

EVIDENCE OF COVERAGE

A complete explanation of your plan

*For University of California Medicare Retirees
Effective 1/1/2011*

Health Net Seniority Plus (Employer HMO)

Plan 3KV EOCID

Important benefit information – please read



Schedule changes in 2011

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

- **Out of Pocket Maximum** - Services which are covered under Medicare Part A & B apply to the \$1500 per member annual copayment maximum (see Section 12 , Chapter 7).
- **Out of Pocket Maximum** - Services that are covered under Medicare Part D apply to the \$2,000 per person per calendar year annual prescription drug out-of-pocket maximum
- **Urgent Care service copayment** - The Urgent Care copayment has been changed from \$50 to \$15.
- **Medical Inpatient, Substance Abuse Inpatient, Mental Health Inpatient, and Detoxification Inpatient** - Under the “**Schedule of Benefits**” The \$250 limit to first three inpatient admissions per calendar year has been removed.
- **CVS Mail Order Pharmacy** Chapter 8 Section 2.3, Mail order can be filled for one month, two months, or three months supply for Medicare members. CVS will charge one month supply for 31 day supply and 2x retail copayment for mail order of 60 day supply or more. In 2010 CVS did not dispense a 34-day or less mail order. Full mail order copay 2x retail was charged to any quantity amount ordered and filed for 34-days or more.
- **Glaucoma tests** The copayment for Glaucoma testing has been changed from \$15 to \$0 (see chapter 3, “Plan benefit chart.”)

Note:

Once you enroll in Medicare, your behavioral health provider network will be different and you will need to obtain new authorizations/self referrals to behavioral health providers. Please review your Health Net ID card for the appropriate phone number for Mental Health and Substance Abuse.

Table of Contents

This list of chapters and page numbers is just your starting point. For more help in finding information you need, go to the first page of a chapter. **You will find a detailed list of topics at the beginning of each chapter.**

Chapter 1.	University of California - Eligibility, Enrollment, Termination and Plan Administration Provisions	1
Chapter 2.	Your Evidence of Coverage.....	14
Chapter 3.	Plan benefits chart.....	15
Chapter 4.	Getting started as a member of our plan	60
Chapter 5.	Important phone numbers and resources	70
Chapter 6.	Using the plan’s coverage for your medical services	85
Chapter 7.	Medical Benefits Chart (what is covered and what you pay).....	97
Chapter 8.	Using the plan’s coverage for your Part D prescription drugs.....	103
Chapter 9.	What you pay for your Part D prescription drugs.....	120
Chapter 10.	Asking the plan to pay its share of a bill you have received for covered services or drugs	138
Chapter 11.	Your rights and responsibilities.....	144
Chapter 12.	What to do if you have a problem or complaint (coverage decisions, appeals, complaints).....	158
Chapter 13.	Ending your membership in the plan	211
Chapter 14.	Legal notices	220
Chapter 15.	Definitions of important words	227

Explains key terms used in this booklet.

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

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

January 1, 2011

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

ELIGIBILITY

The following individuals are eligible to enroll in this Plan. If the Plan is a Health Maintenance Organization (HMO) or Exclusive Provider Organization (EPO) Plan, they are only eligible to enroll in the Plan if they meet the Plan's geographic service area criteria. Anyone enrolled in a non-University Medicare Advantage Managed Care contract or enrolled in a non-University Medicare Part D Prescription Drug Plan will be 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 provided that 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), domestic partner verification, adoption records, Federal Income Tax Return, or other official documentation.

Eligible Adult:

Spouse: Your legal spouse.

Same Sex-Domestic Partner: 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.

Opposite-Sex Domestic Partner: 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.

Note: 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 Medicare Part A may continue coverage in UC-sponsored plans.

Child:

All eligible children must be under the limiting age of 26 (18 for legal wards except for a child who is incapable of self-support due to a physical or mentally disabling injury, illness or condition). The following categories are eligible:

- (a) your natural or legally adopted children;
- (b) your spouse's natural or legally adopted children (your stepchildren);
- (c) your eligible domestic partner's natural or legally adopted children;

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

Any child described above (except a legal ward) who is incapable of self-support due to a physical or mental disability may continue to be covered past age 26 provided:

- the plan-certified disability began before age 26, the child was enrolled in a UC group medical plan before age 26 and coverage is continuous;
- the child is chiefly dependent upon you, your spouse, or your eligible domestic partner's for support and maintenance; and
- the child is claimed as your, your spouse, or your eligible domestic partner's dependent for income tax purposes, or if not claimed as such dependent for income tax purposes, is eligible for Social Security Income or Supplemental Security Income as a disabled person or working in supported employment which may offset the Social Security or Supplemental Security Income.

Application for coverage beyond age 26 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. Disabled children approved for continued coverage under a University-sponsored medical plan are eligible for continued coverage under any other University-sponsored medical plan; if enrollment is transferred from one plan to another, a new application for continued coverage is not required; however, the new Plan may require proof of continued disability, but not more than once a year.

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

Important Note: Health and welfare benefits and eligibility requirements, including dependent eligibility requirements are subject to change (e.g., for compliance with applicable laws and regulations). UC dependent eligibility

requirements may change following final health care reform legislation, regulatory guidance, or other applicable laws.

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

More Information

For information on who qualifies and how to enroll, contact your local Benefits Office or the University of California's (UC) Customer Service Center at (800) 888-8267. You may also access eligibility factsheets on UC's *At Your Service* web site: <http://atyourservice.ucop.edu>.

ENROLLMENT

For information about enrolling yourself or an eligible Family Member, 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 the last day of a PIE falls on a weekend or holiday, the PIE is extended to the following business day when enrolling with forms.

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

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

If the child is not enrolled during the PIE beginning on that date, there is an additional PIE beginning on the date the adoption becomes final.

(e) 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 available in the new location. Your PIE starts with the effective date of the move or the date you leave the Plan's service area. Upon return to the service area, you will have a PIE to reenroll yourself and eligible Family Members in the same HMO, EPO or POS you had at the time of the move out of the area. The PIE begins with the effective date of the return to the 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. You or your eligible Family Members are not currently enrolled and you or your eligible Family Members become eligible for premium assistance under the Medi-Cal Health Insurance Premium Payment (HIPP) Program or a Medicaid or CHIP premium assistance program in another state. Your PIE is 60 days from the date you are determined eligible for premium assistance. If the last day of the PIE falls on a weekend or holiday, the PIE is extended to the following business day. Electronic transactions must be completed by the deadline on the last day of the enrollment period.
3. 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.)
4. You have a change in family status through marriage or domestic partnership, or the birth, adoption, or placement for adoption of a child:
 - a. If you are enrolling following marriage or establishment of a domestic partnership, you and your new spouse or domestic partner must enroll during the PIE. Your new spouse or domestic partner's eligible children may also enroll at that time. Coverage will be effective as of the date of marriage or domestic partnership provided you enroll during the PIE.
 - b. If you are enrolling following the birth, adoption, or placement for adoption of a child, your spouse or domestic partner, who is eligible but not enrolled, may also enroll at that time. Application must be made during the PIE; coverage will be effective as of the date of birth, adoption, or placement for adoption provided you enroll during the PIE.

5. 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 to enroll or change 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 form is received by your local Benefits or Payroll Office.

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

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 or Intentional Misrepresentation

Coverage for you and/or your Family Members may be suspended for up to 12 months if you or a Family Member commit fraud or make an intentional misrepresentation of material fact relating to Plan coverage. Individuals who are enrolled, but who are not eligible Family Members will be permanently deenrolled...

Leave of Absence, Layoff, Change in Employment Status or Retirement

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

Optional Continuation of Coverage

As 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. .

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 plan administrator for the Plan provisions described in this insert to the Plan Evidence of Coverage booklet. If you have a question about eligibility or enrollment, you may direct it to:

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

Retirees and Survivors may also direct questions to the UC Customer Service Center at the above phone number.

Claims and appeals for benefits under the Plan are processed by Health Net. If you have a question about benefits under the Plan or about a specific claim, please contact Health Net at the following address and phone number:

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

Group Contract Number

The Group Contract Number for this Plan is: 5047RB, L, 5047SH, 5047TA, G, R,W, 5047UL, S, 5047VG, 5522SM, N, Q, R, S, T, U.

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 Health Net 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 Health Net at the address listed above.

Your Rights under the Plan

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

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

Claims under the Plan

To file a claim or to 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.

Special Reinstatement Rule For Reservists Returning From Active Duty

Reservists ordered to active duty on or after January 1, 2007 who were covered under this Plan at the time they were ordered to active duty and their eligible dependents will be reinstated without

waiting periods or exclusion of coverage for pre-existing conditions. A reservist means a member of the U.S. Military Reserve or California National Guard called to active duty as a result of the Iraq conflict pursuant to Public Law 107-243 or the Afghanistan conflict pursuant to Presidential Order No. 13239. Please notify the Group when you return to employment if you want to reinstate your coverage under the Plan.

Special Reinstatement Rule Under USERRA

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

Effect of Medicare

If you are eligible for Medicare, you must enroll in Medicare according to UC's Medicare Rules. Once you and/or a family member are enrolled in Medicare, you are ineligible for mental health and substance abuse benefits through the United Behavioral Health portion of your plan. Employees should contact the local benefits office and Retirees should contact the University's Customer Service Center to transfer to the portion of your plan for Medicare enrollees.

Chapter 2. Your Evidence of Coverage

This Evidence of Coverage gives you the details about your Medicare health and prescription drug coverage for your 2011 benefit period. It explains how to get the health care and prescription drugs you need. This is an important legal document. Please keep it in a safe place.

Health Net Seniority Plus (Employer HMO) Member Services:

For help or information, please call Member Services or go to our plan website at www.healthnet.com/uc.

Health Net Seniority Plus (Employer HMO) 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 of California, Inc., referred throughout the *Evidence of Coverage* as “we,” “us,” or “our.” Health Net Seniority Plus (Employer HMO) is referred to as “plan” or “our plan.”

This information is available in a different format, including large print and audio tape. Please call Member Services at the number listed above if you need plan information in another format or language.

Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change for the 2012 plan year.

Chapter 3. Plan benefits chart**SECTION 1 Medical Benefits Chart****Medical Benefits Chart**

Services that are covered for you

What you must pay
when you get these
services**Inpatient Care****Inpatient hospital care**

You are covered for unlimited days per Benefit period. Covered services include:

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

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

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.

