under the Plan or is limited according to Medicare guidelines.
- Services, procedures, treatment, supply or medication not specifically listed as a covered benefit or service in this Evidence of Coverage.
- Services provided to veterans in Veteran's Affairs (VA) facilities. 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 Seniority Plus, we will reimburse veterans for the difference. Members are still responsible for the Seniority Plus cost sharing amount.
- Services that are not covered under Original Medicare, *unless* such services are specifically listed in your Summary of Benefit or in this Evidence of Coverage.
- Services that are not reasonable and necessary under Original Medicare Plan standards unless otherwise listed as a Covered Service. As noted in Section 5, we provide all Covered Services according to Medicare guidelines.
- Services that you get from Non-Plan Providers, *except* for care for a Medical Emergency and Urgently Needed Care, renal (kidney) dialysis services that you get when you are temporarily outside the Plan's Service Area, and care from Non-Plan Providers that is arranged or approved by a Plan Provider. See other parts of this booklet (especially Sections 2 and 3) for information about using Plan Providers and the exceptions that apply.
- Services that you get without a Referral from your PCP, when a Referral from your PCP is required for getting that service.
- Services that you get without Prior Authorization from Health Net or your Medical Group, when Prior Authorization is required for getting that service. (Please refer to Appendix A for a definition of Prior Authorization.)
- Stem cell harvesting and storage not associated with an approved transplant.
- Supportive devices for the feet. *There is an exception:* orthopedic or therapeutic shoes for people with diabetic foot disease (as shown in Section 5, in "Your Schedule of Medical Benefits").

- Surgical treatment of morbid obesity *unless* Medically Necessary and covered under Original Medicare.

Vision Care Exclusions and Limitations

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

- Eye exams are not covered. For covered eye exams please refer to the "Your Coverage – the medical benefits and services you get as a Member of Seniority Plus" section.
- The fitting or dispensing of more than one set of Frames and one pair of Standard Plastic Eyeglass Lenses or Contact Lenses during any 24-month period is not covered, except in cases where the Member's prescription changes significantly (refer to footnote #1).
- Lenses that correct the vision defect known as aniseikonia are not covered.
- Diagnostic services, and medical or surgical treatment of the eye are not covered. For covered surgical treatments please refer to the please refer to "Your Coverage – the medical benefits and services you get as a Member of Seniority Plus" section.
- Services or supplies provided by a Provider other than a Health Net Vision Participating Eyewear Provider are not covered.
- Nonprescription vision devices and sunglasses are not covered.
- Additional fitting and measurement charges, or special consultation charges due to the purchase of optional Frames, are not covered.
- Orthoptics or vision training aids are not covered.
- Prescription drugs or over-the-counter drugs are not covered. For covered Prescription drugs or over-the-counter drugs, please refer to the "Your Coverage – the medical benefits and services you get as a Member of Seniority Plus" section.
- Vision aids (other than Eyeglasses or Contact Lenses) are not covered.
- The Eyewear allowance for Progressive Lenses is $82.50. Any difference between that and the retail price is your responsibility.
- The cost of tinting Lenses is limited to pink or rose #1 and #2 tints.
- Cost Sharing amounts are a one-time use benefit; no remaining balances.
- Out-of-Network vision care services not covered.
- Lost or broken materials are not covered.

Chiropractic Services Exclusions and Limitations

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

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

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

Paying the Plan Premium for your coverage as a Member of Seniority Plus

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

We will Disenroll you from Seniority Plus if you or your Group do not pay the Plan Premiums within the 90-day grace period. Disenrolling you ends your membership in Health Net. You will then have Original Medicare coverage (Section 11 explains about Disenrollment and Original Medicare coverage). We will tell you in writing when the 90-day grace period begins if you have not paid your Plan Premiums.

Can the Plan Premium change?

We are allowed to *decrease* your Plan Premium described in the Group Service Agreement at any time during the Calendar Year, but we are not allowed increase it. If we decide to decrease your Plans premium during the Calendar Year, we will let your Group know in writing. **Increases in your Plan Premium are only allowed at the beginning of each Calendar Year, and must be approved by Medicare**. Your Group will let you know if there will be any changes in your Plan Premiums or the amount you will have to pay when you get Covered Services. Your Group will also let you know if we plan to decrease your Plan Premium.

Paying your share of the cost when you get Covered Services

What are "Copayments" and "Coinsurance?"

- A "**Copayment**" is a payment that you make for your share of the cost of certain Covered Services you receive. A Copayment is **a set amount per service**. You pay it when you get the services. The "Your Schedule of Medical Benefits" chart in Section 5 gives Copayments for Covered Services.
- **"Coinsurance"** is a payment you make for your share of the cost of certain Covered Services you receive. Coinsurance is **a *percentage* of the cost of the service**. You pay your coinsurance when you get the service. The "Your Schedule of Medical Benefits" chart in Section 5 gives your coinsurance for Covered Services.

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

You are personally responsible to pay for care and services that are not covered by Original Medicare, your Group or Health Net. Other sections of this booklet tell about Covered Services and the rules that apply to getting your care as a Plan Member. With few exceptions, you must pay for services you receive from Providers who are not part of Seniority Plus unless Health Net has approved these services in advance. The exceptions are medical emergency, Urgently Needed Care, out-of-area renal (kidney) dialysis services, and 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.)

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

Let us know if you have additional insurance

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

- Coverage that you have from an employer's Group health insurance for *employees* or *retirees*, either through yourself or your spouse;
- Coverage that you have under workers' compensation because of a job-related illness or injury, or under the Federal Black Lung Program;
- Coverage you have for an accident where no-fault insurance or liability insurance is involved;
- Coverage you have through Medicaid.
- Coverage you have through the "Tricare for Life" program (veteran's benefits);
- Coverage you have for dental insurance or Prescription Drugs

Who pays first when you have additional insurance?

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

In general, the insurance company that pays its share of your bills *first* is called the "**primary payer**." Then the other company or companies that are involved -- called the "**secondary payers**" -- each pay their share of what is left of your bills. Often your other insurance company will settle its share of payment directly with 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 on the first page of this booklet to find out which rules apply to your situation, and how payment will be handled. Also, the Medicare program has written a booklet with general information about what happens when people with Medicare have additional insurance. It's called *Medicare and Other Health Benefits: Your Guide to Who Pays First*. 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 website.

What should you do if you have bills from Non-Plan Providers that you think we should pay for?

As explained in Sections 2 and 3, we cover certain health care services that you get from Non-Plan Providers. These include care for a Medical Emergency, Urgently Needed Care, renal dialysis that you get when you are outside the Plan's Service Area, care that has been approved in advance by Health Net, and services that we denied but that were overturned in an Appeal. If a Non-Plan Provider asks you to pay for Covered Services you get in these situations, please contact us at:

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

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

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

It is best to ask a Non-Plan Provider to bill us first, but if you have already paid for the Covered Services we will reimburse you for our share of the cost. If you received a bill for the services, you can send the bill to us for payment. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay. You will not have to pay a Non-Plan Provider any more than what he or she would have received from you if you had been covered with Original Medicare.

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

Introduction

We encourage you to let us know right away if you have questions, concerns, or problems with any part of your Covered Services or the care you receive. Please call Member Services at the number listed in Section 1.

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 Appendix E for detailed information about how to make an Appeal or Grievance that involves a request for Part D Drug benefits.

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 medical 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 Seniority Plus or penalized in any way if you make a complaint.

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

What are Appeals and Grievances?

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.

- An "**Appeal**" is the type of complaint you make when you want us to reconsider and change a decision we have made about what services or benefits are covered for you or what we will pay for a service or benefit. For example, if we refuse to cover or pay for services you think we should cover, you can file an Appeal. If Health Net or one of our Plan Providers refuses to give you a service you think should be covered, you can file an Appeal. If Health Net or one of our Plan Providers reduces or cuts back on services or benefits you have been receiving, you can file an Appeal. If you think we are stopping your coverage of a service or benefit too soon, you can file an Appeal.

- A "**Grievance**" is the type of complaint you make **if you have any other type of problem with Health Net/Seniority Plus or one of our Plan Providers**. For example, you would file a Grievance if you have a problem with things such as the quality of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor's office.

