



A COMPLETE

explanation of your plan

Health Net Prescription Drug Plan

*For University of California Medicare members
in Madera, Nevada or Ventura Counties
Effective 1/1/2010*

Evidence of Coverage
Health Net Medicare
Prescription Drug Plan (PDP)
Plan POB
EOCID: 264779

Schedule changes in 2010

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

Changes to this Plan

Part D Prescription Drugs

➤ Under **“Part D Prescription Drugs,”**

Retail prescription drug copayment change from \$10/\$20/\$35 to \$5/\$20/\$35.

Mail Order prescription drug copayment change from \$20/\$40/\$70 to \$10/\$40/\$70.

If the member requests a brand name drug or if the prescription drug order states "dispense as written, "do not substitute" or words of similar meaning in the physician's handwriting, the Tier 3 Prescription Drug copayment will apply.

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

January 1, 2010

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.

The covered services and supplies of this Plan are available to the following people as long as they live in the continental United States, either work or live in the Health Net Service Area, and meet any additional eligibility requirements of the Group and this Evidence of Coverage:

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 disenrolled from this health plan.

Subscriber

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

* Lecturers - see your benefits office for eligibility.

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

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

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

- (a) you meet the University's service credit requirements for Retiree medical eligibility;
- (b) the effective date of your Retiree status is within 120 calendar days of the date employment ends; and
- (c) you elect to continue (or effective 1/1/05 suspend) 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* or the *Survivor and Beneficiary Handbook*.

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

Eligible Dependents (Family Members)

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

Spouse: Your legal spouse.

Child: All eligible children must be under the limiting age (18 for legal wards, 23 for all others except for a child who is incapable of self-support due to a physical or mentally disabling injury, illness or condition), unmarried, and may not be emancipated minors. The following categories are eligible:

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

- (d) children for whom you are the legal guardian if living with you, dependent on you for at least 50% of their support and are your dependents for income tax purposes.
- (e) children for whom you are legally required to provide group health insurance pursuant to an administrative or court order. (Child must also meet UC eligibility requirements.)

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

- the plan-certified incapacity began before age 23, the child was enrolled in a group medical plan before age 23 and coverage is continuous;
- the child is chiefly dependent upon you for support and maintenance;
- the child is claimed as your dependent for income tax purposes or is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment which may offset the Social Security or Supplemental Security Income; and
- the child lives with you (unless he or she is your natural or adopted child).

Application for coverage beyond age 23 due to disability must be made to the Plan sixty days prior to the date coverage is to end due to reaching limiting age. If application is received timely but Plan does not complete determination of the child's continuing eligibility by the date the child reaches the Plan's upper age limit, the child will remain covered pending Plan's determination. The Plan may periodically request proof of continued disability, but not more than once a year after the initial certification. Incapacitated children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required; however, the new Plan may require proof of continued disability, but not more than once a year.

If you are a newly hired Employee with an incapacitated child over age 23 or if you newly acquire an incapacitated child over age 23 (through marriage or adoption), you may also apply for coverage for that child. The child's incapacity must have begun prior to the child turning age 23. Additionally, the child must have had continuous group medical coverage since age 23, and you must apply for University coverage during your Period of Initial Eligibility. The Plan will ask for proof that the child is incapable of self-support due to a physical or mentally disabling injury, illness or condition, but not more than once a year after the initial certification.

Other Eligible Dependents (Family Members): You may enroll a same-sex domestic partner (and the same-sex domestic partner's children/grandchildren) as set forth in the University of California Group Insurance Regulations. The University recognizes an opposite-sex domestic partner as a family member that is eligible for coverage in UC-sponsored benefits if the employee/retiree or domestic partner is age 62 or older and eligible to receive Social Security benefits and both the employee/retiree and domestic partner are at least 18 years of age.

An adult dependent relative is no longer eligible for coverage. Only an adult dependent relative who was enrolled as an eligible dependent as of December 31, 2003 and continues to be ineligible for Social Security 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 (UC) Customer Service Center. You may also access eligibility factsheets on UC's *At Your Service* web site: <http://atyourservice.ucop.edu>.

For additional information, see: Chapter 1. University of California Eligibility, Enrollment, Termination and Plan Administration Provisions

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 UC 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 UC Customer Service Center by the last business day within the applicable enrollment period; electronic transactions must be completed by the deadline on the last day of the enrollment period.

During a Period of Initial Eligibility (PIE)

A PIE begins the day you become eligible and ends 31 days after it began (but see exception under "Special Circumstances" paragraph 1.d below). Also see "At Other Times for Employees and Retirees" below.

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 Domestic Partner, on the date the domestic partnership is legally established. Also see “At Other Times for Employees and Retirees” below.
- (c) For a natural child, on the child's date of birth.
- (d) For an adopted child, the earlier of:
 - (i) the date you or your Spouse or Domestic Partner 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.

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

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

At Other Times for Employees and Retirees

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

90-Day Waiting Period. If you are an Employee and 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 unless one of the “Special Circumstances” described below applies.

If you are an Employee or Retiree and fail to enroll your eligible Family Members during a PIE or open enrollment period, you may enroll your eligible Family Members at any other time upon completion of a 90 consecutive calendar day waiting period unless one of the “Special Circumstances” described below applies.

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

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

Special Circumstances. You may enroll before the end of the 90-day waiting period or without waiting for the University's next open enrollment period if you are otherwise eligible under any one of the circumstances set forth below:

1. You have met all of the following requirements:
 - a. You were covered under another health plan as an individual or dependent, including coverage under COBRA or CalCOBRA (or similar program in another state), the Children's Health Insurance Program or "CHIP" (called the Healthy Families Program in California), or Medicaid (called Medi-Cal in California).
 - b. You stated at the time you became eligible for coverage under this Plan that you were declining coverage under this Plan or disenrolling because you were covered under another health plan as stated above.
 - c. Your coverage under the other health plan wherein you or your eligible Family Members were covered as an individual or dependent ended because you lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, your coverage under COBRA or CalCOBRA continuation was exhausted, or you lost coverage under CHIP or Medicaid because you were no longer eligible for those programs.
 - d. You properly file an application with the University during the PIE which starts on the day after the other coverage ends. **Note that if you lose coverage under CHIP or Medicaid, your PIE is 60 days.**
2. A court has ordered coverage be provided for a spouse, domestic partner or dependent child under your UC-sponsored medical plan and an application is filed within the PIE which begins the date the court order is issued. (Family member(s) must also meet UC eligibility requirements.)
3. You have a change in family status through marriage or domestic partnership, or the birth, adoption, or placement for adoption of a child:
 - a. If you are enrolling following marriage or establishment of a domestic partnership, you and your new spouse or domestic partner must enroll during the PIE. Your new spouse or domestic partner's eligible children may also enroll at that time. Coverage will be effective as of the date of marriage or domestic partnership provided you enroll during the PIE.
 - b. If you are enrolling following the birth, adoption, or placement for adoption of a child, your spouse (if you are already married) or domestic partner, who is eligible but not enrolled, may also enroll at that time. Application must be made during the PIE; coverage

will be effective as of the date of birth, adoption, or placement for adoption provided you enroll during the PIE.

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

If you are an Employee or a Retiree and there is a lifetime maximum for all benefits under this plan, and you or a Family Member reaches that maximum, you and your eligible Family Members may be eligible to enroll in another UC-sponsored medical plan. Contact the person who handles benefits at your location (or the UC 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, and you may change your plan during the University's next open enrollment period. 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). Retirement alone does not grant a PIE nor allow the changing of your medical plan.

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 make any of the changes described above, contact the person who handles benefits at your location (or the UC 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 between July 1, 1991 and January 1, 2004, but declined to enroll in Part B of Medicare, are assessed a monthly offset fee by the University to cover increased costs. The offset fee may increase annually, but will stop when the Retiree or Family Member becomes covered under Part B.

Retirees or 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 Part A and Part B 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 UC Customer Service Center or from the web site: <http://atyourservice.ucop.edu>. Completed forms should be returned to University of California, Human Resources, Retiree Insurance Program, Post Office Box 24570, Oakland, CA 94623-1570.

Any individual enrolled in a University-sponsored Medicare Advantage Managed Care contract must assign his/her Medicare benefit (including Part D) to that plan or lose UC-sponsored medical coverage. Anyone enrolled concurrently in a non-University Medicare Advantage Managed Care contract will be disenrolled from this health plan. Any individual enrolled in a University-sponsored Medicare Part D Prescription Drug Plan must assign his/her Part D benefit to the plan or lose UC-sponsored medical coverage. Anyone enrolled concurrently in a non-University Medicare Part D Prescription Drug Plan will be disenrolled 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. Employees or their spouses, age 65 or over, and UC Retirees re-hired into positions making them eligible for UC-sponsored medical coverage, including CORE and mid-level benefits, are subject to MSP. For those 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 and your spouse should carefully consider the impact on your health benefits and premiums at age 65 or should you decide to return to work after you retire. Continued employment past age 65 may delay enrollment into Part B, however, once enrolled, Part B must be continuous.

Medicare Private Contracting Provision and Providers Who do Not Accept Medicare

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

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

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

confirm that your provider takes Medicare prior to obtaining services for which you wish the Plan to pay.

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

TERMINATION OF COVERAGE

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

Deenrollment Due to Loss of Eligible Status

If you are an Employee and lose eligibility, your coverage and that of any enrolled Family Member stops at the end of the last month for which premiums are taken from earnings based on an eligible appointment. If you are hospitalized or undergoing treatment of a medical condition covered by this Plan, benefits will cease to be provided and you may have to pay for the cost of those benefits yourself. You may be entitled to continued benefits under terms which are specified elsewhere in this document. (If you apply for HIPAA coverage and conversion the benefits may not be the same as you had under this Plan.)

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

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

Deenrollment Due to Fraud

Coverage for you or your Family Members may be terminated for fraud or deception in the use of the services of the Plan, or for knowingly permitting such fraud or deception by another. Such termination shall be effective upon the later of (1) the date shown on the written notice to you; or (2) the date of the mailing of written notice to you (and to the University if notice is given by the Plan). A Family Member who commits fraud or deception or on whose behalf you commit fraud or deception will be permanently deenrolled. If you commit fraud or deception, you and any eligible 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

As a participant in this plan you may be entitled to continue health care coverage for yourself, spouse or family members if there is a loss of coverage under the plan as a result of a qualifying event under the terms of the federal COBRA continuation requirements under the Public Health Service Act, as amended, and, if that continued coverage ends, you may be eligible for further continuation under California law. You or your family members will have to pay for such coverage. You may direct questions about these provisions to CONEXIS, UC's COBRA administrator or visit the website

http://atyourservice.ucop.edu/employees/health_welfare/cobra.html

PLAN ADMINISTRATION

By authority of the Regents, University of California Human Resources, 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 insurance contracts. What is written in this document does not constitute a guarantee of plan coverage or benefits--particular rules and eligibility requirements must be met before benefits can be received. 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
300 Lakeside Drive
Oakland, CA 94612
(800) 888-8267

Retirees and Survivors may also direct questions to the UC 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 Medicare COB
P.O. Box 10198
Van Nuys, CA 91410-09108
1-800-539-4072

Group Contract Number

The Group Contract Number for this Plan is: 5047RC, G, M, R, V, Z, 5047SD, J, N, S, W, 5047TB, H, M, S, X, 5047UC, G, M, T, Y, 5047VC, H

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 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 (carrier's name) under a Group Service Agreement.

The cost of the premiums is currently shared between you and the University of California.

Agent for Serving of Legal Process

Legal process may be served on (carrier's name) 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 file an appeal regarding denied claims of benefits or services, refer to the appeal section found later in this document. Any appeals regarding coverage denials that relate to eligibility requirements are subject to the UC Group Insurance Regulations. To obtain a copy of the Eligibility Claims Appeal Process, please contact the person who handles benefits at your location (or the UC Customer Service Center if you are a retiree).

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.

Evidence of Coverage: Your Medicare Prescription Drug Coverage as a Member of Health Net Prescription Drug (Employer Group PDP - UC)

This booklet gives you the details about your Medicare prescription drug coverage for the 2010 benefit period. It explains how to get the prescription drugs you need. This is an important legal document. Please keep it in a safe place.

Health Net Prescription Drug (Employer Group PDP - UC) Customer Service:

For help or information, please call Customer Service or go to our plan website at

www.healthnet.com/uc

1-800-539-4072 (Calls to these numbers are free.)

TTY/TDD users call: 1-800-929-9955

This plan is offered by Health Net Life Insurance Company, referred throughout the Evidence of Coverage as “we,” “us,” or “our.” Health Net Prescription Drug (Employer Group PDP - UC) is referred to as “plan” or “our plan.”