Requires prior authorization (approval in advance) to be covered, except in an emergency

There is a \$250 copayment for each Medicare-covered hospital stay.

A Benefit period begins the day you are admitted to a hospital or skilled nursing facility.

The Benefit period ends when you have not received hospital and/or skilled nursing care for 60 consecutive days.

If you go into the hospital after one Benefit period has ended, a new Benefit period begins.

You must pay the inpatient hospital copayment for each Benefit period.

There is no limit to the number of Benefit periods you can have.

Services that are covered for you	What you must pay when you get these services
<p>Inpatient Hospital Transgender Surgery/Services** (including hysterectomy, oophorectomy and mastectomy)</p> <ul style="list-style-type: none"> • Travel, lodging and meals included. <p>The transgender surgery must be performed by a Health Net qualified provider in conjunction with gender transformation treatment. The treatment plan must conform to Harry Benjamin International Gender Dysphoria Association (HBIIGDA) standards. Psychotherapy and hormonal treatment are excluded from the lifetime maximum.</p>	<p><i>Requires prior authorization (approval in advance) to be covered, except in an emergency</i></p> <p>You pay a \$250 Copayment for transgender services.</p> <p>Transgender surgery and related services (including travel, lodging and meal expenses) approved by the plan are subject to a combined inpatient and outpatient lifetime benefit maximum of \$75,000 for each Member.</p>
<p>Inpatient mental health care</p> <ul style="list-style-type: none"> • Covered services include mental health care services that require a hospital stay. 	<p><i>Requires prior authorization (approval in advance) to be covered, except in an emergency</i></p> <p>You pay: \$250 copayment for each Medicare-covered hospital stay.</p> <p>Refer to Section 3.1 of this Chapter for more information about inpatient mental health care.</p>

Services that are covered for you

What you must pay when you get these services

Inpatient Substance Abuse Care*

- Residential care in a Hospital or substance abuse facility
- For more information about inpatient substance abuse benefits, please see "Using Your Mental Health Care and Substance Abuse Benefits" in Section 10.*

Requires prior authorization (approval in advance) to be covered, except in an emergency

You pay a \$250 Copayment for services in a network Hospital.

Acute Care Detoxification*

Requires prior authorization (approval in advance) to be covered, except in an emergency

There is a \$250 Copayment for acute care detoxification services.

Skilled nursing facility (SNF) care

(For a definition of "skilled nursing facility," see Chapter 15 of this booklet. Skilled nursing facilities are sometimes called "SNFs.")

You are covered for 100 days each Benefit period. Covered services include:

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

Requires prior authorization (approval in advance) to be covered, except in an emergency

There is no copayment for each Benefit period for Skilled Nursing Facility care.

A Benefit period begins the day you are admitted to a hospital or skilled nursing facility.

The Benefit period ends when you have not received hospital and/or skilled nursing care for 60 consecutive days.

Services that are covered for you

What you must pay when you get these services

- Laboratory tests ordinarily provided by SNFs
- X-rays and other radiology services ordinarily provided by SNFs
- Use of appliances such as wheelchairs ordinarily provided by SNFs
- Physician services

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

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care).
- A SNF where your spouse is living at the time you leave the hospital.

If you go into the skilled nursing facility after one Benefit period has ended, a new Benefit period begins. You must pay the applicable SNF copayment for each Benefit period.

There is no limit to the number of Benefit periods you can have.

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

Inpatient services covered when the hospital or SNF days aren't, or are no longer, covered

As described above, the plan covers unlimited days per benefit period for inpatient hospital care and up to 100 days per benefit period for skilled nursing facility (SNF) care. Once you have reached these coverage limits, the plan will no longer cover your stay in the hospital or SNF. However, we will cover certain types of services that you receive while you are still in the hospital or the SNF. Covered services include:

- Physician services
- Tests (like X-ray or lab tests)
- X-ray, radium, and isotope therapy including technician materials and services
- Surgical dressings, splints, casts and other devices used to reduce fractures and dislocations
- Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices
- Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition
- Physical therapy, speech therapy, and occupational therapy

There is no copayment for the Medicare-covered services listed.

Services that are covered for you

What you must pay when you get these services

Home health agency care

Covered services include:

- Part-time or intermittent skilled nursing and home health aide services (To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week)
- Physical therapy, occupational therapy, and speech therapy
- Medical social services
- Medical equipment and supplies

Requires prior authorization (approval in advance) to be covered, except in an emergency

There is no copayment for Medicare-covered home health visits.

Hospice care

You may receive care from any Medicare-certified hospice program. Original Medicare (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice doctor can be a network provider or an out-of-network provider. You will still be a plan member and will continue to get the rest of your care that is unrelated to your terminal condition through our Plan. However, we will cover certain types of services that you receive while you are still in the hospital or the SNF. Covered services include:

- Drugs for symptom control and pain relief, short-term respite care, and other services not otherwise covered by Original Medicare
- Home care

Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.

When you enroll in a Medicare-certified hospice program, your hospice services are paid for by Original Medicare services not your plan.

Outpatient Services

Physician services, including doctor's office visits

Covered services include:

- Office visits, including medical and surgical care in a physician's office or certified ambulatory surgical center
- Medical or surgical services furnished in a certified ambulatory surgical center or in a hospital outpatient setting
- Consultation, diagnosis, and treatment by a specialist
- Hearing and balance exams, if your doctor orders it to see if you need medical treatment.

You pay \$15 for each primary care doctor office visit for Medicare-covered services.

You pay \$15 for each specialist visit for Medicare-covered services.

You pay \$15 for each visit

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> • Telehealth office visits including consultation, diagnosis and treatment by a specialist • Second opinion by another network provider prior to surgery • Outpatient hospital services • Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician) 	<p>to an in-network urgent care facility</p>
<p>Chiropractic services</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Manual manipulation of the spine to correct subluxation • Routine (non-Medicare covered) chiropractic visit- <i>no initial authorization or referral for first time visits; authorization required for subsequent visits and treatments</i>) 	<p><i>Requires prior authorization (approval in advance) to be covered, except in an emergency</i></p> <p>You pay \$15 for each Medicare-covered visit for the manual manipulation of the spine to correct subluxation.</p> <p>You pay \$15 for each routine visit up to 20 visits every year.</p> <p>Please refer to Section 3.3 of this Chapter for further information regarding chiropractic services.</p>
<p>Health and Fitness – Silver&Fit®</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Written health education materials, including newsletter • Nutritional training • Smoking cessation • Nursing hotline (Decision Power) • Health club membership/fitness classes (Silver&Fit) 	<p>There is no copayment for health club and fitness benefits.</p> <p>Please refer to Section 3.4 of this Chapter for further information regarding the Silver&Fit® benefits.</p>

Services that are covered for you

What you must pay
when you get these
services**Podiatry services**

Covered services include:

- Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).
- Routine foot care for members with certain medical conditions affecting the lower limbs

Requires prior authorization (approval in advance) to be covered, except in an emergency

You pay \$15 for each Medicare-covered visit (Medically Necessary foot care).

You pay \$15 for each routine (non Medicare-covered) visit.

Care is limited to one visit per calendar month.

Additional visits or referrals must be arranged and approved by your PCP.

Services that are covered for you	What you must pay when you get these services
<p>Outpatient mental health care</p> <p>Covered services include:</p> <p>Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.</p>	<p><i>Requires prior authorization (approval in advance) to be covered, except in an emergency</i></p> <p>For Medicare-covered Mental Health services, you pay:</p> <ul style="list-style-type: none"> - \$15 for each individual therapy - \$7.50 for each group therapy visit <p>For Medicare-covered Mental Health services with a psychiatrist, you pay:</p> <ul style="list-style-type: none"> - \$15 for individual therapy visit(s) - \$7.50 for each group therapy visit(s). <p>Refer to Section 3.1 of this Chapter for further information regarding outpatient mental health services.</p>
<p>Partial hospitalization services</p> <p>“Partial hospitalization” is a structured program of active psychiatric treatment that is more intense than the care received in your doctor’s or therapist’s office and is an alternative to inpatient hospitalization.</p>	<p><i>Requires prior authorization (approval in advance) to be covered, except in an emergency.</i></p> <p>There is no copayment for partial hospitalization.</p> <p>Refer to Section 3.1 of this chapter for more information on outpatient mental health services.</p>

Services that are covered for you	What you must pay when you get these services
<p>Outpatient substance abuse services</p>	<p><i>Requires prior authorization (approval in advance) to be covered, except in an emergency</i></p> <p>For Medicare-covered Substance Abuse services, you pay:</p> <ul style="list-style-type: none"> - \$15 for each individual therapy visit. - \$7.50 for each group therapy visit. <p>For Medicare-covered Substance Abuse services with a psychiatrist, you pay:</p> <ul style="list-style-type: none"> - \$15 for individual visit(s). - \$7.50 for group therapy visit(s). <p>Refer to Section 3.1 of this Chapter for further information regarding outpatient substance abuse services.</p>
<p>Behavioral Health Care Telephonic clinical consultations (Limited to a maximum of 3 consultations per member per calendar year provided by licensed clinicians for non-crisis issues such as stress, anxiety, grief, depression, relationship issues and substance abuse concerns; sessions are scheduled and designed to manage a situation over time to a clinical resolution.). (Behavioral Health Care Telephonic clinical consultation services are provided by a licensed counselor - 1-800-663-9355.)</p>	<p>There is no Copayment for Telephonic clinical consultations.</p>

Services that are covered for you	What you must pay when you get these services
<p>Outpatient surgery, including services provided at hospital facility and ambulatory surgical centers</p>	<p><i>Requires prior authorization (approval in advance) to be covered, except in an emergency</i></p> <p>There is no Copayment for Medicare-covered visits to an outpatient Hospital facility.</p>
<p>Outpatient Transgender Surgery/Services** (including hysterectomy, oophorectomy and mastectomy)</p> <ul style="list-style-type: none"> • Travel, lodging and meals included. <p>The transgender surgery must be performed by a Health Net qualified provider in conjunction with gender transformation treatment. The treatment plan must conform to Harry Benjamin International Gender Dysphoria Association (HBIIGDA) standards. Psychotherapy and hormonal treatment are excluded from the lifetime maximum.</p>	<p><i>Requires prior authorization by Health Net (approval in advance) to be covered, except in an emergency</i></p> <p>There is no Copayment for transgender surgery. Transgender surgery and related services (including travel, lodging and meal expenses) approved by the plan are subject to a combined inpatient and outpatient lifetime benefit maximum of \$75,000 for each Member.</p>
<p>Ambulance services</p> <ul style="list-style-type: none"> • Covered ambulance services include fixed wing, rotary wing aircraft, and ground ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health). The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's 	<p>There is no Copayment for Medicare-covered ambulance services.</p>

Services that are covered for you

What you must pay when you get these services

health) and that transportation by ambulance is medically required.