This section tells how to make complaints in different situations

The rest of this section has separate parts that tell you how to make a complaint in each of the following situations:

1. **Complaints about what we will cover for you or what we will pay for**. If Health Net or your doctor or another Plan Provider has refused to give you a service you think is covered, you can make a complaint called an **Appeal**. If we have refused to pay for a service you think is covered for you, you can make an Appeal. If you have been receiving a covered service, and you think that service is being reduced or ending too soon, you can make an Appeal. When you file an Appeal, you are asking us to reconsider and change a decision we have made about what services we will cover for you (which includes whether we will pay for your care or how much we will pay).

2. **Complaints if you think you are being discharged from the Hospital too soon.** There is a special type of Appeal that applies only to Hospital discharges. If you think our coverage of your Hospital stay is ending too soon, you can Appeal directly and immediately to Lumetra, which is the Quality Improvement Organization in the state of California. Lumetra is a group of health professionals in California that is paid to handle this type of Appeal from Medicare patients. If you make this type of Appeal, your stay may be covered during the time period that Lumetra uses to make its determination. You must act very quickly to make this type of Appeal, and it will be decided quickly.

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.** There is another special type of Appeal that applies only when coverage will end for SNF, HHA or CORF services. If you think your coverage is ending too soon, you can Appeal directly and immediately to Lumetra, which is the Quality Improvement Organization in the state of California. If you make this type of Appeal, your stay may be covered during the time period Lumetra uses to make its determination. You must act very quickly to make this type of Appeal, and it will be decided quickly.

4. **Complaints about your Employer-Sponsored Benefits.** There is a special type of Appeal that applies only to Employer-Sponsored Benefits. Employer-Sponsored Benefits are covered benefits that are beyond the Basic Benefits or Part D Drugs benefit. If you make this type of Appeal, you must follow the steps outlined in Part 4 later in this section. They are different from the Appeal process that is set by the Medicare program.

5. **Complaints about any other type of problem you have with Health Net Seniority Plus or one of our Plan Providers. 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 example, you would file a Grievance to complain about problems with the quality or timeliness of your care, waiting times for appointments or in the waiting room, the way your doctors or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of the doctor's office. Generally, you would file the Grievance with Health Net. But for many problems related to quality of care you get from Plan Providers, you can also complain to Lumetra.

Part 1. Complaints (Appeals) to Health Net to change a decision about what services we will cover or what we will pay for

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

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

Six possible steps for requesting care or payment from Seniority Plus

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

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

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

STEP 1: The Initial Decision by Health Net

The starting point is when we make an "Initial Decision" (also called an "organizational determination") about your medical care or about paying for care you have already received. When we make an "Initial Decision," we are giving our interpretation of how the benefits and services that are covered for Members of Seniority Plus apply to your specific situation. As explained in Appendix B, you can ask for a "fast Initial Decision" if you have a request for medical care that needs to be decided more quickly than the standard time frame.

STEP 2: Appealing the Initial Decision by Health Net

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an "**Appeal**" or a "request for reconsideration." As explained in Appendix B, you can ask for a "fast Appeal" if your request is for medical care and it needs to be decided more quickly than the standard time frame. After reviewing your Appeal, we will decide whether to stay with our original decision, or change this decision and give you some or all of the care or payment you want.

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

If we turn down part or all of your request in Step 2, we are **required** to send your request to an independent review organization that has a contract with the federal government and is not part of Health Net. This organization will review your request and make a decision about whether we must give you the care or payment you want.

STEP 4: Review by an Administrative Law Judge

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

STEP 5: Review by a Medicare Appeals Council

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

STEP 6: Federal Court

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

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

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 Seniority Plus that is necessary to diagnose and treat your illness or injury. The date you leave the Hospital (your "discharge date") is based on when your stay is no longer Medically Necessary. This part of Section 10 explains what to do if you believe that you are being discharged too soon.

Information you should receive during your Hospital stay

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

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

What is the "Quality Improvement Organization?"

"QIO" stands for **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 or your Hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. In California, the QIO is called Lumetra. The doctors and other health experts in Lumetra review certain types of complaints made by Medicare patients. These include complaints about quality of care and complaints from Medicare patients who think the coverage for their Hospital stay is ending too soon. Section 1 tells how to contact Lumetra.

Getting a Lumetra's review of your Hospital discharge

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

- You must ask Lumetra for a **"fast review"** of whether you are ready to leave the Hospital. This "fast review" is also called a "fast Appeal" because you are appealing the discharge date that has been set for you.
- You must be sure that you have made your request to Lumetra **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 Lumetra (see below).

If Lumetra reviews your discharge, it will 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. Lumetra 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.

- If Lumetra decides that your discharge date was medically appropriate, you will not be responsible for paying the Hospital charges until noon of the calendar day after Lumetra gives you its decision.
- If Lumetra agrees with you, then we will continue to cover your Hospital stay for as long as Medically Necessary.

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

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

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

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

- If we decide, based on the fast Appeal, that you need to stay in the Hospital, we will continue to cover your Hospital care for as long as Medically Necessary.
- If we decide that you should not have stayed in the Hospital beyond your discharge date, then we will **not** cover any Hospital care you receive if you stayed in the Hospital after the discharge date. Unless the IRE overturns our decision.

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

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

Part 3. Complaints (Appeals) if you think your coverage for SNF, home health, or comprehensive outpatient rehabilitation facility services are 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 Seniority Plus 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 of Section 10 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 someone you authorize) will be asked to sign and date this document to show that you received the notice. Signing the notice does not mean that you agree that coverage should end – it only means that you received the notice.

How to 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"), Lumetra, to do an independent review of whether our terminating your coverage is medically appropriate.

How soon you have to ask Lumetra to review your coverage?

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

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

What will happen during the review?

If Lumetra reviews your case, Lumetra 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. Lumetra will also look at your medical information, talk to your doctor, and review other information that we have given to Lumetra. You and Lumetra will each get a copy of our explanation about why your services should not continue.

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

What happens if Lumetra decides in your favor?

If Lumetra agrees with you, then we will continue to cover your SNF, HHA or CORF services for as long as Medically Necessary.

What happens if the QIO denies your request?

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

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

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

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

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

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

You may have to pay if you stay past your discharge date. (Lumetra does not decide in your favor.)

If you do not ask Lumetra by noon after the day you are given written notice that we will be terminating coverage for your SNF, HHA or CORF services, and if you stay in the SNF, HHA or CORF after this date, you run the risk of having to pay for the SNF, HHA or CORF care you receive on and after this date. However, you can Appeal any bills for SNF, HHA or CORF care you receive using Step 1 of the Appeals process described in Appendix B.

Part 4. Complaints (Appeals) about your Employer-Sponsored Benefits

This part of Section 10 explains what you can do if you have problems getting Employer-Sponsored Benefits you believe we should provide. The word "provide" includes such thing as authorizing care, paying for it, or arrange for someone to provide it. There are 4 possible steps for requesting care or payment of Employer-Sponsored Benefits.

STEP 1: The Initial Decision

The starting point is when we make an Initial Decision about your care or about paying for care you have already received. When we make an Initial Decision, we are giving our interpretation of how the benefits and services that are covered for Members of Seniority Plus apply to your specific situation.

STEP 2: Appealing the Initial Decision

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an "**Appeal.**" You can file the Appeal by calling Health Net Member Services Department at **1-800-275-4737** or by sending information to:

Health Net
Appeals & Grievance Department
P.O. Box 10344
Van Nuys, CA 91410-0344

We will:

- Review your complaint and inform you of our decision in writing within 30 days from the receipt of the Appeal. For conditions where there is an immediate and serious threat to your health, including severe Pain, or the potential for loss of life, limb or major bodily function exists, We must notify you of the status of your grievance no later than three days from receipt of the grievance.

- Inform you if additional time is necessary to complete our investigation.

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

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

If you are not satisfied with the outcome of your Appeal in Step 2, you can request for an independent review organization to review your case. This organization will review your request and make a decision about whether we must give you the care or payment you want. You may call Health Net Member Services Department at **1-800-275-4737** to request the independent review or by sending the request to:

Health Net
Appeals & Grievance Department
P.O. Box 10344
Van Nuys, CA 91410-0344

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

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

STEP 4: Binding Arbitration

If you continue to be dissatisfied after the independent review process in Step 3 has been completed, you may then initiate binding arbitration as described at the end of this section. Binding arbitration is generally the final process to resolve disputes concerning Employer-Sponsored Benefits.