Our organization contracts with the Federal Government. Our plan’s contract with the Centers for Medicare & Medicaid Services (CMS) is renewed annually, and availability of coverage beyond the end of the current contract year is not guaranteed.

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

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

Plan Benefit Chart

Initial Coverage Stage

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

You will pay the following for your covered prescription drugs until you reach the plan's Out-of-Pocket Maximum or the Catastrophic Coverage Stage:

Drug Tier	Retail Pharmacy (30 day supply)	Retail Pharmacy (90 day Supply)	Mail-Order Pharmacy (60-day supply)	Mail-Order Pharmacy or obtained through the UC Walk-Up Service (90-day supply)	Out of Network Retail Pharmacy (30 day supply)
Tier 1 - Preferred Generic Drugs (Generally includes preferred generic drugs. May include some preferred brand drugs.)	\$5	\$15	\$10	\$10	\$5
Tier 2 - Preferred Brand Drugs (Generally includes preferred brand drugs. May include some preferred generic drugs.)	\$20	\$60	\$40	\$40	\$20
Tier 3 - Preferred Brand Drugs (Generally includes preferred brand drugs. May include some preferred generic drugs.)	\$35	\$105	\$70	\$70	\$35
Injectable Drugs (Lower cost injectable drugs. Injectable drugs are limited to a maximum 30-day supply per fill even when obtained through mail order. Not all Injectable drugs are available through mail order.)	25%	25%	25%	25 %	25 %

Drug Tier	Retail Pharmacy (30 day supply)	Retail Pharmacy (90 day Supply)	Mail-Order Pharmacy (60-day supply)	Mail-Order Pharmacy or obtained through the UC Walk-Up Service (90-day supply)	Out of Network Retail Pharmacy (30 day supply)
Specialty Drugs (High-cost oral and injectable drugs. Specialty drugs are limited to a maximum 30-day supply per fill even when obtained through mail order and are not eligible for exceptions for payment at a lower tier. Not all Specialty drugs are available through mail order.)	25%	25%	25%	25%	25%
Erectile Dysfunction Drugs	50%	N/A	N/A	N/A	N/A

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

Once your copayment/coinsurance for outpatient prescription drugs total \$2,000 in the calendar year, you will not pay any more copayment/coinsurance for covered prescription drugs for the rest of the year. All expenses that apply to the \$2000 out-of-pocket maximum will automatically be calculated by Health Net. .

Catastrophic Coverage Stage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend \$4,550 out-of-pocket for the year. When the total amount you have paid toward your coinsurance or co-payments reaches \$4,550, you will qualify for catastrophic coverage. During catastrophic coverage you will pay: the greater of \$2.50 for generics or drugs that are treated like generics and the greater of 5% coinsurance or \$6.30 for all other drugs. We will pay the rest.

Notes:

- Generic drugs will be dispensed when a generic drug equivalent is available. If the member requests a brand name drug or if the prescription drug order states “dispense as written,” “do not substitute,” or words of similar meaning in the physician’s handwriting, the Tier 3 Prescription Drug copayment will apply.
- After your yearly out-of-pocket drug costs reach \$2,000, copayments and coinsurances will not be required for the remainder of the calendar year until you qualify for Catastrophic Coverage.
- 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 counts towards this plan’s out-of-pocket maximum, but does not count towards your total out of pocket costs to qualify you for catastrophic coverage.
- Prescription drugs for erectile dysfunction are covered as stated in the formulary and are limited to 4 doses per month.
- Prescription drugs for the treatment of diabetes (including insulin) are covered as stated in the formulary, specific brands of blood glucose monitors and testing strips, Ketone test strips, lancet puncture devices and lancets when used in monitoring blood glucose levels.
- Some retail pharmacies may provide up to a 90-day supply of maintenance medication for a copayment per 30-day supply. Please check with your retail pharmacy to see if this service is available to you.
- Your provider must get prior authorization from Health Net for certain prescription drugs. Contact Health Net for details.

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Chapter 1. Getting started as a member of our plan

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SECTION 1 Introduction

Section 1.1 What is the <i>Evidence of Coverage</i> booklet about?
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This *Evidence of Coverage* booklet tells you how to get your Medicare prescription drug coverage through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

- You are covered by Original Medicare for your health care coverage, and you have chosen to get your Medicare prescription drug coverage through our plan.

This plan is offered by Health Net Life Insurance Company, referred throughout the Evidence of Coverage as “we,” “us,” or “our.” Health Net Prescription Drug (Employer Group PDP - UC) is referred to as “plan” or “our plan.”

The word “coverage” and “covered drugs” refers to the prescription drug coverage available to you as a member of our plan.

Section 1.2 What does this Chapter tell you?
--

Look through Chapter 1 of this *Evidence of Coverage* to learn:

- What makes you eligible to be a plan member?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- What is your plan’s service area?
- How do you keep the information in your membership record up to date?

Section 1.3 What if you are new to our plan?
--

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

If you are confused or concerned or just have a question, please contact our plan's Customer Service (contact information is on the cover of this booklet).

Section 1.4	Legal information about the <i>Evidence of Coverage</i>
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This *Evidence of Coverage* is part of our contract with your Group about how our plan covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes or extra conditions that can affect your coverage. These notices are sometimes called “riders” or “amendments.”

Medicare must approve our plan each year

Our contract with the Centers for Medicare & Medicaid Services (CMS) is renewed annually. You can continue to get Medicare coverage as a member of our plan only as long as we choose to continue to offer the plan for the year in question and the Centers for Medicare & Medicaid Services renews its approval of the plan.

SECTION 2

What makes you eligible to be a plan member?

Section 2.1	Your eligibility requirements (also see Chapter 1. Eligibility, Enrollment and Termination).
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This Plan is available to the following people as long as they live in the United States, either work or live in our service area and meet any additional eligibility requirements of the Group:

- The principal member who is entitled to Medicare Part A and enrolled in Medicare Part B;
- Spouse, who must be listed on the enrollment form completed by the principal member and meets the same qualifications as the principal member. (The term "spouse" may also include the member's domestic partner as defined, as required by the law in your State.)

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

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

Section 2.2 What are Medicare Part A and Medicare Part B?

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally covers services furnished by providers such as hospitals, skilled nursing facilities or home health agencies.
- Medicare Part B is for most other medical services, such as physician's services and other outpatient services.

Section 2.3 Here is the plan service area for our plan

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

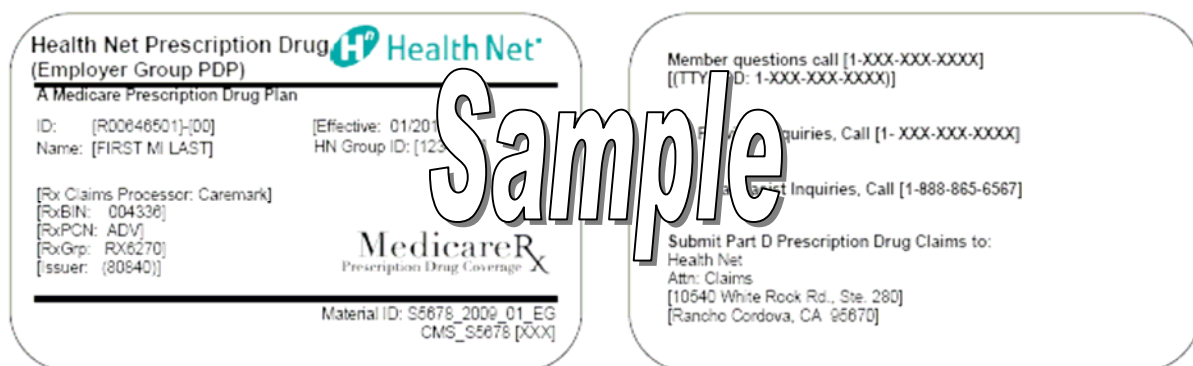
Our service area includes these counties:

Madera, Nevada and Ventura counties.

SECTION 3 What other materials will you get from us?

Section 3.1 Your plan membership card – Use it to get all covered prescription drugs

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



Please carry your card with you at all times and remember to show your card when you get covered drugs. If your plan membership card is damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

Section 3.2	The <i>Pharmacy Directory</i>: your guide to pharmacies in our network
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What are “network pharmacies”?

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

Why do you need to know about network pharmacies?

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

We will send you a complete *Pharmacy Directory* **once a year**.

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

Section 3.3	The plan's <i>List of Covered Drugs (Formulary)</i>
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The plan has a *List of Covered Drugs (Formulary)*. We call it the “Drug List” for short. It tells which Part D prescription drugs are covered by our plan. The drugs on this list are selected by the plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved the plan's Drug List.

We will send you a copy of the Drug List. To get the most complete and current information about which drugs are covered, you can visit the plan's website (www.healthnet.com/uc) or call Customer Service (phone numbers are on the back cover of this booklet).

Section 3.4	Reports with a summary of payments made for your prescription drugs
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When you use your prescription drug benefits, we will send you a report to help you understand and keep track of payments for your prescription drugs. This summary report is called the *Explanation of Benefits*.

The *Explanation of Benefits* tells you the total amount you have spent on your prescription drugs and the total amount we have paid for each of your prescription drugs during the month. Chapter 4 (*What you pay for your Part D prescription drugs*) gives more information about the *Explanation of Benefits* and how it can help you keep track of your drug coverage.

An *Explanation of Benefits* summary is also available upon request. To get a copy, please contact Customer Service.

SECTION 4 Your monthly premium for our plan

Section 4.1 How much is your plan premium?
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Please see your Group for information about the premium payment for this Plan.

In some situations, your plan premium could be less

There are programs to help people with limited resources pay for their drugs. Chapter 2, Section 7 tells more about these programs. If you qualify for one of these programs, enrolling in the program might make your monthly plan premium lower.

If you are *already enrolled* and getting help from one of these programs, **some of the payment information in this *Evidence of Coverage* may not apply to you**. We have included a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), that tells you about your drug coverage. If you don’t have this insert, please call Customer Service and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Customer Service are on the back cover.

In some situations, your plan premium could be more

Some members are required to pay a **late enrollment penalty** because they did not join a Medicare drug plan when they first became eligible or because they had a continuous period of 63 days or more when they didn’t keep their coverage. For these members, the plan’s monthly premium will be higher. It will be the monthly plan premium plus the amount of their late enrollment penalty.

If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 4, Section 10 explains the late enrollment penalty.

Many members are required to pay other Medicare premiums

In addition to paying the monthly plan premium, some plan members will be paying a premium for Medicare Part A and most plan members will be paying a premium for Medicare Part B. You must continue paying your Medicare Part B premium for you to remain as a member of the plan.

- Your copy of *Medicare & You 2010* tells about these premiums in the section called “2010 Medicare Costs.” This explains how the Part B premium differs for people with different incomes.
- Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2010* from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.

Section 4.2	Can your monthly plan premium change during the year?
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In some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for Extra Help or if you lose your eligibility for Extra Help during the year. If a member qualifies for Extra Help with their prescription drug costs, Extra Help will pay part of the member’s monthly plan premium. So a member who becomes eligible for Extra Help during the year would begin to pay less toward their monthly premium. And a member who loses their eligibility during the year will need to start paying their full monthly premium. You can find out more about Extra Help in Chapter 2, Section 7.

What if you believe you have qualified for “Extra Help”

If you believe you have qualified for Extra Help and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper co-payment level, or, if you already have the evidence, to provide this evidence to us. Contact the Customer Service number on your membership card and advise the representative that you believe you qualify for extra help and are paying an incorrect co-payment. You may be required to provide one of the following:

- A copy of your Medicaid card that includes your name and your eligibility date during a month after June of the previous calendar year;
- A copy of a state document that confirms your active Medicaid status during a month after June of the previous calendar year;

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

If you are institutionalized and believe you qualify for zero cost-sharing, contact the Customer Service number on your membership card and advise the representative that you believe you qualify for extra help and are paying an incorrect co-payment. You may be required to provide one of the following:

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

When we receive the evidence showing your copayment level, we will update our system so that you can pay the correct copayment when you get your next prescription at the pharmacy. If you overpay your copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future copayments. If the pharmacy hasn't collected a copayment from you and is carrying your copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Service if you have questions.

SECTION 5 Please keep your plan membership record up to date

Section 5.1 How to help make sure that we have accurate information about you

Your membership record has information from your enrollment form, including your address and telephone number. It shows your specific plan coverage.

The pharmacists in the plan's network need to have correct information about you. **These network providers use your membership record to know what drugs are covered for you.** Because of this, it is very important that you help us keep your information up to date.