Emergency care

- Coverage in the United States*

* United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

- Worldwide Coverage.

If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital

Coverage in the United States*

You pay \$50 for each Medicare-covered emergency room visit; you do not pay this amount if you are admitted to the hospital.

WORLDWIDE COVERAGE OUTSIDE THE UNITED STATES*

There is no copayment or deductible for Emergency Services and Urgently Needed Services outside of the United States.

Urgently needed care

- Coverage in the United States*

* United States means the 50 states, the District of Columbia, Puerto Rico, the Virgin Islands, Guam, the Northern Mariana Islands, and American Samoa.

Coverage in the United States*

You pay \$15 for each Medicare-covered urgently needed care visit. You do not pay this amount if you are immediately admitted to the hospital.

Services that are covered for you	What you must pay when you get these services
<ul style="list-style-type: none"> Worldwide Coverage. 	<p>Worldwide Coverage Outside the United States*</p> <p>There is no copayment or deductible for worldwide urgently needed care services outside the United States.</p>
<p>Outpatient rehabilitation service</p> <p>Covered services include: physical therapy, occupational therapy, speech language therapy, cardiac rehabilitative therapy, intensive cardiac rehabilitation services, pulmonary rehabilitation services, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.</p>	<p><i>Requires prior authorization (approval in advance) to be covered, except in an emergency</i></p> <p>You pay \$15 for each Medicare-covered outpatient rehabilitation service visits.</p>
<p>Durable medical equipment and related supplies</p> <p>(For a definition of “durable medical equipment,” see Chapter 15 of this booklet.)</p> <p>Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.</p>	<p><i>Requires prior authorization (approval in advance) to be covered, except in an emergency</i></p>
<p>Prosthetic devices and related supplies</p> <p>Devices (other than dental) that replace a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see “Vision Care” later in this section for more detail.</p>	<p><i>Requires prior authorization (approval in advance) to be covered, except in an emergency</i></p>

Services that are covered for you

What you must pay when you get these services**Diabetes self-monitoring, training, and supplies**

For all people who have diabetes (insulin and non-insulin users).

Covered services include:

- Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.
- For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes).coverage includes fitting.
- Self-management training is covered under certain conditions.
- For persons at risk of diabetes: Fasting plasma glucose tests. Please call Member Services at the phone number on the cover for more information on how often we will cover these tests.

Requires prior authorization (approval in advance) to be covered, except in an emergency

There is no copayment for Diabetes supplies.

There is no Copayment for therapeutic shoes based on the Medicare Allowable Cost (MAC) for people with diabetes who have severe diabetic foot disease.

There is no copayment for Diabetes Self-monitoring training.

There is no Copayment for fasting plasma glucose tests for persons at risk of diabetes.

When obtained through a pharmacy, coverage of blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors are limited to those listed in the formulary.

Medical nutrition therapy

For people with diabetes, renal (kidney) disease (but not on dialysis), and after a transplant when referred by your doctor.

Requires prior authorization (approval in advance) to be covered, except in an emergency

There is no copayment for Medicare-covered Medical Nutrition Therapy visit.

Services that are covered for you	What you must pay when you get these services
<p>Kidney Disease Education Services</p> <p>Education to teach kidney care and help members make informed decisions about their care. For people with stage IV chronic kidney disease when referred by their doctor. We cover up to six sessions of kidney disease education services.</p>	<p><i>Requires prior authorization (approval in advance) to be covered, except in an emergency.</i></p> <p>There is no copayment for Medicare-covered kidney disease education services, up to six sessions.</p>
<p>Outpatient diagnostic tests and therapeutic services and supplies</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • X-rays • Radiation therapy • Surgical supplies, such as dressings. • Supplies, such as splints and casts • Laboratory tests • Blood - including storage and administration. Coverage of whole blood and packed red cells begins with the first pint of blood that you need. All other components of blood are covered beginning with the first pint used. • Other outpatient diagnostic tests 	<p><i>Requires prior authorization (approval in advance) to be covered, except in an emergency</i></p> <p>There is no copayment for Medicare-covered X-ray services.</p> <p>There is no copayment for Medicare-covered laboratory services, blood and Medicare-covered blood services.</p>
Preventive Care and Screening Tests	
<p>Abdominal aortic aneurysm screening</p> <p>A one-time screening ultrasound for people at risk. The plan only covers this screening if you get a referral for it as a result of your “Welcome to Medicare” physical exam.</p>	<p>There is no copayment for each Medicare-covered abdominal aortic aneurysm screening.</p>
<p>Bone mass measurement</p> <p>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 2 years or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician’s interpretation of the results.</p>	<p><i>Requires prior authorization (approval in advance) to be covered, except in an emergency</i></p> <p>There is no copayment for each Medicare-covered Bone Mass Measurement.</p>

Services that are covered for you	What you must pay when you get these services
<p>Colorectal screening</p> <p>For people 50 and older, the following are covered:</p> <ul style="list-style-type: none"> • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months • Fecal occult blood test, every 12 months <p>For people at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy (or screening barium enema as an alternative) every 24 months <p>For people not at high risk of colorectal cancer, we cover:</p> <ul style="list-style-type: none"> • Screening colonoscopy every 10 years, but not within 48 months of a screening sigmoidoscopy 	<p><i>Requires prior authorization (approval in advance) to be covered, except in an emergency</i></p> <p>There is no copayment for Medicare-covered Colorectal Screening Exams.</p> <p>There is no copayment for Medicare-covered colon cancer screening performed in an outpatient hospital facility or ambulatory surgical center.</p>
<p>HIV screening</p> <p>For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover:</p> <ul style="list-style-type: none"> • One screening exam every 12 months <p>For women who are pregnant, we cover:</p> <ul style="list-style-type: none"> • Up to three screening exams during a pregnancy 	<p>There is no copayment for Medicare-covered HIV screening.</p>
<p>Immunizations</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • Pneumonia vaccine • Flu shots, once a year in the fall or winter. • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B. • Other vaccines if you are at risk • Immunizations for Foreign Travel and Occupational Purposes 	<p>There is no copayment for the Medicare-covered Flu vaccine.</p> <p>There is no copayment for the Medicare-covered Pneumonia vaccine.</p> <p><i>Requires prior authorization (approval in advance) to be covered, except in an emergency</i></p>

Services that are covered for you	What you must pay when you get these services
<p>We also cover some vaccines under our outpatient prescription drug benefit.</p>	<p>There is no copayment for the Hepatitis B vaccine.</p> <p>You pay 20% of the charges for travel or occupational purposes.</p> <p>There is no copayment for other vaccines for those at risk (e.g., anti-rabies vaccine for those possibly exposed to rabies).</p>
<p>Allergy Testing</p>	<p>There is no copayment for each Medicare-covered Allergy testing services.</p>
<p>Allergy desensitizing Serum</p>	<p>There is no Copayment for the Medicare-covered allergy desensitizing serum service.</p>
<p>Mammography screening</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • One baseline exam between the ages of 35 and 39 • One screening every 12 months for women age 40 and older 	<p>There is no copayment for Medicare-covered Mammogram Screenings.</p>
<p>Pap test, pelvic exams, and clinical breast exams</p> <p>Covered services include:</p> <ul style="list-style-type: none"> • For all women, Pap tests, pelvic exams, and clinical breast exams are covered once every 24 months • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months 	<p>There is no copayment for Medicare-covered Pap Tests and Medicare-covered Pelvic Exams.</p>

Services that are covered for you	What you must pay when you get these services
<p>Prostate cancer screening exams</p> <p>For men age 50 and older, covered services include the following - once every 12 months:</p> <ul style="list-style-type: none"> • Digital rectal exam • Prostate Specific Antigen (PSA) test 	<p><i>Requires prior authorization (approval in advance) to be covered, except in an emergency</i></p> <p>There is no copayment for Medicare-covered Prostate Cancer Screening exams.</p>
<p>Cardiovascular disease testing</p> <p>Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease). Contact Member Services for more information on how often we will cover these tests.</p>	<p><i>Requires prior authorization (approval in advance) to be covered, except in an emergency</i></p> <p>There is no copayment for Medicare-covered cardiovascular screening blood tests.</p>
<p>Initial Preventative Physical exam (Welcome to Medicare Physical Exam)</p> <p>A one-time physical exam for members within the first 12 months that they have Medicare Part B. Includes measurement of height, weight, body mass index, blood pressure, visual acuity screen and other routine measurements; an electrocardiogram; education, counseling and referral with respect to covered screening and preventive services. Doesn't include lab tests.</p>	<p>There is no copayment for the Welcome to Medicare Physical exam.</p>
<p>Personalized Prevention Plan Services (Annual Wellness Visit)</p> <p>Available to members in the first 12 months that have Medicare Part B or 12 months after the member has the one-time Initial Preventative Physical Exam (Welcome to Medicare Physical Exam).</p>	<p>There is no copayment for routine physical exams, limited to one exam each year.</p>

Services that are covered for you

What you must pay when you get these services

Other Services

Dialysis (Kidney)

Covered services include:

- Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 6)
- Inpatient dialysis treatments (if you are admitted to a hospital for special care)
- Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments)
- Home dialysis equipment and supplies
- Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply)

Requires prior authorization (approval in advance) to be covered, except in an emergency

There is no copayment for Medicare-covered Renal Dialysis (Kidney) services.

Medicare Part B prescription drugs

These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:

- Drugs that usually aren't self-administered by the patient and are injected while you are getting physician services
- Drugs you take using durable medical equipment (such as nebulizers) that was authorized by the plan
- Clotting factors you give yourself by injection if you have hemophilia
- Immunosuppressive Drugs, if you were enrolled in Medicare Part A at the time of the organ transplant
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Antigens
- Certain oral anti-cancer drugs and anti-nausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)

Your provider must get prior authorization for certain prescription drugs. Contact Member Services for details.