Part 5. Complaints (Grievances) about any other type of problem you have with Health Net Seniority Plus or one of our Plan Providers

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

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

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

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

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

Filing a Grievance with Seniority Plus

If you have a complaint, we encourage you to first call Member Services at the number shown in Section 1. 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 Seniority Plus Member Services Department at **1-800-539-4072** (TTY/TDD **1-800-929-9955**).

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

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

Fax: **1-818-676-8179**

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.

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 your Appeal of denied medical care.

Requests for Expedited Grievances may be submitted telephonically at **1-800-539-4072** (TTY/TDD **1-800-929-9955**). You may also submit your complaint in writing or via facsimile to Health Net at:

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

Fax: **1-818-676-8179**

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

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

Complaints about a decision regarding payment for, or provision of, Covered Services that you believe are covered by Original Medicare and should be provided or paid for by Health Net must be appealed through Health Net's Medicare Appeals procedure (described in Part 1 of this Section).

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

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

If you are concerned about the quality of care you received, including care during a Hospital stay, you can also complain to an independent organization called the QIO, Lumetra. See Section 1 for more about Lumetra.

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 as described in detail in Appendix B and Appendix E.

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

When Coverage Ends

You must notify the Group of changes that will affect your eligibility. The Group will send the appropriate request to Health Net according to current procedures. Coverage ends on the last day of the month in which the eligible Member(s), listed above, cease to be eligible for coverage. Health Net is not obligated to notify you that you are no longer eligible or that your coverage has been terminated.

All Group Members

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

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

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

If Health Net does not receive payment of the delinquent subscription charges from your employer within 15 days of the date of mailing of the Prospective Notice of Cancellation, Health Net will cancel the Group Service Agreement and mail the Subscriber and your employer a Notice Confirming Termination of Coverage, which will provide you and your employer with the following information: (1) that the Group Service Agreement has been canceled for non-payment of subscription charges; (2) the specific date and time when your Group coverage ended; (3) the Health Net telephone number you can call to obtain additional information, including whether your employer obtained reinstatement of the Group Service Agreement (Health Net allows one reinstatement during any twelve-month period if the Group requests reinstatement and pays the amounts owed within 15 days of the date of mailing of the Notice Confirming Termination of Coverage); and (4) an explanation of your options to purchase continuation coverage, including coverage effective as of the retroactive termination date so you can avoid a break in coverage and the deadline by which you must elect to purchase such continuation coverage, which will be 63 days after the date Health Net mails you the Notice Confirming Termination of Coverage.

If coverage through this Plan ends for reasons other than non-payment of subscription charges, see the "Coverage Options Following Termination" section below for coverage options.

Subscriber and All Family Members
The Subscriber and all his or her Family Members will become ineligible for coverage at the same time if the Subscriber loses eligibility for this plan.

Individual Members – Termination for Loss of Eligibility
Individual Members become ineligible on the last day of the month from the date any of the following occurs:

- The Member no longer meets the eligibility requirements established by the Group and Health Net. This will include a child subject to a Medical Child Support Order, according to state or federal law, who becomes ineligible on the earlier of:

  1. The date established by the order.
  2. The date the order expired.

- The Member establishes primary residency outside the continental United States.
- The Member establishes primary residency outside the Health Net Service Area.

  However, a child subject to a Medical Child Support Order, according to state or federal law, who moves out of the Health Net Service Area does not cease to be eligible for this Plan. But, while that child may continue to be enrolled, coverage of care received outside the Health Net Service Area will be limited to services provided in connection with Emergency Care or Urgently Needed Care.

  Follow-Up Care, routine care and all other benefits of this Plan are covered only when authorized by the contracting Physician Group (medical) or the Behavioral Health Administrator (Mental Disorders and Chemical Dependency).

- The Subscriber's marriage or domestic partnership ends by divorce, annulment or some other form of dissolution. Eligibility for the Subscriber's enrolled spouse or Domestic Partner (now former spouse or Domestic Partner) and that spouse's or Domestic Partner's enrolled dependents, who were related to the Subscriber only because of the marriage or domestic partnership, will end.

Individual Members - Termination for Cause
Health Net has the right to terminate your coverage from this plan under certain circumstances. The following are examples of circumstances that may result in a termination:

- Disruptive or Threatening Behavior: Your coverage may be terminated 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 at midnight on the date the notice of termination is mailed if you knowingly omit or misrepresent a meaningful fact on your enrollment form or fraudulently or deceptively use services or facilities of Health Net, its contracting Physician Groups or other contracting providers, (or knowingly allow another person to do so), including altering a prescription.

If coverage is terminated for any of the above reasons, you forfeit all rights to enroll in the COBRA plan or any plan that is owned or operated by Health Net's parent company or its subsidiaries and lose the right to re-enroll in Health Net in the future.

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

Your health status or requirements for health care services will not determine eligibility for coverage. If you believe that coverage was terminated because of health status or the need for health services, you may request a review of the termination by the Director of the California Department of Managed Health Care.

Coverage Options Following Termination
If coverage through this Plan ends as a result of the Group's non-payment of subscription charges, see "All Group Members" portion of "When Coverage Ends" in this section for coverage options following termination. If coverage through this Plan ends for reasons other than the Group's non-payment of subscription charges, the terminated Member may be eligible for additional coverage.

What is "Disenrollment?"

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

- You might leave Seniority Plus because you have decided that you *want* to leave. You can do this for any reason. However, as we explain in this section, **there are limits to <u>when</u> you may leave, <u>how often</u> you can make changes, and what type of plan you can join after you leave.**
- There are also a few situations where you would be *required* to leave. For example, you would have to leave Seniority Plus if you move permanently out of our geographic Service Area or if Seniority Plus leaves the Medicare program. We are not allowed to ask you to leave the Plan because of your health.

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

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

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

If you get services from doctors or other medical Providers who are **not** Plan Providers before your membership in Seniority Plus ends, neither Health Net nor the Medicare program will pay for these services, with just a few exceptions. The exceptions are Urgently Needed Care, care for a medical emergency, out-of-area renal (kidney) dialysis services, and care that has been approved by us. There is another possible exception if you happen to be hospitalized on the day your membership ends. If this happens to you, call Member Services at the number in Section 1 to find out if your Hospital care will be covered by Seniority Plus. If you have any questions about leaving Seniority Plus, please call Member Services.

When and how often can I change my Medicare choices?

In general, there are only certain times during the year when you can change the way you get Medicare.

Here are the rules:

1. 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. During the AEP, you are **not limited** in the type of change you may make to your coverage. See "What are my choices, and how do I make changes, if I leave Seniority Plus between November 15 and December 31?" below for details.
2. From January 1 until March 31, during the Medicare Advantage Open Enrollment Period (OEP), anyone eligible for Medicare Advantage has another chance to review the coverage they have and make one change. Your new enrollment will be effective the first day of the month that comes *after* the month we receive your request to leave. However, with this chance, you **are limited** in the type of plan you may join. ***You may not use this chance to add or drop Medicare prescription drug coverage.*** See "What are my choices, and how do I make changes, if I leave Seniority Plus between January 1 and March 31?" below for details.

Generally, you can't make any other changes during the year unless you meet special exceptions, such as if you move or if you have Medicaid coverage. Contact us for information.

What are my choices, and how do I make changes, if I leave Seniority Plus between November 15 and December 31?

If you leave Seniority Plus between November 15 and December 31 (during the AEP), you have a number of choices for how you receive your Medicare after you leave. If they are available in your area, and if they are accepting new members, you can switch to any of the following types of plans:

- **Other Medicare Advantage Plans** (including HMOs such as Seniority Plus, PPOs, and Private Fee-for-service plans) are available in some parts of the country. In HMOs and PPOs, you generally get all your Medicare-covered Part A and Part B health care through the plan. Medicare Advantage Plans ***may include prescription drug coverage*** as part of the Medicare Prescription Drug (Part D) benefit. Medicare pays a set amount of money for your care every month to these private health plans whether or not you use services. Seniority Plus is a Medicare Advantage Plan offered by Health Net.
- **Original Medicare** is available throughout the country. Original Medicare is a fee-for-service health plan that lets you go to any doctor, hospital, or other health care provider who accepts Medicare. You must pay a deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share (coinsurance). Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance).
- **Medicare Prescription Drug Plans** (PDPs) are stand-alone drug plans that only cover prescription drugs, not other benefits or services. If you choose Original Medicare and want to receive Medicare prescription drug coverage, you must join a Medicare Prescription Drug Plan.
- **Other Medicare Health Plans** (including Medicare Cost Plans, Programs of All-Inclusive Care for the Elderly (PACE), and Demonstrations) may be available. In some of these plans, you generally get all your Medicare-covered health care from that plan. This coverage ***may include prescription drug coverage***.