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

- Changes to your name, your address, or your phone number
- Changes in any other medical or drug insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home

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

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan.

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

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SECTION 1 Our plans contacts (how to contact us, including how to reach Customer Service at the plan)

How to contact our plan's Customer Service

For assistance with claims, billing or member card questions, please call or write to Health Net Prescription Drug (Employer Group PDP - UC) Customer Service. We will be happy to help you.

Customer Service	
CALL	1-800-539-4072 Calls to this number are free. Hours of Operation 8:00 a.m to 8:00 p.m Pacific time seven days a week During the annual enrollment period (between November 15th and December 31st) through 60 days past the beginning of the following contract year, our plan operates a toll-free call center for both current and prospective members that is staffed seven days a week from 8:00 a.m. to 8:00 p.m. Pacific time. During this time period, current and prospective members are able to speak with a Customer Service representative. If you call outside these hours, when leaving a message, you should include your name, number, the time you called, and a representative will return your call no later than one business day after you leave a message.) However, after March 2, 2010, your call will be handled by our automated phone system on Saturdays, Sundays, and holidays. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day after you leave a message.
TTY/TDD	1-800-929-9955 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Calls to this number are free.	
FAX	1-800-956-4609
WRITE	Health Net Medicare P.O. Box 6501 Rensselaer, NY 12144
WEBSITE	www.healthnet.com/uc

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

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

Coverage Decisions for Part D Prescription Drugs	
CALL	1-800-539-4072 Calls to this number are free.
TTY/TDD	1-800-929-9955 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
FAX	1-916-463-9754
WRITE	Health Net Pharmaceutical Services Attn: Pharmacy Service Center 10540 White Rock Road, Suite 280

Rancho Cordova, CA 95670

For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)*).

How to contact us when you are making an appeal or complaint about your Part D prescription drugs

Appeals or Complaints for Part D Prescription Drugs	
CALL	1-800-539-4072. Calls to this number are free.
TTY	1-800-977-1959 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free
FAX	1-800-977-1959
WRITE	Health Net Appeals & Grievances Department P.O. Box 10450 Van Nuys, CA 91410-0450

For more information on making an appeal or complaint about your Part D prescription drugs, see Chapter 7 (*What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)*).

Where to send a request that asks us to pay for our share of the cost of a drug you have received

The coverage determination process includes determining requests that asks us to pay for our share of the costs of a drug that you have received. For more information on situations in which you may need to ask the plan for reimbursement or to pay a bill you have received from a provider, see Chapter 5 (*Asking the plan to pay its share of the cost of a drug*).

Payment Requests	
CALL	1-800-539-4072 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. Calls to this number are free.
FAX	1-916-463-9754
WRITE	Health Net Pharmaceutical Services Attn: Pharmacy Service Center 10540 White Rock Road, Suite 280 Rancho Cordova, CA 95670

SECTION 2 Medicare (how to get help and information directly from the Federal Medicare program)

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

The Federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called “CMS”). This agency contracts with Medicare Prescription Drug Plans, including us.

Medicare	
CALL	<p>1-800-MEDICARE, or 1-800-633-4227</p> <p>Calls to this number are free.</p> <p>24 hours a day, 7 days a week.</p>
TTY	<p>1-877-486-2048</p> <p>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</p> <p>Calls to this number are free.</p>
WEBSITE	<p>http://www.medicare.gov</p> <p>This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare drug plans in your area. You can also find Medicare contacts in your state by selecting “Helpful Phone Numbers and Websites.”</p> <p>If you don’t have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.</p>

SECTION 3 State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state.

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

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

You may contact the SHIP in your state in the “State Health Insurance Assistance Program (SHIP)” chart at the end of this Evidence of Coverage. You can find contact information for the SHIP in your state in the “State Health Insurance Assistance Program (SHIP)” chart at the end of this Evidence of Coverage. You may also find the website for your local SHIP at www.medicare.gov under “Search Tools” by selecting “Helpful Phone Numbers and Websites.”

SECTION 4 Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a Quality Improvement Organization in each state.

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

You should contact QIO in any of these situations:

- You have a complaint about the quality of care you have received.
- You think coverage for your hospital stay is ending too soon.
- You think coverage for your home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon.

You may contact QIO in your state in the “Quality Improvement Organization (QIO)” chart at the end of this Evidence of Coverage.

SECTION 5 Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or end stage renal disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare and pay the Part B premium. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

SECTION 6 Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint Federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, refer to the chart of state Medicaid programs located at the end of this Evidence of Coverage.

SECTION 7 Information about programs to help people pay for their prescription drugs

Medicare’s “Extra Help” Program

Medicare provides “Extra Help” to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan’s monthly premium and prescription copayments. This Extra Help also counts toward your out-of-pocket costs.

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

If you think you may qualify for Extra Help, call Social Security (see Section 5 of this chapter for contact information) to apply for the program. You may also be able to apply at your State Medical Assistance or Medicaid Office (see Section 6 of this chapter for contact information). After you apply, you will get a letter letting you know if you qualify for Extra Help and what you need to do next.

State Pharmaceutical Assistance Programs

Many states have State Pharmaceutical Assistance Programs that help some people pay for prescription drugs based on financial need, age, or medical condition. Each state has different rules to provide drug coverage to its members.

SPAP is a state organization that provides limited income and medically needy seniors and individuals with disabilities financial help for prescription drugs.

You may contact the SPAP in your state. Please refer to the chart at the end of this Evidence of Coverage to locate the Qualified SPAP(s) in your state.

SECTION 8 How to contact the Railroad Retirement Board

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

Railroad Retirement Board	
CALL	1-877-772-5772 Calls to this number are free. Available 9:00 am to 3:30 pm, Monday through Friday If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	1-312-751-4701 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are <i>not</i> free.
WEBSITE	http://www.rrb.gov

Chapter 3. Using the plan's coverage for your Part D prescription drugs

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

There are programs to help people with limited resources pay for their drugs. These include “Extra Help” and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage may not apply to you.** We have included a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), that tells you about your drug coverage. If you don’t have this insert, please call Customer Service and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Customer Service are on the back cover.

SECTION 1 Introduction

Section 1.1 This chapter describes your coverage for Part D drugs
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This chapter explains rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs (Chapter 4, *What you pay for your Part D prescription drugs*).

In addition to your coverage for Part D drugs through our plan, Original Medicare (Medicare Part A and Part B) also covers some drugs:

- Medicare Part A covers drugs you are given during Medicare-covered stays in the hospital or in a skilled nursing facility.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility.

The two examples of drugs described above are covered by Original Medicare. To find out more about this coverage, see your *Medicare & You* handbook.

This chapter explains rules for using your coverage for Part D drugs under our plan. The next chapter tells what you pay for Part D drugs (Chapter 4, *What you pay for your Part D prescription drugs*).

Section 1.2 Basic rules for the plan's Part D drug coverage

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

- You must use a network pharmacy to fill your prescription. (See Section 2, *Fill your prescriptions at a network pharmacy*.)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 3, *Your drugs need to be on the plan's drug list*.)
- Your drug must be considered "medically necessary", meaning reasonable and necessary for treatment of your illness or injury. It also needs to be an accepted treatment for your medical condition.

SECTION 2 Fill your prescription at a network pharmacy or through the plan's mail-order service

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at the plan's network pharmacies.

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered by the plan.

Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?

You can look in your *Pharmacy Directory*, visit our website (www.healthnet.com/uc), or call Customer Service (phone numbers are on the cover). Choose whatever is easiest for you.

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

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

If the pharmacy you have been using leaves the plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Customer Service (phone numbers are on the cover) or use the *Pharmacy Directory*.

What if you need a non-retail, network pharmacy?

Sometimes prescriptions must be filled at a non-retail, network pharmacy. Non-retail, network pharmacies include:

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

To locate a non-retail, network pharmacy, look in your *Pharmacy Directory* or call Customer Service.

Section 2.3	Using the plan's mail-order services
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Our plan's mail-order service requires you to order **no more than a 90-day supply**.

To get order forms and information about filling your prescriptions by mail contact Customer Service (phone number located on the back cover). If you use a mail-order pharmacy not in the plan's network, your prescription will not be covered.

Usually a mail-order pharmacy order will get to you in no more than 14 days. If your order is delayed, contact Customer Service (phone number located on the back cover).

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.

Section 2.4 How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost sharing may be lower. The plan offers two ways to get a long-term supply of “maintenance” drugs on our plan’s Drug List. Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.

- Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Some of these retail pharmacies may agree to accept the mail-order cost-sharing amount for a long-term supply of maintenance drugs. Other retail pharmacies may not agree to accept the mail-order cost-sharing amounts for an extended supply of maintenance drugs. In this case you will be responsible for the difference in price. Your Pharmacy Directory tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Customer Service for more information.
- For most kinds of drugs, you can use the plan’s network mail-order services. These drugs are marked as mail-order drugs on our plan’s Drug List. Our plan’s mail-order service requires you to order no more than a 90-day supply. See Section 3.3 for more information about using our mail-order services.

Section 2.5 When can you use a pharmacy that is not in the plan’s network?

Your prescription might be covered in certain situations

We have network pharmacies outside of our service area where you can get your prescriptions filled as a member of our plan. Generally, we cover drugs filled at an out-of-network pharmacy *only* when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24-hour service.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail order pharmacy (including high cost and unique drugs).
- If you are getting a vaccine that is medically necessary but not covered by Medicare Part B or other covered drugs that are administered in your doctor’s office.
- If you need a prescription filled that is related to care for a medical emergency or urgent care.

In these situations, **please check first with Customer Service** to see if there is a network pharmacy nearby.

How do you ask for reimbursement from the plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than paying your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 5, Section 2.1 explains how to ask the plan to pay you back.)

SECTION 3 Your drugs need to be on the plan's "Drug List"

Section 3.1 The "Drug List" tells which Part D drugs are covered

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

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

The drugs on the Drug List are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

We will generally cover a drug on the plan's Drug List as long as you follow the other coverage rules explained in this chapter and the drug is medically necessary, meaning reasonable and necessary for treatment of your illness or injury. It also needs to be an accepted treatment for your medical condition.

The Drug List includes both brand-name and generic drugs

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

What is *not* on the Drug list?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more about this, see Section 8.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.

Section 3.2	There are different “cost-sharing tiers” for drugs on the Drug List
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Every drug on the plan's Drug List is in one of the cost-sharing tiers. To find out what type of drugs are covered under each drug tier, refer to the “Plan Benefit Chart” section at the beginning of this EOC. In general, the higher the cost-sharing tier, the higher your cost for the drug.

To find out which cost-sharing tier your drug is in, look it up in the plan's *Drug List*. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 4 (*What you pay for your Part D prescription drugs*).

Section 3.3	How can you find out if a specific drug is on the Drug List?
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You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail.
2. Visit the plan's website (www.healthnet.com/uc). The Drug List on the website is always the most current.
3. Call Customer Service to find out if a particular drug is on the plan's Drug List or to ask for a copy of the list. Phone numbers for Customer Service are on the back cover.

SECTION 4	There are restrictions on coverage for some drugs
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Section 4.1	Why do some drugs have restrictions?
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For certain prescription drugs, special rules restrict how and when the plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

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

Section 4.2 What kinds of restrictions?

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

Using generic drugs whenever you can

If the member requests a brand name drug or if the prescription drug order states "dispense as written, "do not substitute" or words of similar meaning in the physician's handwriting, the Tier 3 Prescription Drug copayment will apply.

Getting plan approval in advance

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

Trying a different drug first

This requirement encourages you to try safer or more effective drugs before the plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, the plan may require you to try Drug A first. If Drug A does not work for you, the plan will then cover Drug B. This requirement to try a different drug first is called "**Step Therapy.**"

Quantity limits

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

Section 4.3 Do any of these restrictions apply to your drugs?

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

SECTION 5 What if one of your drugs is not covered in the way you'd like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered
--

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

- **What if the drug you want to take is not covered by the plan?** For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand-name version you want to take is not covered.
- **What if the drug is covered, but there are extra rules or restrictions on coverage for that drug?** As explained in Section 4, some of the drugs covered by the plan have extra rules to restrict their use. For example, you might be required to try a different drug first, to see if it will work, before the drug you want to take will be covered for you. Or there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period.
- **What if the drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be?** The plan puts each covered drug into one of the different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

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

- If your drug is not on the Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.

Section 5.2	What can you do if your drug is not on the Drug List or if the drug is restricted in some way?
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If your drug is not on the Drug List or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply) until you and your doctor decide it is okay to change to another drug, or while you file an exception.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug covered.