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

The applicable Brand Name, Generic, or Specialty Drug Copayment applies for Part B Drugs.

Services that are covered for you

What you must pay when you get these services

- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases

Outpatient prescription drugs

The “Using the plan’s coverage for your prescription drugs” section of this booklet explains the prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your prescription drugs through our plan is listed in the section 8 of this booklet.

Part D Prescription Drugs

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

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

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

Section 8 explains about the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. Section 8 also tells about drugs that are not covered by this benefit.

Notes

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

There is a \$15 Copayment for injections or injectable substances obtained at a physician’s office. Injections or injectable substances obtained through a retail pharmacy are subject to the applicable Injectable or Specialty Coinsurance.

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

One-month (30-day) supply of Part D Drugs purchased at local pharmacies

- \$5 Copayment – Tier 1
- \$20 Copayment – Tier 2
- \$35 Copayment – Tier 3
- 25% Coinsurance – Tier 4
- Injectable
- 25% Coinsurance – Tier 5
- Specialty
- 50% Coinsurance – Erectile Dysfunction drugs, up to 4 doses.

Services that are covered for you

**What you must pay
when you get these
services****Three-month (90-day)
supply of Part D Drugs
purchased at local
pharmacies:**

- \$15 Copayment – Tier 1
- \$60 Copayment – Tier 2
- \$105 Copayment – Tier 3
- 25% Coinsurance – Tier 4
Injectable
- 25% Coinsurance – Tier 5
Specialty

**Three-month (90-day)
supply of Part D Drugs
purchased via mail order
or obtained through the
UC Walk –Up Service:**

- \$10 Copayment – Tier 1
- \$40 Copayment – Tier 2
- \$70 Copayment – Tier 3

After your yearly out-of-pocket drug costs reach \$4,550 you will qualify for Catastrophic Coverage and you will pay the greater of:

- \$2.50 for generic or a preferred brand drug that is a multi-source drug and
- \$6.30 for all other drugs,
or
- 5% coinsurance.

Certain Prescription Drugs will have maximum quantity limits and may have a pre-authorization requirement. Contact plan for details.

Services that are covered for you

What you must pay
when you get these
services

Additional Benefits

Dental services

Medicare-covered dental services include services by a dentist or oral surgeon are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic disease, or services that would be covered when provided by a doctor.

You pay 100% for Medicare-covered dental services.

Hearing services

- Diagnostic hearing exams
- Routine hearing exams.

Requires prior authorization (approval in advance) to be covered, except in an emergency

Hearing Aids (2 standard Hearing Aids (analog or digital) every 36 months up to \$2,000 total benefit maximum that adequately meet the Member's medical needs and are determined to be Medically Necessary.).

No benefits will be provided for hearing aid charges, which exceeds specifications prescribed for the correction of hearing loss.

Hearing screenings, provided as part of a periodic health evaluation, are covered at no charge.

You pay \$15 for each Medicare-covered hearing exam (diagnostic hearing exams).

You pay \$15 for each routine hearing test up to 1 test every year

Services that are covered for you

What you must pay when you get these services**Vision care**

Covered services include:

- Outpatient physician services for eye care.
- For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year

One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.

Requires prior authorization (approval in advance) to be covered, except in an emergency

You pay \$15 for each Medicare-covered eye exam (diagnosis and treatment for diseases and conditions of the eye).

You pay \$15 for each routine eye exam. Limited to 1 exam every year.

There is no copayment for each Medicare-covered Glaucoma test.

Vision screenings, provided as part of a periodic health evaluation, are covered at no charge.

There is no copayment for Medicare-covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery).

Refer to Section 3.2 of this Chapter for more information regarding optional supplemental vision services.

- Glasses, limited to 1 pair of glasses every 2 years*
- Contacts, limited to 1 pair of contacts every 2 years*
- Lenses, limited to 1 pair of lenses every 2 years*
- Frames, limited to 1 frames every 2 years*

You are covered up to \$100 for eye wear every 2 years.*

Services that are covered for you	What you must pay when you get these services
	<p>Medically necessary contact lenses are covered in full once every 24 months.*</p> <p>There is a \$100 frame allowance; you pay 80% of the remaining balance.</p> <p>There is a \$100 contact lens allowance; you pay 85% of the remaining balance.</p> <p>*multi-year benefits may not be available in subsequent years.</p> <p>For further information, please refer to Section 3.2 of this Chapter</p>

SECTION 2 Prescription Drug (Part D) benefits chart

Section 2.1 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 for prescription drugs or the Catastrophic Coverage Stage:

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

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

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

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

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

	Network pharmacy	The plan's mail-order service (Preferred Pharmacy)	The plan's mail-order service (Non-preferred Pharmacy)	Network long-term care pharmacy	Out-of-network pharmacy (coverage is limited to certain situations; see "Using the plan's coverage for your prescription drugs" section for details)
Cost-Sharing Tier 1 (Generally includes preferred generic drugs. May include some preferred brand drugs.)	\$5	\$5	\$5	\$5	\$5
Cost-Sharing Tier 2 (Generally includes preferred brand drugs. May include some generic drugs.)	\$20	\$20	\$20	\$20	\$20
Cost-Sharing Tier 3 (Non-preferred generic and non-preferred brand drugs.)	\$35	\$35	\$35	\$35	\$35

	Network pharmacy	The plan's mail-order service (Preferred Pharmacy)	The plan's mail-order service (Non-preferred Pharmacy)	Network long-term care pharmacy	Out-of-network pharmacy (coverage is limited to certain situations; see "Using the plan's coverage for your prescription drugs" section for details)
<p>Cost-Sharing Injectable Drugs Tier 4 (Includes injectable drugs that do not meet the Centers for Medicare & Medicaid Services (CMS) minimum cost threshold required to be placed on the Specialty Drugs Tier. Some drugs are limited to a maximum 30-day supply per fill.)</p>	25%	25%	25%	25%	25%
<p>Cost-Sharing Specialty Drugs Tier 5 (High cost drugs. Some drugs are limited to a maximum 30-day supply per fill and Drugs on this Tier are not eligible for exceptions for payment at a lower tier.)</p>	25%	25%	25%	25%	25%

	Network pharmacy	The plan's mail-order service (Preferred Pharmacy)	The plan's mail-order service (Non-preferred Pharmacy)	Network long-term care pharmacy	Out-of-network pharmacy (coverage is limited to certain situations; see "Using the plan's coverage for your prescription drugs" section for details)
Erectile Dysfunction Drugs	50%	N/A	N/A	N/A	N/A

A table that shows your costs for a long-term (90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. This can be up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see the Using the plan's coverage for your prescription drugs section in this booklet.)

The table below shows what you pay when you get a long-term 90-day supply of a drug.

Your share of the cost when you get a long-term (90-day) supply of a covered prescription drug from:

	Network pharmacy	The plan's mail-order service (Preferred Pharmacy)	The plan's mail-order service (Non-preferred Pharmacy)
Cost-Sharing Tier 1 (Generally includes preferred generic drugs. May include some preferred brand drugs.)	\$15	\$10	\$15
Cost-Sharing Tier 2 (Generally includes preferred brand drugs. May include some generic drugs.)	\$60	\$40	\$60

	Network pharmacy	The plan's mail- order service (Preferred Pharmacy)	The plan's mail- order service (Non-preferred Pharmacy)
Cost-Sharing Tier 3 (Non-preferred generic and non- preferred brand drugs.)	\$105	\$70	\$105
Cost-Sharing Tier 4 Injectable Drugs (Includes injectable drugs that do not meet the Centers for Medicare & Medicaid Services (CMS) minimum cost threshold required to be placed on the Specialty Drugs Tier. Some drugs are limited to a maximum 30-day supply per fill.)	25%	25%	25%
Cost-Sharing Tier 5 Specialty Drugs (High cost drugs. Some drugs are limited to a maximum 30-day supply per fill and drugs on this tier are not eligible for exceptions for payment at a lower tier.)	25%	25%	25%

Section 2.2	Plan Specific Out-of-Pocket Maximum for Outpatient Prescription drugs
--------------------	--

Once your copayment/coinsurance for outpatient Part D prescription drugs total \$2,000 in the calendar year, you will not pay any more copayment/coinsurance for covered Part D 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. .

Section 2.3	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 Part D 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.

SECTION 3 Additional Information About Your Benefits

Section 3.1 Mental Health Care and Substance Abuse Benefits

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

- **Camino Medical Group**
- **Palo Alto Medical Foundation**
- **Sutter Independent Physicians**
- **Sutter Medical Group**
- **Sutter West Medical Group**

Members of these medical groups **must** obtain a referral from their primary care physician and use network hospitals and specialists associated with their Medical Group for all mental health services, except in an emergency or for urgent care when outside the Service Area. Mental health services should not be obtained from MHN Services as discussed below (or throughout this Evidence of Coverage), but only through your medical group. Please refer to the Benefits Chart under “Inpatient Mental Health Care”, “Outpatient Mental Health Care” and “Outpatient Substance Abuse”, for information on your mental health benefits and copayments. If you have any questions about this or any other Seniority Plus benefit, please contact our Member Services Department by calling; **1-800-539-4072** (TDD/TTY **1-800-929-9955**) 8:00 a.m. to 8:00 p.m., 7 days a week.

The Mental Health and Substance Abuse benefits are administered by MHN Services. MHN Services is licensed in the State of California as a specialized health care service plan and contracts with Health Net to administer these benefits.

To be covered, MHN Services must authorize these services and supplies.

MHN Services will refer you to a nearby Contracted Mental Health Professional. That professional will evaluate you to determine if additional treatment is necessary. If you need treatment, the Contracted Mental Health Professional will develop a Treatment Plan and submit that plan to MHN Services for review. When authorized by MHN Services, the proposed services will be covered by this Plan.

If MHN Services does not approve the Treatment Plan, no further services or supplies will be covered for that condition. However, MHN Services may direct you to community resources where alternative forms of assistance are available.

Emergency Services

MHN Services has a licensed clinician available 24 hours a day, seven days a week to address all requests for immediate admission to a facility if the patient poses a danger to self or others or is gravely disabled. MHN Services can be contacted at **1-800-646-5610** (or TDD/TTY **1-800-327-0801** for the hearing and speech impaired) 24 hours a day, seven days a week.