Note: For more information about your choices, please refer to the "Medicare & You" handbook you received in the fall. You may also call 1-800-MEDICARE (1-800-633-4227), or visit **www.medicare.gov** to learn more about your choices.

How do I switch from Seniority Plus to another Medicare Advantage Plan or Other Medicare Health Plan between November 15 and December 31?

If you want to change from Seniority Plus to a different Medicare Advantage Plan or Other Medicare Health Plan, here is what to do:

1. Contact the new plan you want to join to be sure it is accepting new members. Also ask the plan if it offers the Medicare Part D prescription drug benefit.
2. Your new plan will tell you the date when your membership in that plan begins, and your membership in Seniority Plus will end on that same day (this will be your "Disenrollment date"). Remember, you are still a member until your Disenrollment date, and must continue to get your medical care as usual through Seniority Plus until the date your membership ends.

What if I want to switch (disenroll) from Seniority Plus to Original Medicare between November 15 and December 31?

Original Medicare does not cover very many prescription drugs outside of a hospital. So, if you want to change from Seniority Plus to Original Medicare, you should think about whether you want to also join a Medicare Prescription Drug Plan.
To get information about Prescription Drug Plans that you can join, you can 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.

- If you want Original Medicare *and* Medicare prescription drug coverage, simply enroll in a stand-alone Medicare Prescription Drug Plan (PDP). That will automatically disenroll you from Seniority Plus.
- If you want Original Medicare and do not want Medicare prescription drug coverage, simply tell us or Medicare that you want to leave Seniority Plus. You do not have to enroll in Original Medicare, because you will automatically be in Original Medicare when you leave Seniority Plus.
    - **To tell us** that you want to leave Seniority Plus:
    - You can write or fax a letter to us or fill out a Disenrollment form and send it to Member Services at Health Net Enrollment Services, Post Office Box 10420, Van Nuys, California 91410-0198 or to our fax number at **1-818-676-7035**. Be sure to sign and date your letter or form. To get a Disenrollment form, call us at the Member Services telephone number shown in Section 1.
- **To tell Medicare** you want to leave Seniority Plus , you can **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.

Whether you tell us or Medicare that you want to leave Seniority Plus you will receive a letter telling you when your membership will end. This is your **Disenrollment date** – the day you officially leave Seniority Plus . Your Disenrollment date will be January 1. Remember, until January 1, you are still a Member of Seniority Plus and must continue to get your medical care as usual through Seniority Plus .

Effective January 1, your membership in Seniority Plus ends and you should use your red, white, and blue Medicare card to get services under Original Medicare. You will not get anything in writing that tells you that you have Original Medicare, because you will *automatically* be in Original Medicare when you leave Seniority Plus. (Call Social Security at **1-800-772-1213** if you need a new red, white, and blue Medicare card.)

What are my choices, and how do I make changes, if I leave Seniority Plus between January 1 and March 31?

Between January 1 and March 31 of every year, individuals who are enrolled in (or eligible for) Medicare Advantage Plans have one opportunity to make (1) change to their Medicare Advantage coverage. This period *may not be used to add or drop Medicare prescription drug coverage*. After March 31, you generally cannot change plans or discontinue your membership.

After March 31, you generally cannot change plans or discontinue your membership.

If plans are available in your area, and if they are accepting new members, you can make one of the following changes:

- As a member of a Medicare Advantage Plan *with* prescription drug coverage (MA-PD), between January 1 and March 31, changes you can make include:
    A. Switch to another Medicare Advantage Plan with prescription drug coverage (MA-PD) by enrolling in the new MA-PD plan; **or**
    B. Switch to Original Medicare and a Prescription Drug Plan (PDP) by enrolling in the PDP.

Do you need to buy a Medigap (Medicare supplement insurance) policy?

If you want to change from Seniority Plus to Original Medicare, and you are thinking about you need to buy a Medigap policy to supplement your Original Medicare coverage. For Medigap advice, you should contact HICAP (the phone number is in Section 1). You can ask HICAP about how and when to buy a Medigap policy if you need one. HICAP can tell you if you have a guaranteed issue right to buy a Medigap policy.

If you are at least 65 and have been eligible for Part B for less than six months, you may still be in your Medigap open enrollment period. If you leave our Plan while you are still in your open enrollment period, and you do not have a guaranteed issue right, the Medigap insurer can refuse to sell you a policy, or impose limits based on your health. If you have a "**guaranteed issue right**," this means that for a limited period the Medigap insurer must sell you a Medigap policy, even if you have health problems. This is a special, temporary right, which means that if you decide to change to Original Medicare, in certain situations you have a limited time to buy a Medigap policy on a guaranteed issue basis. For example, you have a guaranteed issue right to buy a Medigap policy if you are in a trial period." You may be in a trial period if, in the past 12 months you: (1) dropped a Medigap policy to join Seniority Plus or Medicare health plan for the first time; or (2) joined Seniority Plus or another Medicare health plan when you first became entitled to Medicare at age 65. Under certain circumstances, if you lose your health plan coverage while you are still in a trial period, the trial period can last for an extra 12 months. HICAP can tell you about other situations where you may have guaranteed issue rights. You may also have a guaranteed issue right if you move out of our Service Area, or if we stop providing Medicare benefits.

If you do want to buy a Medigap policy, you have to follow the instructions below for changing from Seniority Plus to Original Medicare. (Buying a Medigap policy does not switch you from Seniority Plus to Original Medicare. In fact, while you are still enrolled in Seniority Plus it is against the law for A Medigap insurance company to sell you a policy. A Medigap sales person or insurance agent cannot cancel your Seniority Plus membership and put you in Original Medicare.)

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

If *we* leave the Medicare program or change our Service Area so that it no longer includes the area where you live, we will tell you in writing. If this happens, your membership in Seniority Plus 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 Seniority Plus until your membership ends.

Your choices for how to get your Medicare will always include Original Medicare, and joining Prescription Drug Plan to complement your Original Medicare coverage. Your choices may also include joining another Health Net 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 Seniority Plus 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 has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract renews each year. At the end of each year, the contract is reviewed, and either Health Net or CMS can decide to end it. You will get 90 days advance notice in this situation. It is also possible for our contract to end at some other time 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.

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

If you plan to move or take a long trip, please call Member Services shown in Section 1 to find out if the place you are moving to or traveling to is in Seniority Plus's Service Area. Health Net has other Seniority Plus Plans in California. They are listed below along with their Service Areas. If you move permanently out of our 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 Seniority Plus. In these situation, if you do not leave on your own, we must end your membership ("Disenroll" you). An earlier part of this section tells about the choices you have if you leave Seniority Plus and explains how to leave. Section 3 gives more information about getting care when you are away from the Service Area.

Under certain conditions Health Net can end your membership and make you leave the Plan

Generally, we *cannot* ask you to leave because of your health

No member of any Medicare health plan can be asked to leave the plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave Seniority Plus because of your health, you should call **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:

- If you move out of our geographic Service Area or live outside the Plan's Service Area for more than six months at a time (see Section 2 for information about the Plan's Service Area).
- If you do *not* stay continuously enrolled in both Medicare Part A and Medicare Part B. (See Section 9 for information about staying enrolled in Part A and Part B.)
- If you give us information on your enrollment form that is false or deliberately misleading, and it affects whether or not you can enroll in Seniority Plus.
- If you behave in a way that is 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 Seniority Plus. We cannot make you leave Seniority Plus for this reason unless we get permission from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
- If you let someone else use your Plan membership card to get medical care. If you are disenrolled CMS may refer your case to the Inspector General, for additional investigation.

- The Group Service Agreement (between the Group and Health Net) is terminated due to nonpayment of premiums by the Group. In this case, your coverage will be converted to the Individual Plan.
- The Group Service Agreement (between the Group and Health Net) is not renewed. In this case, your coverage will be converted to an Individual Plan.