You may be able to get a temporary supply

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

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

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

- The drug you have been taking is **no longer on the plan's Drug List**.
- -- or -- the drug you have been taking is **now restricted in some way** (Section 4 in this chapter tells about restrictions).

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

- **For those members who were in the plan last year:**

We will cover a temporary supply of your drug **one time only during the first 90 days of group's effective date**. This temporary supply will be for a maximum of a 30-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

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

We will cover a temporary supply of your drug **one time only during the first 90 days of your membership** in the plan. This temporary supply will be for a maximum of a 30-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.

- **For those who are new members, and are residents in a long-term care facility:**

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

- **For those who have been a member of the plan for more than 90 days, and are a resident of a long-term care facility and need a supply right away:**

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

- **For those members who experience a change in level of care:**

If you experience a change in level of care, e.g., hospital discharge, you will be granted a temporary supply of up to a 30-day supply at home or up to a 34-day supply at a long-term care facility so you can continue to receive your drug(s) while your exception request is being processed. Each time you experience a change in level of care to home, you are eligible to receive a 30-day temporary supply of each of your drug(s). Each time you experience a change in level of care to a long-term care facility, you are eligible to receive a 34-day temporary supply of each of your drug(s).

To ask for a temporary supply, call Customer Service (phone numbers are on the back cover).

During the time when you are getting a temporary supply of a drug, you should talk with your doctor or other prescriber to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. The sections below tell you more about these options.

You can change to another drug

Start by talking with your doctor or other prescriber. Perhaps there is a different drug covered by the plan that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.

You can file an exception

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

If you and your doctor or other prescriber want to ask for an exception, Chapter 7 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 5.3	What can you do if your drug is in a cost-sharing tier you think is too high?
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If your drug is a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

Start by talking with your doctor or other prescriber. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Customer Service to ask for a list of covered drugs that treat the same medical condition. This list can help your doctor or other prescriber to find a covered drug that might work for you.

You can file an exception

You and your doctor or other prescriber can ask the plan to make an exception in the cost-sharing tier for the drug so that you pay less for the drug. If your doctor or other prescriber says that you have medical reasons that justify asking us for an exception, your doctor or other prescriber can help you request an exception to the rule.

If you and your doctor or other prescriber want to ask for an exception, Chapter 7 tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

SECTION 6	What if your coverage changes for one of your drugs?
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Section 6.1	The Drug List can change during the year
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Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, the plan might make many kinds of changes to the Drug List. For example, the plan might:

- **Add or remove drugs from the Drug List.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier.**

- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 4 in this chapter).
- **Replace a brand-name drug with a generic drug.**

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

Section 6.2 What happens if coverage changes for a drug you are taking?

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

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

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

Do changes to your drug coverage affect you right away?

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

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

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

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

- If a **brand-name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your brand-name drug at a network pharmacy.
 - During this 60-day period, you should be working with your doctor to switch to the generic or to a different drug that we cover.
 - Or you and your doctor or other prescriber can ask the plan to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see Chapter 7 (*What to do if you have a problem or complaint*).

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

SECTION 7 What types of drugs are *not* covered by the plan?

Section 7.1 Types of drugs we do not cover
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This section tells you what kinds of prescription drugs are “excluded.” Excluded means that the plan doesn’t cover these types of drugs because the law doesn’t allow any Medicare drug plan to cover them.

If you get drugs that are excluded, you must pay for them yourself. We won’t pay for the drugs that are listed in this section (unless our plan covers certain excluded drugs). The only exception: If the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9 in this booklet.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

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

Also, by law, these categories of drugs are not covered by Medicare drug plans unless we offer enhanced drug coverage, for which you may be charged additional premium:

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility

- Drugs when used for the relief of cough or cold symptoms
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction, such as Viagra, Cialis, Levitra, and Caverject
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Barbiturates and Benzodiazepines

We offer additional coverage of some prescription drugs not normally covered in a Medicare Prescription Drug Plan.

In addition, if you are **receiving extra help from Medicare** to pay for your prescriptions, the extra help will not pay for the drugs not normally covered. (Please refer to your formulary or call Member Services for more information.) However, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you.

SECTION 8 Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

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

Section 8.2 What if you don't have your membership card with you?

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

If the pharmacy is not able to get the necessary information, **you may have to pay the full cost of the prescription when you pick it up.** (You can then **ask us to reimburse you** for our share. See Chapter 5, Section 2.1 for information about how to ask the plan for reimbursement.)

SECTION 9 Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?
--

If you are **admitted to a hospital** for a stay covered by Original Medicare, Medicare Part A will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

If you are **admitted to a skilled nursing facility** for a stay covered by Original Medicare, Medicare Part A will generally cover your prescription drugs during all or part of your stay. If you are still in the skilled nursing facility, and Part A is no longer covering your drugs, our plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this chapter that tell about the rules for getting drug coverage.

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage at any time. (Chapter 8, *Ending your membership in the plan*, tells you can leave our plan and join a different Medicare plan.)

Section 9.2 What if you're a resident in a long-term care facility?

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

Check your *Pharmacy Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Customer Service.

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

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

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

During the time when you are getting a temporary supply of a drug, you should talk with your doctor or other prescriber to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by the plan that might work just as well for you. Or you and your doctor can ask the plan to make an exception for you and cover the drug in the way you would like it to be covered. If you and your doctor want to ask for an exception, Chapter 7 tells what to do.

Section 9.3 What if you are taking drugs covered by Original Medicare?

Your enrollment in *our* plan doesn't affect your coverage for drugs covered under Medicare Part A or Part B. If you meet Medicare's coverage requirements, your drug will still be covered under Medicare Part A or Part B, even though you are enrolled this plan. In addition, if your drug would be covered by Medicare Part A or Part B, our plan can't cover it, even if you choose not to enroll in Part A or Part B.

Some drugs may be covered under Medicare Part B in some situations and through our plan in other situations. But drugs are never covered by both Part B and our plan at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or our plan for the drug.

Section 9.4 What if you have a Medigap (Medicare Supplement Insurance) policy with prescription drug coverage?

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and lower your premium.

Each year your Medigap insurance company should send you a notice by November 15 that tells if your prescription drug coverage is "creditable," and the choices you have for drug coverage. (If the coverage from the Medigap policy is "**creditable**," it means that it has drug coverage that pays, on average, at least as much as Medicare's standard drug coverage.) The notice will also explain how much your premium would be lowered if you remove the prescription drug coverage portion of your Medigap policy. If you didn't get this notice, or if you can't find it, contact your Medicare insurance company and ask for another copy.

Special note about 'creditable coverage':

Each year your employer or retiree group should send you a notice by November 15 that tells if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for drug coverage.

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

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

SECTION 10 Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

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

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

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

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

Section 10.2 Programs to help members manage their medications
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We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

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

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw your participation in the program.

Chapter 4. What you pay for your Part D prescription drugs

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

There are programs to help people with limited resources pay for their drugs. These include “Extra Help” and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this Evidence of Coverage may not apply to you.** We have included a separate insert, called the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider), that tells you about your drug coverage. If you don’t have this insert, please call Customer Service and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Customer Service are on the back cover.

SECTION 1 Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use “drug” in this chapter to mean a Part D prescription drug. As explained in Chapter 3, some drugs are covered under Original Medicare or are excluded by law.

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

- **The plan’s List of Covered Drugs (Formulary).** To keep things simple, we call this the “Drug List.”
 - This Drug List tells which drugs are covered for you.
 - It also tells which of the “cost-sharing tiers” the drug is in and whether there are any restrictions on your coverage for the drug.
 - If you need a copy of the Drug List, call Customer Service (phone numbers are on the cover of this booklet). You can also find the Drug List on our website at www.healthnet.com/uc. The Drug List on the website is always the most current.
- **Chapter 3 of this booklet.** Chapter 3 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 3 also tells which types of prescription drugs are not covered by our plan.

- **The plan's *Pharmacy Directory*.** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 3 for the details). The *Pharmacy Directory* has a list of pharmacies in the plan's network and it tells how you can use the plan's mail-order service to get certain types of drugs. It also explains how you can get a long-term supply of a drug (such as filling a prescription for a three month's supply).

SECTION 2 What you pay for a drug depends on which "drug payment stage" you are in when you get the drug

Section 2.1 What are the different drug payment stages?

As shown in the "Plan Benefit Chart" at the beginning of the EOC, there are different "drug payment stages" for your prescription drug coverage. How much you pay for a drug depends on which of these stages you are in at the time you get a prescription filled or refilled. Keep in mind you are always responsible for the plan's monthly premium regardless of the drug payment stage. This section gives you more information about the different stages.

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

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

The plan's Cost-Sharing Tiers

Every drug on the plan's Drug List is in one of the cost-sharing tiers. To find out the type of drugs that are covered under each drug tier, refer to the "Plan Benefit Chart" at the beginning of the EOC. In general, the higher the cost-sharing tier number, the higher your cost for the drug: Health Net has two Medicare Part D formularies, both of which include the following cost sharing tiers. To determine which formulary applies to your plan, please refer to page 7 of the Formulary (Drug List):

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

Your pharmacy choices

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

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

For more information about these pharmacy choices and filling your prescriptions, see Chapter 3 in this booklet and the plan's *Pharmacy Directory*.

Once your copayment/coinsurance for outpatient prescription drugs total \$2,000 in the calendar year, you will not pay any more copayment/coinsurance for covered prescription drugs for the rest of the year. All expenses that apply to the \$2000 out-of-pocket maximum will automatically be calculated by Health Net. .

You stay in the Initial Coverage Stage until your total out-of-pocket drug costs for the year reach \$4,550.00.

How Medicare calculates your out-of-pocket costs for prescription drugs

Here are Medicare's rules that we must follow when we keep track of your out-of-pocket costs for your drugs.

*These payments **are included** in your out-of-pocket costs*

*When you add up your out-of-pocket costs, you **can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):*

- The amount you pay for drugs when you are in any of the following drug payment stages:
 - The Initial Coverage Stage.
- Any payments you made during this calendar year under another Medicare prescription drug plan before you joined our plan.

It matters who pays:

- If you make these payments **yourself**, they are included in your out-of-pocket costs.
- These payments are *also included* if they are made on your behalf by **certain other individuals or organizations**. This includes payments for your drugs made by a friend or relative, by most charities, or by a State Pharmaceutical Assistance Program that is qualified by Medicare. Payments made by “Extra Help” from Medicare are also included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of \$4,550.00 in out-of-pocket costs within the calendar year, you will move to the Catastrophic Coverage Stage.

*These payments are **not included** in your out-of-pocket costs*

When you add up your out-of-pocket costs, you are **not allowed to include** any of these types of payments for prescription drugs:

- The amount you pay for your monthly premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet the plan's requirements for out-of-network coverage
- Prescription drugs covered by Part A or Part B.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments you make toward prescription drugs not normally covered in a Medicare Prescription Drug Plan.
- Payments for your drugs that are made by group health plans including employer health plans.
- Payments for your drugs that are made by insurance plans and government-funded health programs such as TRICARE, the Veteran's Administration, the Indian Health Service, or AIDS Drug Assistance Programs.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Customer Service to let us know (phone numbers are on the cover of this booklet).

How can you keep track of your out-of-pocket total?

- **We will help you.** The *Explanation of Benefits* report we send to you includes the current amount of your out-of-pocket costs (Section 3 above tells about this report). When you reach a total of \$4,550.00 in out-of-pocket costs for the year, this report will tell you that you have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need.** Section 3 above tells what you can do to help make sure that our records of what you have spent are complete and up to date.

During the Catastrophic Coverage Stage, the plan pays most of the cost for your drugs

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the \$4,550.00 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year.

During this stage, the plan will pay most of the cost for your drugs.

- **Your share** of the cost for a covered drug will be either coinsurance or a copayment, whichever is the *larger* amount:
 - *–either –* coinsurance of 5% of the cost of the drug
 - *–or –* \$2.50 copayment for a generic drug or a drug that is treated like a generic. Or a \$6.30 copayment for all other drugs.
- **Our plan pays the rest** of the cost.

SECTION 3 We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1	We send you a monthly report called the “Explanation of Benefits”
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Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

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

Our plan will prepare a written report called the *Explanation of Benefits* (it is sometimes called the “EOB”) when you have had one or more prescriptions filled. It includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drugs costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called “year-to-date” information. It shows you the total drug costs and total payments for your drugs since the year began.