Transition of Care For New Enrollees

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

Your non-Participating Mental Health Professional must be willing to accept MHN Services' standard mental health provider contract terms and conditions, and be located in the Plan's Service Area.

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

The following benefits are provided:

The following services are covered under Health Net Seniority Plus. Please refer to the Evidence of Coverage for copayment and coinsurance information.

Outpatient Services

Outpatient crisis intervention, short-term evaluation and therapy, longer-term specialized therapy and any rehabilitative care that is related to Substance Abuse are covered with unlimited visits. Medication management care is also covered when appropriate. Refer to the "Outpatient mental health care", "Outpatient substance abuse services" and "Outpatient Substance Abuse" portions in the Evidence of Coverage for member cost shares.

Second Opinion

You may request a second opinion when:

- Your Contracted Mental Health Professional renders a diagnosis or recommends a Treatment Plan that you are not satisfied with;
- You are not satisfied with the result of the treatment rendered;
- You are diagnosed with, or a treatment plan is recommended for, a condition that threatens loss of life, limb or bodily function or a substantial impairment, including but not limited to a Serious Chronic Condition; or
- Your Contracted Mental Health Professional is unable to diagnose your condition or test results are conflicting.

To request an authorization for a second opinion contact MHN Services. Participating Mental Health Professionals will review the request in accordance with MHN Services' second opinion policy.

When you request a second opinion, you will be responsible for any applicable copayments.

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

Any service recommended must be authorized by MHN Services in order to be covered.

Inpatient Services

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

Covered services and supplies include:

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

Detoxification

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

Serious Emotional Disturbances of a Child (SED)

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

Severe Mental Illness

Treatment of Severe Mental Illness is covered.

Covered services include treatment of:

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

Mental Disorders and Substance Abuse Exclusions and Limitations

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

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

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

- Court-ordered testing and treatment, except when Medically Necessary and within the allowable visits under the plan contract.
- Private Hospital rooms and/or private duty nursing, unless determined to be a Medically Necessary Service and Authorization from MHN Services is obtained.
- Ancillary services such as:
 - a. Vocational rehabilitation and other rehabilitation services.
 - b. Behavioral training.
 - c. Speech or occupational therapy.
 - d. Sleep therapy and employment counseling.
 - e. Training or educational therapy or services.
 - f. Other education services.
 - g. Nutrition services.
- Treatment by providers other than those within licensing categories then recognized by MHN Services as providing Medically Necessary Services in accordance with applicable medical community standards.
- Services in excess of those with respect to which Authorization by MHN Services is obtained.
- Psychological testing except as conducted by a licensed psychologist for assistance in Treatment Planning, including medication management or diagnostic clarification and specifically excluding all educational, academic and achievement tests, psychological testing related to medical conditions or to determine surgical readiness and automated computer based reports.
- All prescription or non-prescription drugs and laboratory fees, except for drugs and laboratory fees prescribed by a practitioner in connection with Inpatient treatment.
- Inpatient services, treatment, or supplies rendered without Authorization, except in the event of Emergency Care Services.
- Healthcare services, treatment, or supplies rendered in a non-emergency by a provider who is not a Contracted Mental Health Professional, unless Authorization by MHN Services has been received or as otherwise provided by the Plan.
- Damage to a hospital or facility caused by the Member.
- Healthcare services, treatment or supplies determined to be Experimental by MHN Services in accordance with accepted mental health standards, except as otherwise required by law.
- Treatment for biofeedback, acupuncture or hypnotherapy.
- Healthcare services, treatment, or supplies rendered to the Member which are not Medically Necessary Services. This includes, but is not limited to, services, treatment, or supplies primarily for rest or convalescence, Custodial Care or Domiciliary Care as determined by MHN Services.
- Services received before the Member's effective date or services received during an Inpatient stay that began before the Member's effective date. Additionally, services received after the Member's coverage ended are not covered, except for services received during an Inpatient stay that began before the Member's termination date.

- Professional services received from a person who lives in the Member's home or who is related to the Member by blood or marriage.
- Services performed in any emergency room which are not directly related to the treatment of a Mental Disorder.
- Services received out of the Member's primary state of residence except in the event of Emergency Services and Care and as otherwise authorized by MHN Services.
- Electro-Convulsive Therapy (ECT) except as authorized by MHN Services according to MHN Services policies and procedures.
- All other services, confinements, treatments or supplies not provided primarily for the treatment of specific covered benefits and/or specifically included as Covered Services elsewhere in this Plan.

How to file a claim for Mental Health and Substance Abuse Services

In most cases your mental health provider will submit your claims to MHN Services. To file a claim you may have, please send a completed Claim Form. If you need a claim form, go online to www.mhn.com or contact MHN Services at **1-800-646-5610** (TDD/TTY **1-800-327-0801** for the hearing and speech impaired) 24 hours a day, seven days a week.

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

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

You can contact MHN Services at **1-800-646-5610** (TDD/TTY **1-800-327-0801**) 24 hrs a day, seven days a week to check the status of your claim. We will be able to provide a status within 72 hours of receipt of your claim. If a reimbursement is due to you, a check will be mailed no later than 60 days of receipt of your claim.

When a Member Receives Emergency/Urgent Services From a Non-Contracting MHN Services Provider/Facility

A member may be hospitalized at a non-MHN Services facility due to an immediate medical emergency. The Member may be transferred to an MHN Services facility as soon as the member's medical condition is stable enough for such a move. If MHN Services arranges a transfer, MHN Services will be financially responsible for the cost of the transportation to an MHN Services facility. When receiving Emergency Care from a non-MHN Services provider, the member should request that the provider bill MHN Services directly for services. If the provider bills you directly, MHN Services will reimburse you charges paid for emergency services and out-of-area urgent care services less any applicable copayments. In order to receive reimbursement, the member should submit an itemized bill and completed claim form to MHN Services. A claim form can be obtained online at www.mhn.com or by contacting MHN Services at **1-800-646-5610** (TDD/TTY **1-800-327-0801** for the hearing and speech impaired) 24 hours a day, seven days a week. Completed claim forms should be submitted to:

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

QUESTIONS?

For up-to-date provider information or to obtain authorization to receive services, please contact MHN Services at **1-800-646-5610** (TDD/TTY **1-800-327-0801** for the hearing and speech impaired) 24 hours a day, seven days a week. Or visit MHN Services' web site at www.mhn.com for a list of MHN Services Contracted Mental Health Professionals in your area.

Section 3.2 Vision Care**Refractive Eye Examination**

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

Eyewear

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

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

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

How to use the plan

- Make arrangements for your routine annual eye exam through your contracting Medical Group or Primary Care Physician (PCP). For referral to a specialist (ophthalmologist or optometrist), please contact your PCP directly. Vision care provided by someone other than a Health Net contracted optometrist or ophthalmologist will not be covered.
- Go to your eye exam and if you require eyeglasses or contact lenses, a prescription will be written. You are able to purchase eyewear from a list of Health Net Vision participating eyewear providers in California. Please note that the specialist who is authorized to provide your eye exam may not be a Health Net Vision contracting provider. Eyewear supplied by providers other than Health Net Vision Participating Eyewear providers are not covered. For more information or a list of Health Net Vision participating eyewear providers in California, please contact Health Net Vision at 1-866-392-6058 or visit our website at www.healthnet.com/uc.
- Payment for the prescription order eyewear received from a Health Net Vision participating eyewear provider will be made directly to that Health Net Vision participating provider.

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

If you have questions about your Vision Care benefits or would like a list of Health Net Vision participating Eyewear providers, you may call the Health Net Vision Member Services Department at **1-866-392-6058**. Normal business hours are Monday-Saturday, 5:00 a.m. to 8:00

p.m. and Sunday, 8:00 a.m. to 5:00 p.m. TDD/TTY services are available Monday-Friday during the hours of 5:30 a.m. to 2:00 p.m. Pacific Time, at **1-866-308-5375**.

Eyewear Benefits

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

Eyewear Schedule:

Frames

(one pair of Frames during a 24-month period)*Health Net Vision pays the first \$100, then the Member pays 80% of the remaining balance, if applicable.

Standard Plastic Eyeglass Lenses (one pair every 24 months *):

Single vision.....Health Net Vision pays in full
 Bifocal.....Health Net Vision pays in full
 Trifocal.....Health Net Vision pays in full
 Standard Progressive Lenses.....Member pays \$65.00, Health Net Vision pays the remaining balance.
 Premium Progressive LensesMember pays \$65.00, and 80% of the retail charge less \$120 allowance.

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

Tint (Solid or Gradient)20% off retail price

Contact Lenses - in lieu of eyeglass lenses

(includes materials only):

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

Disposable / Cosmetic

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

Health Net Vision pays the first \$100, Member pays the remaining balance.

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

Conventional or Disposable

Health Net Vision pays in full.

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

- **Keratoconus** where the patient is not correctable to 20/30 in either or both eyes using standard spectacle lenses or the provider attests to the specified level of visual improvement.
- **High Ametropia** exceeding -12 D or +9 D in spherical equivalent in either eye.
- **Anisometropia** of 3 D or more.
- **Vision Improvement** for patients whose vision can be corrected two lines of improvement on the visual acuity chart when compared to best corrected standard spectacle lenses.

If the Member is diagnosed with one of the above conditions, the Health Net Vision provider will submit a request for pre-authorization to Health Net Vision. The Health Net Vision Medical Director reviews all requests for Medically Necessary contact lenses. If approved, the individual will be covered for Medically Necessary contact lenses in full.

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

Additional Purchases and Out-of-Pocket Discounts

Member receives a 20% discount on items not covered by the plan at network Providers, which cannot be combined with any other discounts or promotional offers. Discount does not apply to EyeMed Provider's professional services, or contact lenses. Retail prices may vary by location. Discounts do not apply for benefits provided by other group benefit plans. Allowances are one-time use benefits; no remaining balance. Lost or broken materials are not covered.

Members also receive a 40% discount off complete pair eyeglass purchases and a 15% discount off conventional contact lenses once the funded benefit has been used. Members also receive

15% off retail price or 5% off promotional price for Lasik or PRK from the US Laser Network, owned and operated by LCA Vision. Since Lasik or PRK vision correction is an elective procedure, performed by specially trained providers, this discount may not always be available from a provider in your immediate location. For a location near you and the discount authorization please call **1-877-5LASER6**. After initial purchase, replacement contact lenses may be obtained via the Internet at substantial savings and mailed directly to the member. Details are available at www.eyemedvisioncare.com. The contact lens benefit allowance is not applicable to this service.