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

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

APPENDIX

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

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

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

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

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 Appendix B explain about Appeals, including the process involved in making an Appeal.

ASH Contracted Chiropractor -- A duly licensed chiropractor who practices in the State of California and who has executed a service contract with ASH Plans. A list of ASH Contracted Chiropractors is available from Health Net upon request.

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

Benefit Period -- For both Seniority Plus 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 7 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.

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

Centers for Medicare & Medicaid Services (CMS) -- The federal agency that runs the Medicare program. Section 1 tells how you can contact CMS.

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

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

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

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

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

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

Coverage Determination -- The plan sponsor has made a Coverage Determination when it makes a decision about the Prescription Drug benefits you can receive under the Plan, and the amount that you must pay for a drug.

Covered Services -- The general term we use in this booklet to mean all of the health care services and supplies that are covered by Seniority Plus. Covered services are listed in the "Your Schedule of Medical Benefits" chart in Section 5

Creditable Coverage -- Coverage that is at least as good as the standard Medicare Prescription Drug coverage.

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

Disenroll or Disenrollment -- The process of ending your membership in Seniority Plus. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 11 tells about Disenrollment.

Domestic Partner -- A person eligible for coverage provided that the partnership with the principal Member meets all domestic partnership requirements under California law or other recognized state or local agency. The Domestic Partner and the principal Member 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 a Medical Emergency. Section 3 and 4 tells about emergency services.

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

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

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

Exception -- A type of Coverage Determination that, if approved, allows you to obtain a drug that is not on our Formulary (a Formulary Exception), or receive a non-preferred drug at the preferred cost-sharing level (a tiering Exception). You may also request an Exception if we require you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a Formulary Exception).

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

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

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

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

Eyewear -- It is either Eyeglasses or Contact Lenses.

Formulary -- A list of drugs that are covered by this Plan. Our Formulary includes drugs that are listed on the Health Net Medicare Drug List and the Health Net Group Formulary Supplement.

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

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 Seniority Plus has issued the Group Service Agreement to provide the benefits of this Plan.

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

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

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

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

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

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

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

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

Inpatient Care -- Health care that you get when you are admitted to a Hospital.

Late Enrollment Penalty -- An amount added to your monthly premium for Medicare drug coverage if you don't join a plan when you're first able. You pay this higher amount as long as you have Medicare. There are some Exceptions. If you do not have creditable Prescription Drug coverage, you will have to pay a penalty.

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

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

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

Medical Emergency -- A medical condition brought on by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that not getting immediate medical attention could result in 1) Serious jeopardy to the health of the individual (or, in the case of a pregnant woman, the health of the woman or her unborn child); 2) Serious impairment to bodily functions; or 3) Serious dysfunction of any bodily organ or part.

Medical Group -- A group of primary care and specialty care physicians, organized as a legal entity, which has an agreement in effect with Health Net to furnish medical care to Seniority Plus Members.

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 Centers for Medicare & Medicaid Services (CMS) to provide Covered Services. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans. Health Net is a Medicare Advantage Organization.

Medicare Advantage 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. Seniority Plus is a Medicare Advantage plan.

Medicare Cost Plan -- Cost plan means a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

Medicare Managed Care Plan -- Means a Medicare Advantage HMO, Medicare Cost Plan, or Medicare Advantage PPO.

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

Member Services -- A department within Health Net responsible for answering your questions about your membership, benefits, Grievances, and Appeals. See Section 1 for information about how to contact Member Services.

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

Network Pharmacy -- A Network Pharmacy is a pharmacy where Members of our Plan can receive covered 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.

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

Non-Plan Provider or Non-Plan Facility -- A Provider or facility that we have not arranged with to coordinate or provide Covered Services as a Member of Seniority Plus. Non-Plan Providers are Providers that are not employed, owned, or operated by Health Net and are not under contract to deliver Covered Services to you. As explained in this booklet, most services you get from Non-Plan Providers are not covered by Health Net or Original Medicare.

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

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

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.

Out-of-Network Pharmacy -- A pharmacy that we have not arranged with to coordinate or provide covered drugs to Members of our Plan. As explained in this Evidence of Coverage, most services you get from non-network pharmacies are not covered by our Plan unless certain conditions apply. See Section 1.

Part D -- 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.

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

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

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

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

Plan Provider --"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 have an agreement with Seniority Plus to accept our payment as payment in full, and in some cases to coordinate as well as provide Covered Services to Members of Seniority Plus. Health Net pays Plan Providers based on the agreements it has with the Providers.

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

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

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

Primary Care Physician/Provider (PCP) -- A health care professional who is trained to give you basic care. Your PCP is responsible for providing or authorizing Covered Services while you are a Plan Member. Section 3 tells you more about PCPs.

Prior Authorization --Approval in advance to get services. Some in-network services are covered only if your doctor or other Plan Provider gets "Prior Authorization" from Health Net or your Medical Group. Covered Services that need Prior Authorization are marked in the benefits chart in Section 5. Prior Authorization is not required for out-of-network services.

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

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

Recommended Drug List (also known as **Health Net Recommended Drug List** or **the List)** is a list of the Prescription Drugs that are covered by this Plan. It is prepared and updated by Health Net and distributed to Members, Member Physicians and Participating Pharmacies and posted on the Health Net website at *www.healthnet.com/uc*. Some Drugs in the Recommended Drug List require Prior Authorization from Health Net in order to be covered.

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

Rehabilitative Services – These services include physical, cardiac, speech and language, and occupational therapies that are provided under the direction of a Plan Provider. See Section 7 for more information.

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

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

Service Area -- Section 2 tells about Seniority Plus'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.

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

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

Special Enrollment Period -- A set time when you can sign up for Medicare Part B if you didn't take Medicare Part B during the Initial Enrollment Period, because you or your spouse were working and had group health plan coverage through the employer or union. You can sign up at anytime you are covered under the group plan based on current employment status. The last eight months of the Special Enrollment Period starts the month after the employment ends or the group health coverage ends, whichever comes first.

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

Specialty Tier I (Injectable)-- Lower cost injectable drugs. These medications may be available to you at a coinsurance level.

Specialty Tier S (Specialty)--High cost oral and injectable specialty drugs. These medications may be available to you at a coinsurance level and are not eligible for exceptions for payment at a lower tier.

Urgently Needed Care -- Section 3 explains about urgently needed services. These are different from Emergency Services.

APPENDIX B. More detailed information about how to make an Appeal that involves your Medicare Advantage benefits

What is the purpose of this Appendix?

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

Note that this Appendix does not apply to Part D Prescription Drug benefits. See Appendix E for detailed information about how to make an Appeal that involves a request for Part D drug benefits.

A note about terminology. In this section, we tend to use simpler language instead of certain legal language, including terms that appear in the government regulations for the Appeals process. For example, we generally say "Initial Decision" instead of "initial Organization Determination," and we generally use the word "fast" rather than "expedited" when referring to decisions that are made more quickly than the standard time frame. Instead of saying "adverse decision," we may say "deny your request," or "turn down your Appeal." We use "independent review organization" rather than "independent review entity."

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

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

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

How does the Appeals process work?

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

- **Moving from one step to the next**. At each step, your request for care or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may 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 medical care involved or on other factors.
- **"Initial decision" vs. "making an Appeal."** Step 1 deals with the starting point for the Appeals process. The decision made in Step 1 is called an "Initial Decision" Or "Organization Determination." If you continue with your complaint by going on to Step 2, it is called making an "Appeal" or a "request for reconsideration" of our Initial Decision because you are "appealing" for a change in the Initial Decision that was made in Step 1. Step 2, and all of the remaining possible steps, also involve *appealing* a decision.
- **Who makes the decision at each step?** In Step 1, you make your request for coverage of care or payment for care directly to us. We review this request, then make an Initial Decision. If our Initial Decision is to turn down your request, you can go on to Step 2, where you Appeal this Initial Decision (asking us to reconsider). **After Step 2, your Appeal goes outside of Health Net, where people who are not connected to us conduct the review and make the decision**. To help ensure a fair, impartial decision, those who make the decision about your Appeal in Steps 3-6 are part of (or in some way connected to) the Medicare program or the federal court system.

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

What is an "Initial Decision?"

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

- If you ask us to pay for medical care you have already received, this is an "Initial

Decision" about payment for your care. You can call us at **1-800-539-4072** (TTY/TDD **1-800-929-9955**) to get help in making this request.