Section 3.2	Help us keep our information about your drug payments up to date
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To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up to date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 5, Section 2 of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
 - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
 - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
 - Any time you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances
- **Check the written report we send you.** When you receive an Explanation of Benefits in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call us at Customer Service (phone numbers are on the cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4	What you pay for vaccinations depends on how and where you get them
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Section 4.1	Our plan has separate coverage for the vaccine medication itself and for the cost of giving you the vaccination shot
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Our plan provides coverage of a number of vaccines. There are two parts to our coverage of vaccinations:

- The first part of coverage is the cost of **the vaccine medication itself**. The vaccine is a prescription medication.

- The second part of coverage is for the cost of **giving you the vaccination shot**. (This is sometimes called the “administration” of the vaccine.)

What do you pay for a vaccination?

What you pay for a vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
 - Some vaccines are considered Part D drugs. You can find these vaccines listed in the plan’s *List of Covered Drugs*.
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccination shot.**

What you pay at the time you get the vaccination can vary depending on the circumstances. For example:

- Sometimes when you get your vaccination shot, you will have to pay the entire cost for both the vaccine medication and for getting the vaccination shot. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccination shot, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a vaccination shot.

Situation 1: You buy the vaccine at the pharmacy and you get your vaccination shot at the network pharmacy. (Whether you have this choice depends on where you live.)

- You will have to pay the pharmacy the amount of your copayment *or* coinsurance for the vaccine and administration of the vaccine.

Situation 2: You get the vaccination at your doctor’s office.

- When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 5 of this booklet (*Asking the plan to pay its share of a bill you have received for medical services or drugs*).
- You will be reimbursed the amount you paid less your normal coinsurance *or* copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what

we normally pay. (If you are in Extra Help, we will reimburse you for this difference.)

Situation 3: You buy the vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccination shot.

- You will have to pay the pharmacy the amount of your coinsurance *or* copayment for the vaccine itself.
- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 5 of this booklet.
- You will be reimbursed the amount charged by the doctor less the amount for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you are in Extra Help, we will reimburse you for this difference.)

Section 4.2	You may want to call us at Customer Service before you get a vaccination
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The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Customer Service whenever you are planning to get a vaccination (phone numbers are on the cover of this booklet).

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

SECTION 5	Do you have to pay the Part D “late enrollment penalty”?
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Section 5.1	What is the Part D “late enrollment penalty”?
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You may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage or you experienced a continuous period of 63 days or more when you didn't keep your prescription drug coverage. The amount of the penalty depends on how long you waited before you enrolled in drug coverage after you became eligible or how many months after 63 days you went without drug coverage.

The penalty is added to your monthly premium. (Members who choose to pay their premium every three months will have the penalty added to their three-month premium.) When you first enroll in our plan, we let you know the amount of the penalty.

Section 5.2 How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have credible prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For our example, let's say it is 14 months without coverage, which will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2010, this average premium amount is \$31.94. This amount may change for 2011.
- You multiply together the two numbers to get your monthly penalty and round it to the nearest 10 cents. In the example here it would be 14% times \$31.94, which equals \$4.47, which rounds to \$4.50. This amount would be added **to the monthly premium for someone with a late enrollment penalty.**

There are three important things to note about this monthly premium penalty:

- First, **the penalty may change each year**, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, **you will continue to pay a penalty** every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.
- Third, if you are under 65 and currently receiving Medicare benefits, the late enrollment penalty will reset when you turn 65. After age 65, your late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for Medicare.

If you are eligible for Medicare and are under 65, any late enrollment penalty you are paying will be eliminated when you attain age 65. After age 65, your late enrollment penalty is based only on the months you do not have coverage after your Age 65 Initial Enrollment Period.

Section 5.3	In some situations, you can enroll late and not have to pay the penalty
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Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the late enrollment penalty.

You will not have to pay a premium penalty for late enrollment if you are in any of these situations:

- You already have prescription drug coverage at least as good as Medicare’s standard drug coverage. Medicare calls this “**creditable drug coverage.**” Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Speak with your insurer or your human resources department to find out if your current drug coverage is as at least as good as Medicare’s.
- If you were without creditable coverage, you can avoid paying the late enrollment penalty if you were without it for less than 63 days in a row.
- If you didn’t receive enough information to know whether or not your previous drug coverage was creditable.
- You lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) – *and* – you signed up for a Medicare prescription drug plan by December 31, 2006 – *and* – you have stayed in a Medicare prescription drug plan.
- You are receiving Extra Help from Medicare.

Section 5.4	What can you do if you disagree about your late enrollment penalty?
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If you disagree about your late enrollment penalty, you can ask us to review the decision about your late enrollment penalty. Call Customer Service at the number on the front of this booklet to find out more about how to do this.

Chapter 5. Asking the plan to pay its share of the costs for covered drugs

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SECTION 1 Situations in which you should ask our plan to pay our share of the cost of your covered drugs

Section 1.1 If you pay our plan's share of the cost of your covered drugs, you can ask us for payment

Sometimes when you get a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). Asking for reimbursement in the first three examples below are types of coverage decisions (for more information about coverage decisions, go to Chapter 7 of this booklet).

Here are examples of situations in which you may need to ask our plan to pay you back:

1. When you use an out-of-network pharmacy to get a prescription filled

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

2. When you pay the full cost for a prescription because you don't have your plan membership card with you

If you do not have your plan membership card with you when you fill a prescription at a network pharmacy, you may need to pay the full cost of the prescription yourself. The pharmacy can usually call the plan to get your member information, but there may be times when you may need to pay if you do not have your card.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

3. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think

should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.

- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

4. If you are retroactively enrolled in our plan because you were eligible for Medicaid.

Medicaid is a joint Federal and state government program that helps with medical costs for some people with limited incomes and resources. Some people with Medicaid are automatically enrolled in our plan to get their prescription drug coverage. Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already past. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit your paperwork to a special plan that will handle the reimbursement.

- Send a copy of your receipts to us when you ask us to pay you back.
- You should ask for payment for your out-of-pocket expenses (not for any expenses paid for by other insurance).
- You have a 7-month period that allows us to cover most drugs you received between your enrollment date and the current time. Depending on your situation, either you or Medicare will need to pay for any out-of-network price differences.
- The plan may not pay for drugs that are not on our drug list that you received outside of the 7-month period.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaint)*) has information about how to make an appeal.

SECTION 2 How to ask us to pay you back

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your receipt documenting the payment you have made. It's a good idea to make a copy of your receipts for your records.

To make sure you are giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment.

- You don't have to use the form, but it's helpful for our plan to process the information faster.
- Either download a copy of the form from our website (www.healthnet.com/uc) or call Customer Service and ask for the form. The phone numbers for Customer Service are on the cover of this booklet.

Mail your request for payment together with any receipts to us at this address:

Health Net Pharmaceutical Services

Attn: Pharmacy Service Center
10540 White Rock Road, Suite 280
Rancho Cordova, CA 95670

Please be sure to contact Customer Service if you have any questions. If you don't know what you owe, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

SECTION 3 We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the drug and how much we owe
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When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and decide whether to pay it and how much we owe.

- If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost. We will mail your reimbursement of all but your share to you. (Chapter 3 explains the rules you need to follow for getting your Part D prescription drugs.)
- If we decide that the drug is *not* covered, or you did *not* follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for the drug, you can make an appeal
--

If you think we have made a mistake in turning you down, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The examples of situations in which you may need to ask our plan to pay you back:

- When you use an out-of-network pharmacy to get a prescription filled
- When you pay the full cost for a prescription because you don't have your plan membership card with you
- When you pay the full cost for a prescription in other situations

For the details on how to make this appeal, go to Chapter 7 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)*). The appeals process is a legal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read Section 4, you can go to the Section 5 in Chapter 7 for a step-by-step explanation of how to file an appeal.

SECTION 4 Other situations in which you should save your receipts and send them to the plan

Section 4.1 In some cases, you should send your receipts to the plan to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here is a situation when you should send us receipts to let us know about payments you have made for your drugs:

When you get a drug through a patient assistance program offered by a drug manufacturer

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside the plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.

- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, the plan will not pay for any share of these drug costs. But sending the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the two cases described above, these situations are not considered coverage decisions. Therefore you cannot make an appeal if you disagree with our decision.

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SECTION 1 Our plan must honor your rights as a member of the plan

Section 1.1	We must provide information in a way that works for you (in languages other than English that are spoken in the plan service area)
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To get information from us in a way that works for you, please call Customer Service (phone numbers are on the back cover).

Our plan has people and translation services available to answer questions from non-English speaking members. We can also give you information in Spanish or Chinese. If you are eligible for Medicare because of disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or disability, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call 1-877-486-2048.

Section 1.2	We must treat you with fairness and respect at all times
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Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin.

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' **Office for Civil Rights** 1-800-368-1019 (TTY 1-800-537-7697) or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call us at Customer Service (phone numbers are on the cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Customer Service can help.

Section 1.3	We must ensure that you get timely access to your covered drugs
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As a member of our plan, you also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your Part D drugs within a reasonable amount of time, Chapter 7 of this booklet tells what you can do.

Section 1.4	We must protect the privacy of your personal health information
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Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your “personal health information” includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a “Notice of Privacy Practice”, that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don’t see or change your records.
- In most situations, if we give your health information to anyone who isn’t providing your care or paying for your care, *we are required to get written permission from you first.* Written permission can be given by you or by someone you have given legal power to make decisions for you.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
 - For example, we are required to release health information to government agencies that are checking on quality of care.
 - Because you are a member of our plan through Medicare, we are required to give Medicare your health information including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to Federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will consider your request and decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Customer Service (phone numbers are on the cover of this booklet).

Notice Of Privacy Practices

THIS NOTICE DESCRIBES HOW PROTECTED HEALTH INFORMATION AND NONPUBLIC PERSONAL FINANCIAL INFORMATION *ABOUT YOU MAY BE USED AND DISCLOSED. THIS NOTICE ALSO DESCRIBES HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

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

We are required by federal and state laws to provide you with this Notice about your rights and our legal duties and privacy practices with respect to your protected health information. We must follow the terms of this Notice while it is in effect. Some of the uses and disclosures described in this Notice may be limited in certain cases by applicable state laws that are more stringent than the federal standards.

How we may use and disclose your protected health information

We may use and disclose your protected health information for different purposes. The examples below are provided to illustrate the types of uses and disclosures we may make without your authorization for payment, health care operations and treatment.

- **Payment.** We use and disclose your protected health information in order to pay for your covered health expenses. For example, we may use your protected health information to process claims to be reimbursed by another insurer that may be responsible for payment or premium billing.
- **Health Care Operations.** We use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or Customer Service.
- **Treatment.** We may use and disclose your protected health information to assist your health care providers (doctors, pharmacies, hospitals and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.
- **Plan Sponsor.** If you are enrolled through a group health plan, we may provide summaries of claims and expenses for enrollees in your group health plan to the plan sponsor, which is usually the employer.

If the plan sponsor provides plan administration services, we may also provide access to health information to support its performance of such services which may include but are not limited to claims audits or Customer Service 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.*

***Nonpublic personal financial information includes personally identifiable financial information that you provided to us to obtain insurance or we obtained in providing benefits to you. Examples include Social Security numbers, account balances and payment history. We do not disclose any nonpublic personal information about you to anyone, except as permitted by law.**

Contact the plan

If you have any complaints or questions about this Notice or you want to submit a written request to the Plan as required in any of the previous sections of this Notice, you may send it in writing to:

Health Net Privacy Office
Attention: Director, Information Privacy
P.O. Box 9103
Van Nuys, CA 91409

You may also contact us at:

Telephone: 1-800-539-4072
Fax: 1-818-676-8314
Email: Privacy@healthnet.com

Section 1.5 We must give you information about the plan, its network of pharmacies, and your covered drugs

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in languages other than English.)

If you want any of the following kinds of information, please call Customer Service (phone numbers are on the cover of this booklet):

- **Information about our plan.** This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare prescription drug plans.
- **Information about our network pharmacies.**
 - For example, you have the right to get information from us about the pharmacies in our network.
 - For a list of the pharmacies in the plan's network, see the *Pharmacy Directory*.
 - For more detailed information about our pharmacies, you can call Customer Service (phone numbers are on the cover of this booklet) or visit our website at www.healthnet.com/uc.
- **Information about your coverage and rules you must follow in using your coverage.**
 - To get the details on your Part D prescription drug coverage, see Chapters 3 and 4 of this booklet plus the plan's *List of Covered Drugs (Formulary)*. These chapters, together with the *List of Covered Drugs*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
 - If you have questions about the rules or restrictions, please call Customer Service (phone numbers are on the cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
 - If a Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the drug from an out-of-network pharmacy.