Vision Care Exclusions and Limitations

The following items and services are limited or excluded under Health Net Vision Care:

- Eye exams are not covered under the Vision Care benefit. Routine eye exams are covered as part of your plan's medical benefit. Please refer to the Medical Benefits Chart.
- The fitting or dispensing of more than one set of Frames and one pair of Standard Plastic Eyeglass Lenses or Contact Lenses during any 24-month period is not covered, except in cases where the Member's prescription changes significantly (refer to "Information about programs to help people pay for their prescription drugs") under "Eyewear Benefits" for further information).
- Lenses that correct the vision defect known as aniseikonia are not covered.
- Diagnostic services, and medical or surgical treatment of the eye are not covered. For covered surgical treatments please refer to "Benefits Chart" earlier in this section section.
- Services or supplies provided by a provider other than a Health Net Vision Participating Eyewear provider are not covered.
- Nonprescription vision devices and sunglasses are not covered.
- Additional fitting and measurement charges, or special consultation charges due to the purchase of optional Frames, are not covered.
- Orthoptics or vision training aids are not covered.
- Prescription Drugs or over-the-counter drugs are not covered as part of your Vision Care benefits. Please refer to "Benefits Chart" section.
- Vision aids (other than Eyeglasses or Contact Lenses) are not covered.
- Cost Sharing amounts are a one-time use benefit; Health Net will not pay any remaining balances.
- Lost or broken materials are not covered.
- Corrective eyewear required by an employer as a condition of employment, and safety eyewear unless specifically covered under plan.
- Two pair of glasses in lieu of bifocals.

LIABILITY FOR PAYMENT

You will be responsible for the cost of any vision services received from a Health Net Vision nonparticipating provider, as well as any charges for services received from

Health Net Vision participating providers that exceed the benefits listed in your Evidence of Coverage.

QUESTIONS?

For up-to-date provider information, to obtain authorization to receive services, or if you have any questions concerning claims about vision care services, please contact Health Net Vision at **1-866-392-6058** Monday through Saturday, 5:00 a.m. – 8:00 p.m. and Sunday 8:00 a.m. – 5:00 p.m. Pacific time (or **1-866-308-5375** TDD/TTY for the hearing and speech impaired Monday through Friday from 5:00 a.m. to 2:00 p.m. Pacific time). Or visit the Health Net Vision web site at www.healthnet.com/uc for a list of Health Net Vision participating providers in your area.

Section 3.3 Chiropractic Care Services

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

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

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

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

The following Chiropractic Services do not require authorization by ASH Plans:

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

The following benefits are provided for Chiropractic Services:

- Each office visit to an ASH Plan Contracted Chiropractor, as described below, requires a Copayment by the Member. A maximum number of visits per calendar year will apply to each Member.
- A new patient exam or an established patient exam for the initial evaluation of a patient with a new condition or new episode to determine the appropriateness of Chiropractic Services. A new patient is one who has not received any professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years. An established patient is one who has received professional services from the provider, or another provider of the same specialty who belongs to the same group practice, within the past three years. A \$15 copayment will be required.
- Established patient exams to assess the need to initiate, continue, extend, or change a Course of Treatment. A reevaluation may be performed during a subsequent office visit or separately. If performed separately, a copay is required. The established patient exam may require verification of Medical Necessity. **A Copayment will be required for each visit to the office.**
- Adjunctive modalities and procedures such as rehabilitative exercise, traction, ultrasound, electrical muscle stimulation, and other therapies are covered only when provided during the same Course of Treatment and in support of chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.
- Follow-up office visits may include manipulation of the spine, joints and/or musculoskeletal soft tissue, a re-evaluation, and/or other services, in various combinations.
- X-rays and Clinical laboratory tests are payable in full by ASH Plans when provided by or referred by ASH Plans Contracted Chiropractor and approved by ASH Plans. Radiological consultations are a covered benefit when authorized by ASH Plans as Medically Necessary Services and provided by a licensed chiropractic radiologist, medical radiologist, radiology group, or hospital that has contracted with ASH Plans to provide those services.
- Chiropractic Supports Appliances are covered up to a maximum of \$50.00 per year when approved by ASH Plans as Medically Necessary for the treatment of either Neuromusculoskeletal Disorders or Pain Syndromes or both. Please refer to the Definitions section for details on covered chiropractic appliances.

Second Opinion

You may request a second opinion in regard to Covered Services provided by contacting another ASH Plans Contracted Chiropractor, you will have direct access to any other ASH Plans Contracted Chiropractor. Your visit to another ASH Plans Contracted Chiropractor for purposes of obtaining a second opinion generally will count as one visit, for purposes of any maximum benefit, and you must pay any copayment that applies for that visit on the same terms and conditions as a visit to any other ASH Plans Contracted Chiropractor.

X-ray and Laboratory Tests

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

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

Chiropractic Services Exclusions and Limitations

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

- Chiropractic Services are covered up to a maximum number of 20 visits per Calendar Year for each Member.
- Prescription drugs or medicines including a non-legend or proprietary medicine or medication not requiring a prescription order.
- Air conditioners, air purifiers, therapeutic mattresses, supplies or any other similar devices or appliances; and chiropractic appliances except those specifically noted as covered or durable medical equipment.
- Education programs, non-medical self-care or self-help, or any self-help physical exercise training or any related diagnostic testing are not covered.
- Hypnotherapy, behavior training, sleep therapy and weight programs are not covered.
- Services or treatments delivered by Contracted Provider except for (a) Emergency Services; (b) Urgent Services; (c) services that are provided pursuant to a continuity of care plan approved by ASH Plans; or (d) services that are provided upon referral by ASH Plans in situations where such services are not available and accessible to a Member from a Contracted Provider within the Service Area.
- Adjunctive physiotherapy modalities and procedures unless provided during the same Course of Treatment and in conjunction with chiropractic manipulation of the spine, joints, and/or musculoskeletal soft tissue.
- Services, exams (other than an initial examination to determine the appropriateness of Chiropractic Services), and/or treatments for conditions other than Neuromusculoskeletal Disorders or Pain Syndromes.
- Services provided by a chiropractor practicing outside California are not covered, except for to Emergency Chiropractic Services or Urgent Services.
- Any service or supply that is not permitted by state law with respect to the provider's scope of practice.

- Thermography; magnets used for diagnostic or therapeutic use; nerve conduction studies (e.g., EEG, EMG, SEMG, SSEP, and NCV); or electrocardiogram (EKG) studies.
- Transportation costs, including local ambulance charges.
- Dietary and nutritional supplements, including vitamins, minerals, herbs, herbals and herbal products, injectable supplements and injection services, or other similar products.
- Magnetic resonance imaging, CAT scans, bone scans, nuclear radiology, therapeutic radiology, and any diagnostic radiology other than covered plain film studies.
- Services or treatments for pre-employment physicals or vocational rehabilitation.
- Any services or treatments for conditions caused by or arising out of the course of employment or covered under Worker's Compensation or similar law
- Auxiliary aids and services, including but not limited to interpreters, transcription services, written materials, telecommunications devices, telephone handset amplifiers, television decoders and telephones compatible with hearing aids
- Hospitalization, surgical procedures, anesthesia, manipulation under anesthesia, proctology, colonic irrigation, injections and injection services under anesthesia, or other related services.

Grievance Procedures

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

Medicare Appeals Procedure

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

Section 3.4	Health and Fitness - SILVER&FIT®
--------------------	---

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

Prior to proceeding in any exercise or weight management program, it is important for you to seek the advice of a physician or other qualified health professional. Participation in Silver&Fit is at your own risk.

How do I enroll?

You will receive a list of fitness facilities in your area with your temporary ID card in your pre-enrollment packet. Simply choose a fitness facility, or for more information for fitness facilities, visit www.SilverandFit.com or call Silver&Fit customer service at **1-877- 427-4788** or TTY/TDD phone **1-877-710-2746** (Monday – Friday, 5 a.m. – 6 p.m. (Pacific Time)). Take your temporary ID card to the fitness facility to sign a membership agreement. The membership agreement that you will be required to sign at the fitness facility is for a no-cost “standard fitness facility membership,” which includes the covered services available through the program, described below. If you choose to access fitness facility services otherwise available by the facility at an additional fee, then the agreement may reflect costs associated with those non-program related services.

If you choose the Silver&Fit Home Fitness program, you can enroll online at SilverandFit.com or by calling Silver&Fit customer service at **1-877- 427-4788** or TTY/TDD phone **1-877-710-2746** (Monday – Friday, 5 a.m. – 6 p.m. (Pacific Time)).

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

Fitness Clubs

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

- Cardiovascular equipment
- Free weights or resistance training equipment
- Exercise classes
- Where available, amenities such as saunas, steamrooms, pools, and whirlpools

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

Exercise Centers

The standard Silver&Fit exercise center membership includes at least thirty minutes of strength, cardiovascular, and/or flexibility training, depending on what is available at the exercise center. Exercise centers may include Jazzercise centers, master swimming programs, rowing clubs, Pilates, yoga studios, or others.