- If you ask for a specific type of medical treatment from your doctor or other medical Provider, this is a request for an "Initial Decision" about whether the treatment you want is covered by Seniority Plus. Depending on the situation, your doctor or other medical Provider may make this decision on behalf of Health Net, or may ask us whether we will authorize the treatment. You may want to ask us for an Initial Decision without involving your doctor. You can call us at **1-800-539-4072** (TTY/TDD **1-800-929-9955**) to ask for an Initial Decision.

When we make an "Initial Decision," we are giving our interpretation of how the benefits and services that are covered for Members of Seniority Plus apply to your specific situation. This booklet and any amendments you may receive describe the benefits and services covered by Seniority Plus, including any limitations that may apply to these services. This booklet also lists Exclusions (services that are "not covered" by Seniority Plus).

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

You can ask us for an Initial Decision yourself, or you can name someone to do it for you. This person you name would be your *authorized representative*. You can name a relative, friend, advocate, doctor, or someone else to act for you. Some other persons may already be authorized under state law to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to act as your authorized representative. This statement must be sent to us at Health Net Medical Management Department, 155 Grand Avenue, Suite #5000, Oakland, CA 94612. You can call us at **1-800-539-4072** to learn how to name your authorized 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.

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

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

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

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

Asking for a standard decision

To ask for a standard decision about medical care or payment for care, you or your authorized representative should mail or deliver a request in writing to the following address: Health Net Medical Management, 155 Grand Avenue, Suite #5000, Oakland, CA 94612.

Asking for a fast decision

You, any doctor, or your authorized representative can ask us to give a "fast" decision (rather than a "standard" decision) about medical care by calling us at **1-800-977-7282** (for TTY, call **1-800-929-9955**). Or, you can deliver a written request to Health Net Medical Management, 155 Grand Avenue, Suite #5000, Oakland, CA 94612, or fax it to **1-800-793-4473** (elective requests or **1-800-672-2135** (urgent requests). Requests received after business hours are handled on the next business day. Be sure to ask for a "fast" or "72-hour" review.

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

What happens when you request an "Initial Decision?"

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

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

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

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

We have up to 14 calendar days to make a decision after we have received your request, but we will make it sooner if your health condition requires. However, we are allowed to take up to an additional 14 calendar days to make a decision if you request additional time, or if we need more time to gather information that may benefit you. For example, we may need more time to get information that would help us approve your request for medical care (such as medical records). When we take additional days, we will notify you in writing of this extension. If you feel that we should not take additional days, you can make a specific type of complaint called a "Grievance." Section 10 of this booklet, tells how to file a Grievance.

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

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

3. For a <u>fast</u> Initial Decision about medical care:

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

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

What happens next if we decide completely in your favor?

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

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

   We must pay within 30 calendar days of your request for payment, unless your request has inaccurate or missing information. Then, we must pay within 60 calendar days.

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

   We must authorize or provide you with the care you have requested as quickly as your health requires, but no later than 14 calendar days after we received the request you made for the Initial Decision. If we extended the time needed to make the decision, we will approve or provide your medical care when we make our decision.

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

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

What happens next if we deny your request?

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

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

Please call us at **1-800-539-4072** (TTY/TDD **1-800-929-9955)** if you need help in filing your Appeal. You may ask us to reconsider the Initial Decision we made in Step 1, even if only part of our decision is not what you requested. When we receive your request to reconsider the Initial Decision, we give the request to different people than those who were involved in making the Initial Decision. This helps ensure that we will give your request a fresh look.

How you make your Appeal depends on whether it is about payment for care you already received, or about authorizing medical care. If your Appeal concerns a decision we made about authorizing medical care, then you and/or your doctor will first need to decide whether you need a "fast" *Appeal*. The procedures for deciding on a "standard" or a "fast" *Appeal* are the same as those described for a "standard" or "fast" *Initial Decision* in Step 1. Please see the discussion in Step 1 under "Do you have a request for medical care that needs to be decided more quickly than the standard time frame?" and "Asking for a fast decision." While the process for deciding on a standard or fast Appeal are the same as in Step 1, 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 Seniority Plus, Appeals and Grievances Department, P.O. Box 10344, Van Nuys, CA 91410-0344.
- By fax, at **1-818-676-8179.**
- By telephone -- if it is a "fast" Appeal -- at **1-800-539-4072** (TTY/TDD **1-800-929-9955**).
- In person at 21281 Burbank Boulevard, Woodland Hills, CA 91367.

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**), Health Net Seniority Plus, Appeals and Grievances Department, P.O. Box 10344, Van Nuys, CA 91410-0344.

How do you file your Appeal of the Initial Decision?

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

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

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

How soon must you file your Appeal?

You need to file your Appeal within 60 calendar days after we notify you of the Initial Decision from Step 1. We can give you more time if you have a good reason for missing the deadline. 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 Seniority Plus, Appeals and Grievances Department, P.O. Box 10344, Van Nuys, Ca 91410-0344.

What if you want a "fast" Appeal?

The rules about asking for a "fast" Appeal in Step 2 are the same as the rules about asking for a "fast" Initial Decision in Step 1. If you want to ask for a "fast" Appeal in Step 2, please follow the instructions in Step 1 under "Asking for a fast decision." While the process for deciding on a standard or fast Appeal are the same as in Step 1, the place where the Appeal is sent is different. You may submit your "fast" Appeal to us in any of the following ways:

- In writing, to Health Net Seniority Plus, Appeals and Grievance Department, P.O. Box 10344, Van Nuys, CA 91410-0344.
- By fax, at **1-818-676-8179**.
- By telephone at **1-800-539-4072** (TTY/TDD **1-800-929-9955**).
- In person, at 21281 Burbank Boulevard, Woodland Hills, CA 91367.

How soon must we decide on your Appeal?

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

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

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

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

What happens next if we decide completely in your favor?

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

   We must pay within 60 calendar days of the day we received your request for us to reconsider our Initial Decision. If we decide only partially in your favor, your Appeal automatically goes to Step 3, where an independent organization will review your case.

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

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

3. **For a fast decision about medical care.**

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

What happens next if we deny your Appeal?

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

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

   We must send all the information about your Appeal to the independent review organization within 60 calendar days from the date we received your Appeal in Step 2.

2. **For a <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 calendar days after we received your Appeal in Step 2.

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.

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

What independent review organization does this review?

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

How soon must the independent review organization decide?

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

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

If the independent review organization decides completely in your favor:

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

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

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

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

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

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

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

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

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

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

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

This Council will first decide whether to review your case
The Medicare Appeals Council does not review every case it receives. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then either you or Health Net may request a review by a Federal Court Judge. However, the Federal Court Judge will only review cases when the amount involved is the minimum requirement or more. If the dollar value is less than the minimum requirement, you may not Appeal any further.

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

If the Council decides in your favor:
We must pay for, authorize, or provide the medical service you have asked for within 60 calendar days from the date we receive notice of the decision. However, we have the right to Appeal this decision by asking a Federal Court Judge to review the case (Step 6), provided the amount involved is at least the minimum requirement. 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 or more, you have the right to continue your Appeal by asking a Federal Court Judge to review the case (Step 6). If the value is less than the minimum requirement, the Council's decision is final and you may not take the Appeal any further.

STEP 6: Your case goes to a Federal Court

If the amount meets the minimum requirement or more, you or we may ask a Federal Court Judge to review the case.

APPENDIX C. Legal Notices

Health care plan fraud

If you believe something has occurred fraudulently, wastefully and/or abusively, in relation to your health coverage, please contact Health Net at **1-800-747-0877**. All calls will be kept confidential, and you may remain anonymous if you choose.

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 Centers for Medicare & Medicaid Services, 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, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that receive federal funding, and any other laws and rules that apply for any other reason.

Member Non-Liability

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

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

Circumstances Beyond Health Net's Control

To the extent that a natural disaster, war, riot, civil insurrection, epidemic, complete or partial destruction of facilities, atomic explosion or other release of nuclear energy, disability of significant medical Group personnel, or other similar events, not within the control of Health Net, results in the facilities, or personnel, of Health Net not being available to provide or arrange for services or benefits under this Evidence of Coverage, Health Net's obligation to provide such services or benefits shall be limited to the requirement that Health Net make a good faith effort to provide or arrange for the provision of such services or benefits within the resulting limitations on the availability of its facilities or personnel.