- If you are not happy or if you disagree with a decision we make about what Part D drug is covered for you, you have the right to ask us to change the decision. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to ask the plan for a decision about your coverage and how to make an appeal if you want us to change our decision. (Chapter 7 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
- If you want to ask our plan to pay our share of the cost for a Part D prescription drug, see Chapter 5 of this booklet.

Section 1.6	We must support your right to make decisions about your care
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You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, *if you want to*, you can:

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **Give your doctors written instructions** about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called “**advance directives**.” There are different types of advance directives and different names for them. Documents called “**living will**” and “**power of attorney for health care**” are examples of advance directives.

If you want to use an “advance directive” to give your instructions, here is what to do:

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare.
- **Fill it out and sign it.** 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.
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, **take a copy with you to the hospital.**

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the Office of Civil Rights. Please refer to the chart at the end of this Evidence of Coverage to locate the Office of Civil Rights for your state.

Section 1.7	You have the right to make complaints and to ask us to reconsider decisions we have made
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If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 7, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Customer Service (phone numbers are on the cover of this booklet).

Section 1.8	What can you do if you think you are being treated unfairly or your rights are not being respected?
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If it is about discrimination, call the Office for Civil Rights

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' **Office for Civil Rights** at 1-800-368-1019 or TTY 1-800-537-7697, or call your local Office for Civil Rights.

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, *and it's not* about discrimination, you can get help dealing with the problem you are having:

- You can **call Customer Service** (phone numbers are on the cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.

Section 1.9 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can **call Customer Service** (phone numbers are on the cover of this booklet).
- You can **call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact **Medicare**.
 - You can visit the Medicare website (<http://www.medicare.gov>) to read or download the publication “Your Medicare Rights & Protections.”
 - Or, you can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 2 You have some responsibilities as a member of the plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of the plan are listed below. If you have any questions, please call Customer Service (phone numbers are on the cover of this booklet). We're here to help.

- **Get familiar with your covered drugs and the rules you must follow to get these covered drugs.** Use this *Evidence of Coverage* booklet to learn what is covered for you and the rules you need to follow to get your covered drugs.
 - Chapters 3 and 4 give the details about your coverage for Part D prescription drugs.

- ***If you have any other prescription drug coverage besides our plan, you are required to tell us.*** *Please call Customer Service to let us know.*
 - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered drugs from our plan. This is called “**coordination of benefits**” because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We’ll help you with it.
- ***Tell your doctor and pharmacist that you are enrolled in our plan.*** *Show your plan membership card whenever you get your Part D prescription drugs.*
- ***Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.***
 - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
 - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don’t understand the answer you are given, ask again.
- ***Pay what you owe.*** *As a plan member, you are responsible for these payments:*
 - You must pay your plan premiums to continue being a member of our plan.
 - For some of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment (a fixed amount) Chapter 4 tells what you must pay for your Part D prescription drugs.
 - If you get any drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
- ***Tell us if you move.*** *If you are going to move, it’s important to tell us right away. Call Customer Service or UC. We need to keep your membership record up to date and know how to contact you.*
 - ***If you move outside of our plan service area, you cannot remain a member of our plan.*** (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
 - ***If you move within our service area, we still need to know*** so we can keep your membership record up to date and know how to contact you.

- **Call Customer Service for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.
 - Phone numbers and calling hours for Customer Service are on the cover of this booklet.
 - For more information on how to reach us, including our mailing address, please see Chapter 2.

Chapter 7. What to do if you have a problem or complaint (coverage decisions, appeals, complaints)

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BACKGROUND

SECTION 1 Introduction

Section 1.1	What to do if you have a problem or concern
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Please call us first

Your health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first: Please call Customer Service (phone numbers are on the cover of this booklet). We will work with you to try to find a satisfactory solution to your problem.

You have rights as a member of our plan and as someone who is getting Medicare. We pledge to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

Two formal processes for dealing with problems

Sometimes you might need a formal process for dealing with a problem you are having as a member of our plan.

This chapter explains two types of formal processes for handling problems:

- For some types of problems, you need to use the **process for coverage decisions and making appeals**.
- For other types of problems you need to use the **process for making complaints**.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

Which one do you use? That depends on the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2	What about the legal terms?
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There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this chapter explains the legal rules and procedures using more common words in place of certain legal terms. For example, this chapter generally says “making a

complaint” rather than “filing a grievance,” “coverage decision” rather than “coverage determination,” and “Independent Review Organization” instead of “Independent Review Entity.” It also uses abbreviations as little as possible.

However, it can be helpful – and sometimes quite important – for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2 You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step. Perhaps both are true for you.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected us. You can always contact your **State Health Insurance Assistance Program**. This government program has trained counselors in every state. The program is not connected with our plan or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

Their services are free. You will find phone numbers in Chapter 2, Section 3 of this booklet.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (<http://www.medicare.gov>).

SECTION 3 To deal with your problem, which process should you use?

Section 3.1	Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?
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If you have a problem or concern and you want to do something about it, you don't need to read this whole chapter. You just need to find and read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter tells what to do for your problem or concern, **START HERE**

Is your problem or concern about your benefits and

(This includes problems about whether particular prescription drugs are covered or not, the way in which they are covered, and problems related to payment for prescription drugs.)

Yes

No

Go on to the next section of this chapter, **Section 4: A guide to the basics of coverage decisions and making appeals.**

Skip ahead to **Section 7** at the end of this chapter: **How to make a complaint about quality of care, waiting times, customer service or other concerns.**

COVERAGE DECISIONS AND APPEALS

SECTION 4 A guide to the basics of coverage decisions and appeals

Section 4.1	Asking for coverage decisions and making appeals: the big picture
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The process for coverage decisions and making appeals deals with problems related to your benefits and coverage for prescription drugs, including problems related to payment. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs. We make a coverage decision for you whenever you fill a prescription at a pharmacy.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay:

- Usually, there is no problem. We decide the drug is covered and pay our share of the cost.
- But in some cases we might decide the drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you make an appeal we review the coverage decision we have made to check to see if we were being fair and following all of the rules properly. When we have completed the review we give you our decision.

If we say no to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to our plan. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

Section 4.2	How to get help when you are asking for a coverage decision or making an appeal
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Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- **You can call us at Customer Service** (phone numbers are on the cover).
- **To get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- **You should consider getting your doctor or other prescriber involved if possible, especially if you want a “fast” or “expedited” decision.** In most situations involving a coverage decision or appeal, your doctor or other prescriber must explain the medical reasons that support your request. Your doctor or other prescriber can’t request every appeal. He/she can request a coverage decision and a Level 1 Appeal with the plan. To request any appeal after Level 1, your doctor or other prescriber must be appointed as your “representative” (see below about “representatives”).
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - There may be someone who is already legally authorized to act as your representative under State law.
 - If you want a friend, relative, your doctor or other prescriber, or other person to be your representative, call Customer Service and ask for the form to give that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give our plan a copy of the signed form.
- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, **you are not required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

SECTION 5 Your Part D prescription drugs: How to ask for a coverage decision or make an appeal



Have you read Section 4 of this chapter (*A guide to “the basics” of coverage decisions and appeals*)? If not, you may want to read it before you start this section.

Section 5.1	This section tells you what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug
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Your benefits as a member of our plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs “Part D drugs.” You can get these drugs as long as they are included in our plan’s *List of Covered Drugs (Formulary)* and they are medically necessary for you, as determined by your primary care doctor or other provider.

- **This section is about your Part D drugs only.** To keep things simple, we generally say “drug” in the rest of this section, instead of repeating “covered outpatient prescription drug” or “Part D drug” every time.
- For details about what we mean by Part D drugs, the *List of Covered Drugs*, rules and restrictions on coverage, and cost information, see Chapter 5 (*Using our plan’s coverage for your Part D prescription drugs*) and Chapter 6 (*What you pay for your Part D prescription drugs*).

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms	A coverage decision is often called an “ initial determination ” or “initial decision.” When the coverage decision is about your Part D drugs, the initial determination is called a “ coverage determination. ”
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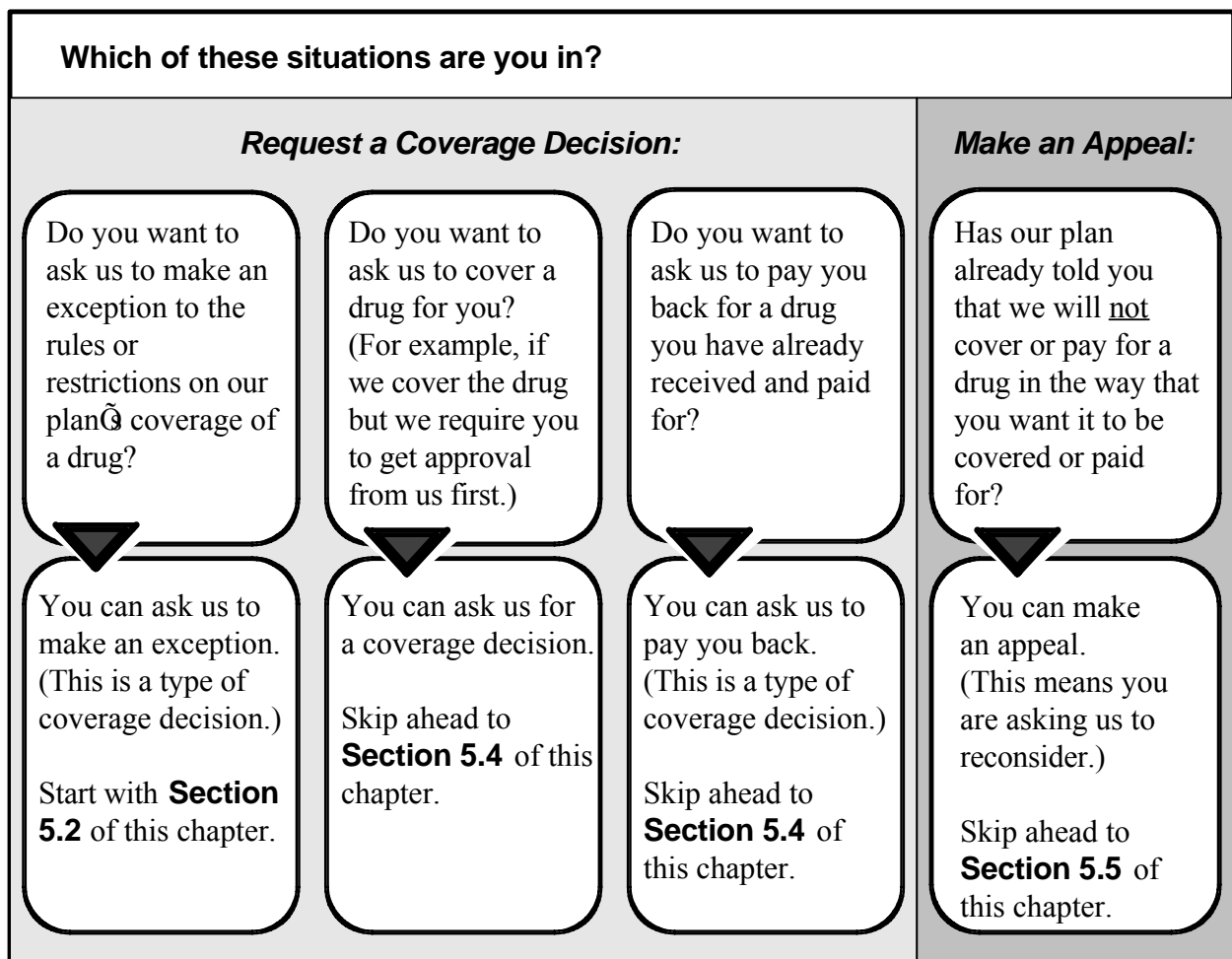
Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
 - Asking us to cover a Part D drug that is not on the plan’s *List of Covered Drugs*
 - Asking us to waive a restriction on the plan’s coverage for a drug (such as limits on the amount of the drug you can get)
 - Asking to pay a lower cost-sharing amount for a covered non-preferred drug

- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on the plan’s *List of Covered Drugs* but we require you to get approval from us before we will cover it for you.)
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.

This section tells you both how to ask for coverage decisions and how to request an appeal. Use this guide to help you determine which part has information for your situation:



Section 5.2 What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask the plan to make an “exception.” An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. Covering a Part D drug for you that is not on our plan’s *List of Covered Drugs (Formulary)*. (We call it the “Drug List” for short.)

Legal Terms	Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a “formulary exception.”
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- If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in *Tier 3*. You cannot ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.
- You cannot ask for coverage of any “excluded drugs” or other non-Part D drugs which Medicare does not cover. (For more information about excluded drugs, see Chapter 5.)