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

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

- Walking Kit
- Strength Exercise Kit
- Yoga Kit
- Tai Chi Kit
- Pilates Kit
- Aqua Aerobics Kit
- Stress Management Kit
- Dance Kit

Services offered through the "Service Hotline"

Members may call Silver&Fit member services at **1-877 427-4788** or TTY/TDD **1-877-710-2746**, Monday through Friday, 5 a.m. – 6 p.m. (Pacific Time), for information on any of the following:

- Fitness Facility search
- Enrollment
- Program design
- Eligibility
- Changing clubs
- Provider nominations

Silver&Fit[®] Web Site

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

- Utilize the fitness facility locator and enrollment change features in the event you wish to change fitness clubs

- Access fitness literature to help you make better health decisions
- Obtain discounts on health and wellness products
- Choose from dozens of health trackers to track your progress
- Access Silver&Fit member newsletters, The Silver Slate®

Exclusions and limitations

The following services are not offered:

- Services or supplies provided by any person, company or provider other than a Silver&Fit participating fitness facility
- All education materials other than those produced for Silver&Fit by American Specialty Health Incorporated
- Telecommunications devices, telephone handset amplifiers, television recorders, and telephones compatible with hearing aids
- Education program services for individuals other than the member
- Prescription drugs, over-the-counter products, dietary supplements, herbal supplements, vitamins, minerals, weight control products, meal-replacement beverages or powders, or any other types of food or food product, whether or not it is recommended, prescribed, or supplied by a health care provider, fitness facility, or program
- All listening devices, including, but not limited to, audiotape and CD players
- Services for members with serious medical conditions for which Silver&Fit services are not appropriate

Silver&Fit and *The Silver Slate* are federally registered trademarks of American Specialty Health Incorporated

Chapter 4. Getting started as a member of our plan

SECTION 1

Introduction.....	62
Section 1.1 What is the <i>Evidence of Coverage</i> booklet about?	62
Section 1.2 What does this Chapter tell you?	62
Section 1.3 What if you are new to our plan?.....	62
Section 1.4 Legal information about the <i>Evidence of Coverage</i>	62

SECTION 2

What makes you eligible to be a plan member?	63
Section 2.1 Your three eligibility requirements.....	63
Section 2.2 What are Medicare Part A and Medicare Part B?.....	63
Section 2.3 Here is the plan service area for our plan	63

SECTION 3

What other materials will you get from us?.....	65
Section 3.1 Your plan membership card – Use it to get all covered care and drugs	65
Section 3.2 The <i>Provider Directory</i> : your guide to all providers in the plan’s network	66
Section 3.3 The <i>Pharmacy Directory</i> : your guide to pharmacies in our network.....	66
Section 3.4 The plan’s <i>List of Covered Drugs (Formulary)</i>	67
Section 3.5 Reports with a summary of payments made for your prescription drugs.....	67

SECTION 4

Your monthly premium for your plan.....	67
Section 4.1 How much is your plan premium?.....	67
Section 4.2 Can your monthly plan premium change during the year?	68

Please keep your plan membership record up to date.....69

Section 5.1 How to help make sure that we have accurate information about you69

SECTION 1 Introduction

Section 1.1 What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare medical care and prescription drugs through our plan, a Medicare Advantage 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 Medicare, and you have chosen to get your Medicare health care and your prescription drug coverage through our plan.
- There are different types of Medicare Advantage Plans. Health Net Seniority Plus (Employer HMO) is a Medicare Advantage Employer Group HMO Plan (HMO stands for Health Maintenance Organization).

This plan is offered by Health Net of California, Inc., referred throughout the Evidence of Coverage as “we,” “us,” or “our.” Health Net Seniority Plus (Employer HMO) is referred to as “plan” or “our plan.”

The word “coverage” and “covered services” refers to the medical care and services and the prescription drugs 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 services are available to you. We encourage you to set aside some time to look through this *Evidence of Coverage* booklet.

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

Section 1.4 Legal information about the *Evidence of Coverage*

This *Evidence of Coverage* is part of our contract with your Group about how we cover your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that 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 three eligibility requirements

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 (ESRD) are not eligible to enroll in this Plan unless you develop EDRS while a current Health Net 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.**

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

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 the following counties in California:

Alameda County
Contra Costa County

Fresno County

Kern County

Los Angeles County

Orange County

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

Riverside County

Sacramento County

San Bernardino County

San Diego County

San Francisco County

San Joaquin County

San Mateo County

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

Santa Clara County

Santa Cruz County

Solano County

Sonoma County

Stanislaus County

Yolo County

If you plan to move out of the service area, please contact Member Services.

SECTION 3 What other materials will you get from us?

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

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

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

Group/Physician Name:
TORRANCE HOSPITAL IPA

JAMES A SCHMIDT
1360 W. Sixth St.
SAN PEDRO CA 90732-3514

PPG Eff. Date:
01-01-08

PPG #: 994

PCP Copay: \$5 copayment

Group Phone: 1-310-540-1070 (TTY/TDD: 1-877-735-2929)
Physician Phone: 1-310-832-0686 (TTY/TDD: 1-877-735-2929)



Health Net Seniority Plus
(Employer HMO)

Subscriber Name:
SAMPLE TEST

Subscriber #: R00000007

RxProcessor: Caremark

RxBIN #: 004336

RxPCN #: ADV

RxGroup: RX6270

Group # 60003S
Issuer: (80840)

CMS Contract H0562 804

MedicareRx
Prescription Drug Coverage

Plan: 58D WITH PHARMACY

For questions or concerns, call the Member Services Department at **1-800-275-4737 (TTY/TDD: 1-800-929-9955)** 8:00 a.m to 8:00 p.m., 7 days a week.

For Provider inquiries, call 1-800-929-9224.
(TTY/TDD: 1-800-929-9955)

Pharmacists call 1-888-865-6567. (TTY/TDD: 1-800-231-4403)

For dental benefits, call Health Net Dental at 1-866-249-2382 (TTY/TDD: 1-800-855-2880)

For vision benefits, call Health Net Vision at 1-866-392-6058 (TTY/TDD: 1-866-308-5375)

For chiropractic/acupuncture call 1-800-678-9133 (TTY/TDD: 1-877-710-2746)

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

Medical Claims:

Health Net Medicare Advantage Claims
P.O. Box 14703
Lexington, KY 40512

Pharmacy Claims:

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

To contact a Decision Power Health Coach, call **1-800-893-5597 (TTY/TDD: 1-800-276-3821)** 24 hours a day, 7 days a week

If an emergency arises: Call 911 or go to the nearest hospital or emergency care facility. If you are unsure of the seriousness of your condition, you may call your physician for assistance.

Material ID# (pending) CMS Approved <MMDDYYYY>

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

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

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card.

Section 3.2	The <i>Provider Directory</i>: your guide to all providers in the plan's network
--------------------	---

Every year that you are a member of our plan, we will send you either a new *Provider Directory* or an update to your *Provider Directory*. This directory lists our network providers.

What are “network providers”?

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

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

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed care when the network is not available (generally, out of the area), out-of-area dialysis services, and cases in which our plan authorizes use of non-network providers. See Chapter 6 (*Using the plan's coverage for your medical services*) for more specific information about emergency, out-of-network, and out-of-area coverage.

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

Section 3.3	The <i>Pharmacy Directory</i>: your guide to pharmacies in our network
--------------------	---

What are “network pharmacies”?

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

Why do you need to know about network pharmacies?

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

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 Member Services (phone numbers are on the back cover). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our website at www.healthnet.com/uc.

Section 3.4 The plan's *List of Covered Drugs (Formulary)*

The plan has a *List of Covered Drugs (Formulary)*. We call it the “Drug List” for short. It tells which 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 Health Net Seniority Plus (Employer HMO) Drug List. We will send you a copy of the Drug List each year. To get the most complete and current information about which drugs are covered, you can visit the plan’s website (www.healthnet.com/uc) or call Member Services (phone numbers are on the back cover of this booklet).

Section 3.5 Reports with a summary of payments made for your Part D prescription drugs

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

The *Explanation of Benefits* tells you the total amount you have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 8 (*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 Part D drug coverage.

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

SECTION 4 Your monthly premium for your plan

Section 4.1 How much is your plan premium?

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. The “Extra Help” program helps people with limited resources pay for their drugs. Chapter 5, Section 7 tells more about these programs. If you qualify enrolling in the program might lower your monthly plan premium.

If you are *already enrolled* and getting help from one of these programs, **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 Part D Prescription Drugs” (LIS Rider), that tells you about your drug coverage. If you don’t have this insert, please call Member Services and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Part D Prescription Drugs” (LIS Rider). Phone numbers for Member Services are on the back cover.

In some situations, your plan premium could be more

In some situations, your plan premium could be more than the amount listed in the “How much is your plan premium?” portion above. These situations are described below..

- Most people will pay the standard monthly Part D premium. However, starting January 1, 2011, some people will pay a higher premium because of their yearly income (over \$85,000 for singles--2010, \$170,000 for married couples--2010). For more information about Part D premiums based on income, you can visit <http://www.medicare.gov> on the web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You may also call the Social Security Administration at 1-800-772-1213. TTY users should call 1-800-325-0778.
- 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 late enrollment penalty is added to the plan's monthly premium. Their premium amount will be the monthly plan premium plus the amount of their late enrollment penalty.
 - If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 8, Section 9 explains the late enrollment penalty.
 - If you have a late enrollment penalty, it is part of your plan premium. If you do not pay the part of your premium that is the late enrollment penalty, you could be disenrolled for failure to pay your plan premium.

Many members are required to pay other Medicare premiums

As explained in the “What makes you eligible to be a plan member?” portion above, in order to be eligible for our plan, you must maintain your eligibility for Medicare Parts A and B. For that reason, some plan members will be paying a premium for Medicare Part A and most plan members will be paying a premium for Medicare Part B, in addition to paying the monthly plan premium. You must continue paying your Medicare Part B premium to remain a member of the plan.

- Your copy of *Medicare & You 2011* tells about these premiums in the section called “2011 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 2011* 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 during the year?

In some cases the part of the premium that you have to pay can change during the year. This happens if you become eligible for 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 5, Section 7 of this booklet.

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 including your Primary Care Provider/Medical Group.

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

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

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

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 Member Services (phone numbers are on the cover of this booklet).

Chapter 5. Important phone numbers and resources

SECTION 1	Our plans contacts (how to contact us, including how to reach Member Services at the plan)	71
SECTION 2	Medicare (how to get help and information directly from the Federal Medicare program).....	78
SECTION 3	State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare).....	79
SECTION 4	Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare).....	79
SECTION 5	Social Security	80
SECTION 6	Medicaid (a joint Federal and state program that helps with medical costs for some people with limited income and resources)	81
SECTION 7	Information about programs to help people pay for their prescription drugs	82
SECTION 8	How to contact the Railroad Retirement Board.....	84
SECTION 9	Do you have “group insurance” or other health insurance from an employer?	84

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

How to contact our plan's Member Services

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

Member Services	
CALL	1-800-539-4072 Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. Calls to this number are free.
TTY	1-800-929-9955 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. Calls to this number are free..
FAX	1-818-676-8100
WRITE	Health Net Medicare Programs Post Office Box 10198 Van Nuys, California, 91410-0198.
WEBSITE	www.healthnet.com/uc

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

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

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

TTY	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	1-800-793-4473 (elective requests) or 1-800-672-2135 (urgent requests)
WRITE	Health Net Medical Management 180 Grand Avenue, 6th Floor Oakland, CA 94612

For more information on asking for coverage decisions about your medical care, see Chapter 12 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) Section of this booklet.