When A Third Party Causes A Member Injuries

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

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

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

Steps You Must Take

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

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

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

companies in trust, and reimbursing Health Net and the medical Providers for the amount of the lien as soon as you are paid by the third party.

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

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

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

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

For more information on organ donations, including how to elect to be an organ donor, please contact the Member Services Department at the telephone number on your Health Net ID Card, or visit the Department of Health and Human Services organ donation website at www.organdonor.gov.

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

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

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

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

- **Payment**. We use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims or be reimbursed by another insurer that may be responsible for payment or for premium billing.
- **Health Care Operations**. We use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or customer service.
- **Treatment**. We may use and disclose your protected health information to assist your health care Providers (doctors, Hospitals and others) in your diagnosis and treatment. For example, we may disclose your protected health information to Providers to provide information about alternative treatments.
- **Plan Sponsor**. If you are enrolled through a group health plan, we may provide summaries of claims and expenses for enrollees in a group health plan to the plan sponsor, which is usually the employer.

  If the plan sponsor provides plan administration services, we may also provide access to identifiable health information to support its performance of such services which may include but are not limited to claims audits or customer services functions. Health Net will only share health information upon a certification from the plan sponsor representing there are restrictions in place to ensure that only plan sponsor employees with a legitimate need to know will have access to health information in order to provide plan administration functions.

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

Other permitted or required disclosures

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

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

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

- **Right To Access Your Protected Health Information**. You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.
- **Right To Amend Your Protected Health Information**. If you feel that protected health information maintained by the Plan is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by the Plan, as is often the case for health information in our records, or you ask to amend a record that is already accurate and complete.

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

  Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.
- **Right To Request Restrictions on the Use and Disclosure of Your Protected Health Information**. You have the right to request that we restrict or limit how we use or disclose your

protected health information for treatment, payment or health care operations. We may not agree to your request. If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

- **Right To Receive Confidential Communications**. You have the right to request that we use a certain method to communicate with you about the Plan or that we send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.
- **Contact Information for Exercising Your Rights**. You may exercise any of the rights described above by contacting our privacy office. See the end of this Notice for the contact information.

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

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

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

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

Contact the Plan
If you have any complaints or questions about this Notice or you want to submit a written request to the Plan as required in any of the previous sections of this Notice, please contact:

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

You may also contact us at:

Telephone: **1-800-522-0088**
Fax: **1-818-676-8981**
Email: Privacy@healthnet.com

This "Notice of Privacy Practices" also applies to enrollees in any of the following Health Net entities:
• Health Net of California, Inc.• Health Life Insurance Company, Inc.

APPENDIX D. Information about "*advance directives*"

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.

- You might want a particular person you trust to make these decisions for you.
- You might want to let health care Providers know the types of medical care you would *want* and *not want* if you were not able to make decisions for yourself.
- You might want to do both – to appoint someone else to make decisions for you, and to let this person and your health care Providers know the kinds of medical care you would want if you were unable to make these decisions for yourself.

If you want to, you can use a special form to give someone you trust the legal authority to make health care 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 document documents that you can use to give your directions in advance in these situations are called "advance directive." 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 do want to have an advance directive, there are several ways to get this type of legal form. You can get a form from your lawyer, from a social worker, and from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare, such as your HICAP. Section 1 of this booklet tells how to contact your local HICAP Agency. 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.

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). If you decide not to sign an advance directive form, you will not be denied care or be discriminated against in the care you are given. 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 the California Department of Health Services, P.O. Box 997413, M.S. 3200, Sacramento, CA 95899-7413. The telephone number for the California Department of Health is **1-916-636-1980**

APPENDIX E Appeals and Grievances: What to do if you have complaints about your Part D Prescription Drug benefits

What to do if you have complaints

Introduction

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 Appendix E addresses complaints about your Part D Prescription Drug benefits. If you have complaints about your MA benefits, you must follow the rules outlined in Sections 10 and Appendix B.

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 Seniority Plus 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. The following section briefly discusses Grievances, Coverage Determinations, and Appeals.

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 Seniority Plus 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.

What is a Coverage Determination?

Whenever you ask for a Part D Prescription Drug benefit, the first step is called requesting 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. Coverage determinations include Exceptions requests. You have the right to ask us for an "Exception" 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 Copayment. If you request an Exception, your physician must provide a statement to support your request.

You must contact us if you would like to request a Coverage Determination (including an Exception). You cannot request an Appeal if we have not issued a Coverage Determination.

What is an Appeal?

An Appeal is any of the procedures that deal with the review of an unfavorable Coverage Determination. You would file an Appeal if you want us to reconsider and change a decision we have made about what Part D Prescription Drug benefits are covered for you or what we will pay for a Prescription Drug.

How to file a Grievance

This part of Appendix E explains how to file a Grievance. A Grievance is different from a request for a Coverage Determination because it usually will not involve coverage or payment for Part D Prescription Drug benefits (concerns about our failure to cover or pay for a certain drug should be addressed through the Coverage Determination process discussed below).

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

- You feel that you are being encouraged to leave (Disenroll from) Seniority Plus.
- Problems with the Member Service you receive.
- Problems with how long you have to spend waiting on the phone or in the pharmacy.
- Disrespectful or rude behavior by pharmacists or other staff.
- Cleanliness or condition of pharmacy.
- If you disagree with our decision not to expedite your request for an expedited Coverage Determination or redetermination.
- You believe our notices and other written materials are difficult to understand.
- Failure to give you a decision within the required timeframe.
- Failure to forward your case to the independent review entity if we do not give you a decision within the required timeframe.
- Failure by the Plan to provide required notices.
- Failure to provide required notices that comply with CMS standards.

In certain cases, you have the right to ask for a "fast Grievance," meaning your Grievance will be decided within 24 hours. We discuss these fast-track Grievances in more detail below.

If you have a Grievance, 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 Seniority Plus Member Service Department at **1-800-539-4072** (TTY/TTD **1-800-929-9955**).

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

Health Net Seniority Plus
Appeals & Grievances Department
Post Office Box 10450
Van Nuys, CA 91410-0450

Fax: **1-818-676-5505 or 1-800-977-1959**

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

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

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

- We deny your request for a fast review of a request for drug benefits
- We deny your request for a fast review of an Appeal of denied drug benefits

Requests for Expedited Grievances may be submitted telephonically at **1-800-539-4072** (TTY/TTD **1-800-929-9955**). You may also submit your complaint in writing or via facsimile to Health Net at:

Health Net Seniority Plus
Appeals & Grievances Department
Post Office Box 10450
Van Nuys, CA 91410-0450

Fax: **1-818-676-5505 or 1-800-977-1959**

Once the Expedited Grievance is received by Health Net, a Clinical Practitioner will review the case to determine the circumstances surrounding the denial of your request for expedited review.

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

Complaints about a decision regarding payment for, or provision of, covered benefits that you believe should be provided or paid for by Health Net must be appealed through Health Net's Medicare Part D Appeals procedure (described in "How to request an Appeal" in this Section).

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

For quality of care complaints, you may also complain to the Quality Improvement Organization (QIO)

Complaints concerning the quality of care received under Medicare may be acted upon by the plan sponsor under the Grievance process, by an independent organization called the QIO, or by both. For example, if an enrollee believes his/her pharmacist provided the incorrect dose of a prescription, the enrollee may file a complaint with the QIO in addition to or in lieu of a complaint filed under the plan sponsor's Grievance process. For any complaint filed with the QIO, the plan sponsor must cooperate with the QIO in resolving the complaint.

How to file a quality of care complaint with the QIO

Quality of care complaints filed with the QIO must be made in writing. 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 Section 10 of the introduction for more information about how to file a quality of care complaint with the QIO.

How to request a Coverage Determination

This part of Appendix E 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.