2. Removing a restriction on the plan’s coverage for a covered drug. There are extra rules or restrictions that apply to certain drugs on the plan’s *List of Covered Drugs* (for more information, go to Chapter 3).

Legal Terms	Asking for removal of a restriction on coverage for a drug is sometimes called asking for a “formulary exception.”
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- The extra rules and restrictions on coverage for certain drugs include:
 - *Being required to use the generic version* of a drug instead of the brand-name drug.
 - *Getting plan approval in advance* before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
 - *Being required to try a different drug first* before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
 - *Quantity limits*. For some drugs, there are restrictions on the amount of the drug you can have.
- If our plan agrees to make an exception and waive a restriction for you, you can ask for an exception to the copayment or co-insurance amount we require you to pay for the drug.

3. Changing coverage of a drug to a lower cost-sharing tier. Every drug on the plan’s Drug List is in one of the cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms	Asking to pay a lower preferred price for a covered non-preferred drug is sometimes called asking for a “tiering exception.”
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- If your drug is in *Tier 3 (Non-preferred drugs)* or the *Injectable drugs tier* you can ask us to cover it at the cost-sharing amount that applies to drugs in *Tier 2 (Preferred brand drugs.)* This would lower your share of the cost for the drug.
- You cannot ask us to change the cost-sharing tier for any drug in the *Specialty drugs tier.*

Section 5.3	Important things to know about asking for exceptions
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Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a written statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally *not* approve your request for an exception.

Our plan can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.
- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 5.5 tells you how to make an appeal if we say no.

The next section tells you how to ask for a coverage decision, including an exception.

Section 5.4	Step-by-step: How to ask for a coverage decision, including an exception
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Step 1: You ask our plan to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a “fast decision.” You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.

What to do

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing our plan to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to Chapter 2, Section 1 and look for the section called, *How to contact our plan when you are asking for a coverage decision about your Part D prescription drugs*. Or if you are asking us to pay you back for a drug, go to the section called, *Where to send a request that asks us to pay for our share of the cost for medical care or a drug you have received*.
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 of this chapter tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.
- **If you want to ask our plan to pay you back for a drug**, start by reading Chapter 7 of this booklet: *Asking the plan to pay its share of a bill you have received for medical services or drugs*. Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- **If you are requesting an exception, provide the “doctor’s statement.”** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “doctor’s statement.”) Your doctor or other prescriber can fax or mail the statement to our plan. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing the signed statement. See Sections 5.2 and 5.3 for more information about exception requests.

If your health requires it, ask us to give you a “fast decision”

Legal Terms	A “fast decision” is called an “expedited decision.”
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- When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast decision means we will answer within 24 hours.

- **To get a fast decision, you must meet two requirements:**
 - You can get a fast decision only if you are asking for a *drug you have not yet received*. (You cannot get a fast decision if you are asking us to pay you back for a drug you are already bought.)
 - You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function*.
- **If your doctor or other prescriber tells us that your health requires a “fast decision,” we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own (without your doctor’s or other prescriber’s support), our plan will decide whether your health requires that we give you a fast decision.
 - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead).
 - This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision.
 - The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a “fast” complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 7 of this chapter.)

Step 2: Our plan considers your request and we give you our answer.

Deadlines for a “fast” coverage decision

- If we are using the fast deadlines, we must give you our answer **within 24 hours**.
 - Generally, this means within 24 hours after we receive your request. If you are requesting an exception, we will give you our answer within 24 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to.

- If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

*Deadlines for a “**standard**” coverage decision*

- If we are using the standard deadlines, we must give you our answer **within 72 hours**.
 - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
- **If our answer is yes to part or all of what you requested –**
 - If we approve your request for coverage, we must **provide the coverage** we have agreed to provide **within 72 hours** after we receive your request or doctor's statement supporting your request.
 - If we approve your request to pay you back for a drug you already bought, we are also required to **send payment to you within 30 calendar days** after we receive your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Step 3: If we say no to your coverage request, you decide if you want to make an appeal.

- If our plan says no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

Section 5.5	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)
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Legal Terms	When you start the appeals process by making an appeal, it is called the “first level of appeal” or a “Level 1 Appeal.” An appeal to the plan about a Part D drug coverage decision is called a plan “ redetermination. ”
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Step 1: You contact our plan and make your Level 1 Appeal. If your health requires a quick response, you must ask for a “**fast appeal.**”

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact our plan.**
 - For details on how to reach us by phone, fax, mail, or in person for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called, *How to contact our plan when you are making an appeal about your Part D prescription drugs.*
- **Make your appeal in writing by submitting a signed request.**
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.
- **You can ask for a copy of the information in your appeal and add more information.**
 - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
 - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal”

Legal Terms	A “fast appeal” is also called an “ expedited appeal. ”
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- If you are appealing a decision our plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal.”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast decision” in Section 5.4 of this chapter.

Step 2: Our plan considers your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were being fair and following all the rules when we said no to your request. We may contact you or your doctor or other prescriber to get more information.

Deadlines for a “fast” appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal.** We will give you our answer sooner if your health requires it.
 - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. (Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.)
- **If our answer is yes to part or all of what you requested,** we must provide the coverage we have agreed to provide within 72 hours.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no and how to appeal our decision.

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days** after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so.
 - If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.

- **If our answer is yes to part or all of what you requested –**
 - If we approve a request for coverage, we must **provide the coverage** we have agreed to provide as quickly as your health requires, but **no later than 7 calendar days** after we receive your appeal.
 - If we approve a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive your appeal request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no and how to appeal our decision.

Step 3: If we say no to your appeal, you decide if you want to continue with the appeals process and make *another* appeal.

- If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal.
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below).

Section 5.6	Step-by-step: How to make a Level 2 Appeal
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If our plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the “Independent Review Organization” is the “ Independent Review Entity .” It is sometimes called the “ IRE .”
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Step 1: To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case.

- If our plan says no to your Level 1 Appeal, the written notice we send you will include **instructions on how to make a Level 2 Appeal** with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called

your “case file.” **You have the right to ask us for a copy of your case file.** We are allowed to charge you a fee for copying and sending this information to you.

- You have a right to give the Independent Review Organization additional information to support your appeal.

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer.

- **The Independent Review Organization is an outside, independent organization that is hired by Medicare.** This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with our plan.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

Deadlines for “fast” appeal at Level 2

- If your health requires it, ask the Independent Review Organization for a “fast appeal.”
- If the review organization agrees to give you a “fast appeal,” the review organization must give you an answer to your Level 2 Appeal **within 72 hours** after it receives your appeal request.
- **If the Independent Review Organization says yes to part or all of what you requested,** we must provide the drug coverage that was approved by the review organization **within 24 hours** after we receive the decision from the review organization.

Deadlines for “standard” appeal at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** after it receives your appeal.
- **If the Independent Review Organization says yes to part or all of what you requested –**
 - If the Independent Review Organization approves a request for coverage, we must **provide the drug coverage** that was approved by the review organization **within 72 hours** after we receive the decision from the review organization.

- If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to **send payment to you within 30 calendar days** after we receive the decision from the review organization.

What if the review organization says no to your appeal?

If this organization says no to your appeal, it means the organization agrees with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”)

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you if the dollar value of the coverage you are requesting is high enough to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 6 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 6 Taking your appeal to Level 3 and beyond

Section 6.1 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal A judge who works for the Federal government will review your appeal and give you an answer. This judge is called an “Administrative Law Judge.”

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved.
- **If the answer is no, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with you appeal. Whenever the reviewer says no to your appeal, the notice you get will tell you whether the rules allow you to go on to another level of appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 4 Appeal The Medicare Appeals Council will review your appeal and give you an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved.
- **If the answer is no, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. It depends on your situation. If the Medicare Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal A judge at the Federal District Court will review your appeal. This is the last stage of the appeals process.

- This is the last step of the administrative appeals process.

MAKING COMPLAINTS

SECTION 7 **How to make a complaint about quality of care, waiting times, Customer Service, or other concerns**



If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 of this chapter.

Section 7.1	What kinds of problems are handled by the complaint process?
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This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

**If you have any of these
kinds of problems,
you can make a complaint**

Quality of your medical care

- ¥ Are you unhappy with the quality of the care you have received?

Respecting your privacy

- ¥ Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be

Disrespect, poor customer service, or other negative behaviors

- ¥ Has someone been rude or disrespectful to you?
- ¥ Are you unhappy with how our Member Services has dealt with you?
- ¥ Do you feel you are being encouraged to leave our plan?

Waiting times

- ¥ Have you been kept waiting too long by pharmacists? Or by Member Services or other staff at our plan?
- ¥ Examples include waiting too long on the phone or when getting a prescription.

Cleanliness

- ¥ Are you unhappy with the cleanliness or condition of a pharmacy?

Information you get from our plan

- ¥ Do you believe we have not given you a notice that we are required to give?
- ¥ Do you think written information we have given you is hard to

*The next page has more examples of
possible reasons for making a complaint*

Possible complaints (continued)

These types of complaints are all related to the *timeliness* of our actions related to coverage decisions and appeals

The process of asking for a coverage decision and making appeals is explained in sections 4-6 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that our plan is not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- ¥ If you have asked us to give you a “fast response” for a coverage decision or appeal, and we have said we will not, you can make a complaint.
- ¥ If you believe our plan is not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- ¥ When a coverage decision we made is reviewed and our plan is told that we must cover or reimburse you for certain drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- ¥ When our plan does not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 7.2 The formal name for “making a complaint” is “filing a grievance”

Legal Terms

- What this section calls a “**complaint**” is also called a “**grievance.**”
- Another term for “**making a complaint**” is “**filing a grievance.**”
- Another way to say “**using the process for complaints**” is “**using the process for filing a grievance.**”

Section 7.3 Step-by-step: Making a complaint

Step 1: Contact us promptly – either by phone or in writing.

- **Usually, calling Customer Service is the first step.** If there is anything else you need to do, Customer Service will let you know. *1-800-539-4072, TTY users call 1-800-929-9955*

Hours of Operation 8:00 A.M. TO 8:00 P.M, Pacific time 7 days a week

- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you do this, it means that we will use our *formal procedure* for answering grievances. Here’s how it works:

Upon receipt of your complaint, we will initiate the Grievance procedure and acknowledge receipt of your request within 5 business days of receipt.

You are also 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

We call this the Expedited Grievance procedure. If you have questions about this procedure, please call Customer Service at the phone number listed on the cover. Requests for Expedited Grievance may be submitted by telephone at 1-800-539-4072 (TTY/TTD 1-800-929-9955). You may also submit your request in writing or via facsimile to Health Net at: 1-800-977-1959

- **Whether you call or write, you should contact Customer Service right away.** The complaint must be made within 60 days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a “fast response” to a coverage decision or appeal, we will automatically give you a “fast” complaint.** If you have a “fast” complaint, it means we will give you **an answer within 24 hours.**

Legal Terms	What this section calls a “fast complaint” is also called a “fast grievance.”
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Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 days, but we may take up to 44 days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more days (44 days total) to answer your complaint.
- **If we do not agree** with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 7.4	You can also make complaints about quality of care to the Quality Improvement Organization
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You can make your complaint about the quality of care you received to our plan by using the step-by-step process outlined above.

When your complaint is about *quality of care*, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (*without* making the complaint to our plan). To find the name, address, and phone number of the Quality Improvement Organization in your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work together with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to our plan and also to the Quality Improvement Organization.

Chapter 8. Ending your membership in the plan

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SECTION 1 Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

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

- You might leave our plan because you have decided that you *want* to leave.
 - There are only certain times during the year, or certain situations, when you may voluntarily end your membership in the plan. Section 2 tells you *when* you can end your membership in the plan.
 - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you *how* to end your membership in each situation.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your Part D prescription drugs through our plan until your membership ends.

SECTION 2 When can you end your membership in our plan?

You may end your membership in our plan only during certain times of the year, known as enrollment periods. All members have the opportunity to leave the plan during the Annual Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1 Usually, you can end your membership during the Annual Enrollment Period

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

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

MEDICARE (1-800-633-4227), or visit www.medicare.gov to learn more about your options.

Section 2.2	You can end your membership during the Medicare Advantage Open Enrollment Period, but your plan choices are more limited
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You have the opportunity to make *one* change to your health coverage during the **Medicare Advantage Open Enrollment Period**.