If your doctor or pharmacist tells you that Seniority Plus will not cover a Prescription Drug, you should contact us and ask for a Coverage Determination. The following are examples of when you may want to ask us for a Coverage Determination:

- If you are not getting a Prescription Drug that you believe may be covered by Seniority Plus.
- If you have received a Part D Prescription Drug you believe may be covered by Seniority Plus while you were a Member, but we have refused to pay for the drug.
- If we will not provide or pay for a Part D Prescription Drug that your doctor has prescribed for you because it is not on our list of covered drugs (called a "Formulary"). You can request an Exception to our Formulary. **See "How Can I Request an Exception" in section 6 for more information about the exceptions process.**
- If you disagree with the amount that we require you to pay for a Part D Prescription Drug that your doctor has prescribed for you. You can request an Exception to the Copayment we require you to pay for a drug. **See "How Can I Request an Exception" in section 6 for more information about the Exceptions process.**
- If you are being told that coverage for a Part D Prescription Drug that you have been getting will be reduced or stopped.
- If there is a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation. **See "How Can I Request an Exception" in section 6 for more information about the Exceptions process.**
- If there is a requirement that you try another drug before we will pay for the drug you are requesting. **See "How Can I Request an Exception" in section 6 for more information about the Exceptions process.**
- You bought a drug at a pharmacy that is not in our network and you want to request reimbursement for the expense.

The process for requesting a Coverage Determination is discussed in greater detail below in the section titled "Detailed information about how to request a Coverage Determination and an Appeal."

How to request an Appeal

This part of Appendix E explains what you can do if you disagree with our Coverage Determination. If you are unhappy with the Coverage Determination, you can ask for an Appeal. The first level of Appeal is called a redetermination. There are also four other levels of Appeal that an enrollee may request.

What kinds of decisions can be appealed?

You can generally Appeal our decision not to cover a 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. You can also Appeal 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 Exception request as described in section 6 of this brochure, you can Appeal. A Coverage Determination, which includes those described on page 90, may be appealed if you disagree with our decision.

Note: If we approve your Exception request for a non-Formulary drug, you cannot request an Exception to the Copayment we require you to pay for the drug.

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 your request (in whole or in part), 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 then sent outside of Seniority Plus, where people who are not connected to us conduct the review 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 in the section titled "Detailed information about how to request a Coverage Determination and an Appeal."

Detailed information about how to request a Coverage Determination and an Appeal

What is the purpose of this section?

The purpose of this section is to give you more information about how to request a Coverage Determination, or Appeal a decision by us not to cover or pay for all or part of a drug, vaccine or other Part D benefit.

Coverage Determinations: Seniority Plus makes a Coverage Determination about your Part D Prescription Drug, or about paying for a Part D Prescription Drug you have already received.

What is a Coverage Determination?

The Coverage Determination made by Seniority Plus 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 Seniority Plus 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**) to get help in making this request.
- You ask for a Part D drug that is not on your plan's list of covered drugs (called a "Formulary"). This is a request for a "Formulary Exception." You can call us at **1-800-539-4072** (TTY/TDD **1-800-929-9955**) to ask for this type of decision.
- You ask for an Exception to our Plan’s utilization management tools - such as 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**) to ask for this type of decision.
- 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**) to ask for this type of decision.

- You ask that we reimburse you for a purchase you made from 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 page 44 for a description of these circumstances. You can call us at **1-800-539-4072** (TTY/TDD **1-800-929-9955**) 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 Seniority Plus apply to your specific situation. This booklet and any amendments you may receive describe the Part D Prescription Drug benefits covered by Seniority Plus, including any limitations that may apply to these benefits. This booklet also lists Exclusions (benefits that are "not covered" by Seniority Plus).

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 Seniority Plus Appeals & Grievances Department, Post Office Box 10450,Van Nuys, CA 91410-0450.

You can call us at **1-800-539-4072** (TTY/TDD **1-800-929-9955**) to learn how to name your appointed representative.

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

Asking for a "standard" or "fast" Coverage Determination

Do you have a request for a Part D Prescription Drug that needs to be decided more quickly than the standard timeframe?

A decision about whether we will cover a Part D Prescription Drug can be a "standard" Coverage Determination that is made within the standard timeframe (typically within 72 hours; see below), or it can be a "fast" Coverage Determination that is made more quickly (typically within 24 hours; see below). A fast decision is sometimes called an "expedited Coverage Determination."

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

Asking for a standard decision

To ask for a standard decision, you, your doctor, or your appointed representative should call us at **1-800-539-4072** (for TTY, call **1-800-929-9955**). Or, you can deliver a written request to Health Net Pharmacy Department, Post Office Box 9103, Van Nuys, CA 91403-9103, or fax it to **1-916-463-9754**. Requests received after business hours are handled on the next business day.

Asking for a fast decision

You, your doctor, or your appointed representative can ask us to give a fast decision (rather than a standard decision) by calling us at **1-800-539-4072** (for TTY, call **1-800-929-9955**). Or, you can deliver a written request to Health Net Pharmacy Department, Post Office Box 9103, Van Nuys, CA 91403-9103, or fax it to **1-916-463-9754**. Be sure to ask for a "fast," "expedited," or "24-hour" review. To request a fast decision outside of regular weekday business hours, call **1-800-539-4072** (TTY/TDD users should call the California Relay Service at **711** or **1-800-735-2929**).

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

What happens when you request a Coverage Determination?

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

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

What happens if we decide completely in your favor?

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

1. **For a <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).

Appeal Level 1: If we deny part or all or 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**) 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 timeframe?" and "Asking for a fast decision."

While the process for deciding on a standard or fast Appeal is the same as in the case of a Coverage Determination, the place where the Appeal is sent is different. See "What if you want a ‘fast’ Appeal" later in this section for more information.

Getting information to support your Appeal

We must gather all the information we need to make a decision about your Appeal. If we need your assistance in gathering this information, we will contact you. You have the right to 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 Seniority Plus, Appeals and Grievance Department, Post Office Box 10450, Van Nuys, California 91410-0450.
- By fax, at **1-818-676-5505 or 1-800-977-1959**.
- By telephone – if it is a fast Appeal – at **1-800-539-4072** (TTY/TDD **1-800-929-9955**).
- In person, at 21281 Burbank Boulevard, Woodland Hills, California, 91367.

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**), Seniority Plus, Appeals and Grievance 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 Seniority Plus, Appeals and Grievance 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**). Or, you can deliver a written request to Seniority Plus, Appeals and Grievance Department, Post Office Box 10450, Van Nuys, California 91410-0450, or fax it to **1-800-676-5505 or 1-800-977-1959**. Requests received after business hours are handled on the next business day. Be sure to ask for a "fast," "expedited," or "72-hour" review.

Remember, that if your prescribing 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. See "Getting information to support your Appeal."

How soon must we decide on your Appeal?

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

1. **For a standard decision about a Part D drug, which includes a request for reimbursement for a Part D drug you already paid for and received.**
   After we 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 within 72 hours of receiving your Appeal – or sooner, if your health would be affected by waiting this long.

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 Seniority Plus.

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 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 you receive from Seniority Plus.

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 supporting statement explaining that you need the fast Appeal, the IRE 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:

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

2. For a fast decision about a Part D drug that you have not received, the independent review organization has up to 72 hours from the time it 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 abided by 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 abided by 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 abided by their decision.

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

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

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 the 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's can also be found at http://www.hhs.gov/omha/offices.html.

During the Administrative Law Judge review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel. The Administrative Law Judge will not review your Appeal if the dollar value of the requested Part D benefit is less than the minimum requirement. If the dollar value is less than 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 the number of refills prescribed for the requested drug during the plan year. Projected value includes your Copayments, 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:

1. The claims involve the delivery of Part D Prescription Drugs to you;
2. All of the claims have received a determination by the independent review organization as described in Appeal Level 2;
3. Each of the combined requests for review are filed in writing within 60 calendar days after the date that each decision was made at Appeal Level 2; and
4. Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

How soon does the Judge make a decision?

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

If the Judge decides in your favor:

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

1. *For a decision about payment for a Part D drug you already received.*
   We must send payment to you no later than 30 calendar days from the date we 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. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

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

If the Council decides in your favor:

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

1. *For a decision about payment for a Part D drug you already received.*
   We must send payment to you no later than 30 calendar days from the date we 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 or more, 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 or more, 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.

INDEX

For more information, please contact us at:

Health Net Seniority Plus
Post Office Box 10198
Van Nuys, California 91410-0198

Member Services Department
1-800-539-4072
Our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week..

Para los que hablan español
1-800-331-1777
Nuestras horas de negocio son de las de 8:00am a 8:00pm, siete días a la semana

Telecommunications Device for the Deaf
1-800-929-9955
Our office hours are 8:00 a.m. to 8:00 p.m., 7 days a week..

WWW.HEALTHNET.COM/UC