- **When is the Medicare Advantage Open Enrollment Period?** This happens every year from January 1 to March 31.
- **What type of plan can you switch to during the Medicare Advantage Open Enrollment Period?** During this time, you can make *one* change to your health plan coverage. However, you may *not* add or drop prescription drug coverage during this time. Since you are currently enrolled in a Medicare prescription drug plan, this means that you can enroll in:
 - A Medicare Advantage plan with prescription drug coverage. (A Medicare Advantage plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits.)
 - **Note:** You can also enroll in a Medicare Private Fee-For-Service Plan without prescription drug coverage or a Medicare Cost Plan. But in these cases, you must keep your prescription drug coverage through our plan.
- **When will your membership end?** Your membership will end on the first day of the month after we get your request to change plans.

Section 2.3	In certain situations, you can end your membership during a Special Enrollment Period
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In certain situations, members of our plan may be eligible to end their membership at other times of the year. This is known as a **Special Enrollment Period**.

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (<http://www.medicare.gov>):
 - If you have moved out of your plan's service area.
 - If you have Medicaid.
 - If you are eligible for Extra Help with paying for your Medicare prescriptions.

- If you live in a facility, such as a nursing home.
 - **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.
 - **What can you do?** If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
 - Another Medicare prescription drug plan.
 - Original Medicare *without* a separate Medicare prescription drug plan.
 - – *or* – A Medicare Advantage plan. A Medicare Advantage plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare Advantage plans also include Part D prescription drug coverage.
 - If you enroll in most Medicare Advantage plans, you will automatically be disenrolled from our plan when your new plan’s coverage begins. However, if you choose a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan and keep our plan for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or to drop Medicare prescription drug coverage.
- Note:** If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. (“Creditable” coverage means the coverage is at least as good as Medicare’s standard prescription drug coverage.)
- **When will your membership end?** Your membership will usually end on the first day of the month after we receive your request to change your plan.

Section 2.4	Where can you get more information about when you can end your membership?
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If you have any questions or would like more information on when you can end your membership:

- You can **call Customer Service** (phone numbers are on the cover of this booklet).
- You can find the information in the *Medicare & You 2010* handbook.
 - Everyone with Medicare receives a copy of *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.

- You can also download a copy from the Medicare website (<http://www.medicare.gov>). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3 How do you end your membership in our plan?

Section 3.1 You end your membership by enrolling in another plan
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Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see Section 2 for information about the enrollment periods). There are a couple of exceptions:

- One exception is when you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan. In this situation, you must contact our plan Customer Service and ask to be disenrolled from our plan.
- Another exception is if you join a Private Fee-For-Service plan without prescription drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan. In this case, you can enroll in that plan and keep our plan for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or to drop your Medicare prescription drug coverage.

The table below explains how you should end your membership in our plan.

If you would like to switch from our plan to:	This is what you should do:
<ul style="list-style-type: none"> • Another Medicare prescription drug plan. 	<ul style="list-style-type: none"> • Enroll in the new Medicare prescription drug plan. <p style="margin-left: 40px;">You will automatically be disenrolled from our plan when your new plan’s coverage begins.</p>
<ul style="list-style-type: none"> • A Medicare Advantage plan. 	<ul style="list-style-type: none"> • Enroll in the Medicare Advantage plan.

If you would like to switch from our plan to:	This is what you should do:
	<p>will automatically be disenrolled from our plan when your new plan's coverage begins.</p> <p>However, if you choose a plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that new plan and keep our plan for your drug coverage. If you want to leave our plan, you must <i>either</i> enroll in another Medicare prescription drug plan <i>or</i> contact Customer Service or Medicare and ask to be disenrolled.</p>
<ul style="list-style-type: none">• Original Medicare <i>without</i> a separate Medicare prescription drug plan.	<ul style="list-style-type: none">• Contact Customer Service and ask to be disenrolled from the plan (phone numbers are on the cover of this booklet).• You can also contact Medicare at 1-800-MEDICARE (1-800-633-4227) and ask to be disenrolled. TTY users should call 1-877-486-2048.

SECTION 4 Until your membership ends, you must keep getting your drugs through our plan

Section 4.1	Until your membership ends, you are still a member of our plan
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If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.

SECTION 5 We must end your membership in the plan in certain situations

Section 5.1 When must we end your membership in the plan?

We must end your membership in the plan if any of the following happen:

- If you do not stay continuously enrolled in Medicare Part A or Part B (or both).
- If you move out of our service area for more than six months.
 - If you move or take a long trip, you need to call Customer Service to find out if the place you are moving or traveling to is in our plan's area.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan.
 - We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get prescription drugs.
 - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for 90-days.
 - We must notify you in writing that you have 90-days to pay the plan premium before we end your membership.

Involuntarily ending your membership due to termination of the Group Policy

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

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

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

Where can you get more information?

If you have questions or would like more information on when we can end your membership:

- You can call **Customer Service** for more information (phone numbers are on the cover of this booklet).

Section 5.2	We <u>cannot</u> ask you to leave our plan for any reason related to your health
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What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Section 5.3	You have the right to make a complaint if we end your membership in our plan
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If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 7, Section 7 for information about how to make a complaint.

Chapter 9. Legal notices

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SECTION 1 Notice about governing law

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

SECTION 2 Notice about nondiscrimination

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

SECTION 3 Health Care Plan Fraud

Health care plan fraud is defined as a deception or misrepresentation by a provider, Member, employer or any person acting on their behalf. It is a felony that can be prosecuted. Any person who willfully and knowingly engages in an activity intended to defraud the health care plan by filing a claim that contains a false or deceptive statement is guilty of insurance fraud.

If you are concerned about any of the charges that appear on a bill or Explanation of Benefits form, or if you know of or suspect any illegal activity, call our plan's toll-free Fraud Hotline at 1-**800-977-3565**. The Fraud Hotline operates 24 hours a day, seven days a week. All calls are strictly confidential.

SECTION 4 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.

SECTION 5 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 medications that you receive through this plan. However, if you receive money because of your injuries, you must reimburse Health Net or the pharmacy for the value of any medications provided to you through this plan. Examples of how an injury could be caused by the actions of another person: You are in a car accident and the other driver is at fault. You slip and fall in a store because a wet spot was left on the floor.

Section 5.2 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 pharmacy's efforts to obtain reimbursement, including: Telling Health Net and the pharmacy the name and address of the third party, if you know it, the name and address of your lawyer, if you are using a lawyer, and describing how the injuries were caused. Completing any paperwork that Health Net or the pharmacy may require to assist in enforcing the lien. Promptly responding to inquiries from the lien holders about the status of the case and any settlement discussions. Notifying the lien holders 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 pharmacy for the amount of the lien as soon as you are paid by the third party.

Section 5.3 How The Amount Of your Reimbursement Is Determined
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Your reimbursement to Health Net or the pharmacy under this lien is based on the value of the medications you receive and the costs of perfecting this lien. For purposes of determining the lien amount, the value of the medications depends on how the pharmacy was paid and will be determined as permitted by law. Unless the money that you receive came from a Workers' Compensation claim, the following applies: The amount of the reimbursement that you owe Health Net or the pharmacy will be reduced by the percentage that your recovery is reduced if a judge, jury or arbitrator determines that you were responsible for some portion of your injuries.

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

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

SECTION 6 Binding Arbitration

Please note that binding arbitration does not apply to disputes that are subject to the Medicare Appeals process as described in detail in Chapter 7 of the Evidence of Coverage.

Sometimes disputes or disagreements may arise between You (including Your enrolled Dependents, heirs or personal representatives) and HNL regarding the construction, interpretation, performance or breach of this Certificate, or regarding other matters relating to or arising out of Your HNL membership. Typically such disputes are handled and resolved through the HNL Grievance, Appeal and Independent Medical Review process described above. However, in the event that a dispute is not resolved in that process, HNL 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 HNL 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 HNL Covered Person, You agree to submit all disputes You may have with HNL, except those described below, to final and binding arbitration. Likewise, HNL agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both You and HNL 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 HNL'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.

HNL's binding arbitration process is conducted by mutually acceptable arbitrator(s) selected by the parties. The Federal Arbitration Act, 9 U.S.C. § 1, et seq., will govern arbitrations under this process. In the event that the total amount of damages claimed is \$200,000 or less (\$50,000 or less with respect to disputes with HNL involving alleged professional liability or medical malpractice), the parties shall, within 30 days of submission of the demand for arbitration to HNL, appoint a mutually acceptable single neutral arbitrator who shall hear and decide the case and have no jurisdiction to award more than \$200,000 or \$50,000, whichever is applicable. In the event that total amount of damages is over \$200,000 or \$50,000, whichever is applicable, the parties shall, within 30 days of submission of the demand for arbitration to HNL, 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 HNL at the address provided below. The demand must have a clear statement of the facts, the relief sought and a dollar amount.

Health Net Life Insurance Company

Attention: Litigation Administrator

P.O. Box 4504

Woodland Hills, CA 91356-4505

The arbitrator is required to follow applicable state or federal law. The arbitrator may interpret this Certificate, 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.

Effective July 1, 2002, Covered Persons 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 HNL to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by HNL to deny, reduce, terminate or not pay for all or a part of a benefit. However, You and HNL may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

Chapter 10. Definitions of important words

Appeal – An appeal is something you do if you disagree with a decision to deny a request for health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with a decision to stop services that you are receiving. For example, you may ask for an appeal if our Plan doesn't pay for a drug, item, or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Brand Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent \$4,550 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs Medicare. Section 2 explains how to contact CMS.

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

Cost-sharing Tier – Every drug on the list of covered drugs is in one of the cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage if you disagree.

Covered Drugs – The term we use to mean all of the prescription drugs covered by our Plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to cover, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

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

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

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor’s formulary (a formulary exception), or get a non-preferred drug at the preferred cost-sharing level (a tiering exception). You may also request an exception if your plan sponsor requires you to try another drug before receiving the drug you are requesting, or the plan limits the quantity or dosage of the drug you are requesting (a formulary exception).

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

Grievance – A type of complaint you make about us or one of our network pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

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

Initial Coverage Stage – This is the stage where we will pay part of the costs for your Covered Drugs and you will pay the other part. The amount you pay when you fill a covered Prescription is called the coinsurance or co-payment. Your coinsurance /copayment will vary depending on the drug and where the prescription is filled.

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

List of Covered Drugs (Formulary or “Drug List”) – A list of covered drugs provided by the plan. The drugs on this list are selected by the plan with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Low Income Subsidy/Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Medically Necessary – Drugs that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical

condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

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

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

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

“Medigap” (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill “gaps” in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage plan is not a Medigap policy.)

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

Customer Service – A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Customer Service.

Network Pharmacy – A network pharmacy is a pharmacy where members of our Plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Original Medicare (“Traditional Medicare” or “Fee-for-service” Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-network Pharmacy – A pharmacy that doesn’t have a contract with our Plan to coordinate or provide covered drugs to members of our Plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our Plan unless certain conditions apply.

Part C – see “**Medicare Advantage (MA) Plan**”.

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

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Preferred Network Pharmacy – A network pharmacy that offers covered drugs to members of our Plan at lower cost-sharing levels than apply at a non-preferred network pharmacy.

Prior Authorization – Approval in advance to get certain drugs that may or may not be on our formulary. Some drugs are covered only if your doctor or other network provider gets “prior authorization” from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the Federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Chapter 2 for information about how to contact the QIO in your state and Chapter 7 for information about making complaints to the QIO.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Service Area “Service area” is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan, and in the case of network plans, where a network must be available to provide services.

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

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Quality Improvement Organization (QIO)

State	Program Name & Address	Contact Number
California	Health Services Advisory Group, Inc. (HSAG) Attn: Beneficiary Protection 700 North Brand Blvd. Ste. 370 Glendale, CA. 91203	1-866-800-8749 (1-800-881-5980 TDD)

State Health Insurance Assistance Program (SHIP)

State	Program Name & Address	Contact Number
California	HICAP California Health Advocates 5380 Elvas Avenue, Suite 104 Sacramento, CA 95819	1-800-434-0222

Medicaid Agency

State	Program Name & Address	Contact Number
California	California Department of Health Services P.O. Box 997413 Sacramento, CA 95899-7413	1-800-541-5555

Office of Civil Rights

State	Program Name & Address	Contact Number
California	Office for Civil Rights U.S. Department of Health & Human Services 90 7 th Street, Suite 4-100 San Francisco, CA 94103	1-415-437-8310 1-415-437-8311 (TDD)

Health Net Medicare Programs
Post Office Box 6501
Rensselaer, NY. 12144-6501

Customer Service Department

1.800.539.4072

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

Telecommunications Device for the Deaf

1.800.929.9955

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

Para los que hablan español

1.800.806.8811

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

Dispositivo de telecomunicaciones para las personas con impedimentos auditivos

1.800.929.9955

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

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