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

Appeals for Medical Care	
CALL	1-800-539-4072 Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. Calls to this number are free.
TTY	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	1-818-676-8179
WRITE	Health Net Seniority Plus (Employer HMO) Appeals and Grievance Department Post Office Box 10344 Van Nuys, California 91410-0344

For more information on making an appeal about your medical care, see Chapter 12 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) section of this booklet.

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

Complaints about Medical Care	
CALL	1-800-539-4072 Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. Calls to this number are free.
TTY	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	1-818-676-8179
WRITE	Health Net Seniority Plus (Employer HMO) Appeals and Grievance Department Post Office Box 10344 Van Nuys, California 91410-0344

For more information on making a complaint about your medical care, see Chapter 12 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) section of this booklet.

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

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

TTY	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	1-818-676-8086
WRITE	Health Net Pharmaceutical Services Attn: Pharmacy P.O. Box 9103 Van Nuys, CA 91409-9103

For more information on asking for coverage decisions about your Part D prescription drugs, see Chapter 12 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) section of this booklet.

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

Appeals for Part D Prescription Drugs	
CALL	1-800-539-4072 Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. Calls to this number are free.
TTY	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	1-800-977-1959
WRITE	Health Net Seniority Plus (Employer HMO) Appeals and Grievance Department P.O. Box 10450 Van Nuys, CA 91410-0450

For more information on making an appeal about your Part D prescription drugs, see Chapter 12 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) section of this booklet.

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

Complaints about Part D prescription drugs	
CALL	<p>1-800-539-4072</p> <p>Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. Calls to this number are free.</p>
TTY	<p>1-800-929-9955</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>
FAX	<p>1-800-977-1959</p>
WRITE	<p>Health Net Seniority Plus (Employer HMO) Appeals and Grievance Department P.O. Box 10450 Van Nuys, CA 91410-0450</p>

For more information on making a complaint about your Part D prescription drugs, see Chapter 12 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) section of this booklet.

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

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

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	1-800-977-1959
WRITE	Health Net Seniority Plus (Employer HMO) Appeals and Grievance Department P.O. Box 10450 Van Nuys, CA 91410-0450

For more information on making an appeal about your Part D prescription drugs, see the “What to do if you have a problem or complaint (coverage decisions, appeals, complaints)” section of this booklet.

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

Complaints about prescription drugs	
CALL	1-800-539-4072
	Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. Calls to this number are free.
TTY	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	1-800-977-1959
WRITE	Health Net Seniority Plus (Employer HMO) Appeals and Grievance Department P.O. Box 10450 Van Nuys, CA 91410-0450

For more information on making a complaint about your prescription drugs, see the “*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*” section of this booklet.

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

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 10 (*Asking the plan to pay its share of a bill you have received for medical services or drugs*).

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 12 (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) for more information.

Payment Requests	
CALL	<p>1-800-539-4072</p> <p>Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. Calls to this number are free..</p>
TTY	<p>1-800-929-9955</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>
FAX	<p>Medical Care and Services - 1-800-793-4473 (elective requests) or 1-800-672-2135 (urgent requests)</p> <p>Part D Prescription Drugs - 1-916-463-9754</p>
WRITE	<p><u>Medical Care and Services:</u></p> <p>Health Net P.O. Box 14703 Lexington, KY 40512</p> <p><u>Part D Prescription Drugs:</u></p> <p>Health Net of California Attn: Pharmacy P.O. Box 9103 Van Nuys, CA 91409-9103</p>

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 Advantage Organizations 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><u>http://www.medicare.gov</u></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. In California, the State Health Insurance Assistance Program is called Health Insurance Counseling and Advocacy Program (HICAP).

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

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

HICAP, California Health Advocates	
CALL	1-800-434-0222
WRITE	HICAP, California Health Advocates 5380 Elvas Avenue, Suite 104 Sacramento, CA 95819

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. In California, the Quality Improvement Organization is called Health Services Advisory Group.

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

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

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

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

Health Services Advisory Group, Inc. (HSAG)	
CALL	Discharge complaints: 1-866-800-8749 Quality of care complaints: 1-866-800-8749
TTY	1-800-881-5980 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Call to this number are free
WRITE	5201 W. Kennedy Blvd. Suite 900 Tampa, FL 33609
WEBSITE	www.hsag.com

SECTION 5 Social Security

The Social Security Administration 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 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, contact California Department of Health Care Services.

California Department of Health Services	
CALL	1-916-636-1980
WRITE	California Department of Health Services P.O. Box 997417, M.S. 4607 Sacramento, CA 95899

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

Medicare’s “Extra Help” Program

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

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

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

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

If you believe you have qualified for Extra Help and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you to either request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

- Contact Member Services at the number on the back cover of this booklet and tell the representative that you believe you qualify for extra help and are paying an incorrect copayment. 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 Member Services at the number on the back cover of this booklet and tell the representative that you believe you qualify for extra help and are paying an incorrect copayment. You may be required to provide one of the following:
 - A remittance from the facility showing Medicaid payment on your behalf for a full calendar month during a month after June of the previous calendar year;
 - A copy of a state document that confirms Medicaid payment on your behalf to the facility for a full calendar month after June of the previous calendar year; or
 - A screen print from the State's Medicaid systems showing your institutional status based on at least a full calendar month stay for Medicaid payment purposes during a month after June of the previous calendar year.

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

Medicare Coverage Gap Discount Program

Beginning in 2011, the Medicare Coverage Gap Discount Program will provide manufacturer discounts on Part D brand name drugs to Part D enrollees who have reached the coverage gap and are not already receiving "Extra Help." A discount on the negotiated price (excluding the dispensing fee) will be available for those Part D brand name drugs from manufacturers that have agreed to pay the discount.

We will automatically apply the discount when your pharmacy bills you for your prescription and your Explanation of Benefits will show any discount provided. The amount discounted by the manufacturer counts toward your out-of-pockets costs as if you had paid this amount and moves you through the coverage gap.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Member Services (phone numbers are on the back).

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	<p>1-877-772-5772</p> <p>Calls to this number are free.</p> <p>Available 9:00 am to 3:30 pm, Monday through Friday</p> <p>If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.</p>
TTY	<p>1-312-751-4701</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 <i>not</i> free.</p>
WEBSITE	<p>http://www.rrb.gov</p>

SECTION 9 Do you have “group insurance” or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group, call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period.

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

Chapter 6. Using the plan's coverage for your medical services

SECTION 1	Things to know about getting your medical care as a member of our plan	87
Section 1.1	What are “network providers” and “covered services”?.....	87
Section 1.2	Basic rules for getting your medical care that is covered by the plan	87
SECTION 2	Use providers in the plan's network to get your medical care.....	88
Section 2.1	You must choose a Primary Care Provider (PCP) to provide and oversee for your medical care	88
Section 2.2	What kinds of medical care can you get without getting approval in advance from your PCP?	90
Section 2.3	How to get care from specialists and other network providers.....	90
SECTION 3	How to get covered services when you have an emergency or an urgent need for care	91
Section 3.1	Getting care if you have a medical emergency	91
Section 3.2	Getting care when you have an urgent need for care.....	92
SECTION 4	What if you are billed directly for the full cost of your covered services?	93
Section 4.1	You can ask the plan to pay our share of the cost of your covered services.....	93
Section 4.2	If services are not covered by our plan, you must pay the full cost.....	93
SECTION 5	How are your medical services covered when you are in a “clinical research study”?	94
Section 5.1	What is a “clinical research study”?	94
Section 5.2	When you participate in a clinical research study, who pays for what?	94
SECTION 6	Rules for getting care in a “religious non-medical health care institution”	95
Section 6.1	What is a religious non-medical health care institution?	95

Section 6.2 What care from a religious non-medical health care institution is covered by our plan?.....95

SECTION 1 Things to know about getting your medical care as a member of our plan

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

For the details on what medical care is covered by our plan and how much you pay as your share of the cost when you get this care, use the benefits chart in the next chapter, Chapter 3, Section 1 (*Medical Benefits Chart*).

Section 1.1	What are “network providers” and “covered services”?
--------------------	---

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

- **“Providers”** are doctors and other health care professionals that the state licenses to provide medical services and care. The term “providers” also includes hospitals and other health care facilities.
- **“Network providers”** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network generally bill us directly for care they give you. When you see a network provider, you usually pay only your share of the cost for their services.
- **“Covered services”** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart in Chapter 4.

Section 1.2	Basic rules for getting your medical care that is covered by the plan
--------------------	--

We will generally cover your medical care as long as:

- **The care you receive is included in the plan’s Medical Benefits Chart** (this chart is in Chapter 3 of this booklet).
- **The care you receive is considered medically necessary.** It needs to be accepted treatment for your medical condition.
- **You have a primary care provider (a PCP) who is providing and overseeing your care.** As a member of our plan, you must choose a PCP (for more information about this, see Section 2.1 in this chapter).
 - In most situations, your PCP must give you approval in advance before you can use other providers in the plan’s network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a “referral.” For more information about this, see Section 2.2 of this chapter.

- Referrals from your PCP are not required for emergency care or urgently needed care. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.3 of this chapter).
- **You generally must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. *Here are two exceptions:*
 - The plan covers emergency care or urgently needed care that you get from a non-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.
 - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider. Your PCP must give you approval in advance before you can use an out-of-network provider. In this situation, you will pay the same as you would pay if you got the care from a network provider.

SECTION 2 Use providers in the plan's network to get your medical care

Section 2.1	You must choose a Primary Care Provider (PCP) to provide and oversee for your medical care
--------------------	---

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

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

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

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

Providers that can act as your PCP are those that provide a basic level of care. These include doctors providing general and/or family medical care, internists who provide internal medical care, obstetricians who provide care for pregnant women, and pediatricians who provide care for children. A nurse practitioner (NP), a State licensed registered nurse with special training, providing a basic level of health care, can act as your PCP.

You will usually see your PCP first for most of your routine health care needs. There are only a few types of covered services you may get on your own, without contacting your PCP first except as we explain below. When your PCP thinks that you need specialized treatment, he/she will give you a referral (approval in advance) to see a plan specialist or certain other providers. Please refer to Section 2.3 in this chapter for more information.

How do you choose your PCP?

When you enroll in our Plan, you will select a contracting Medical Group from our network. You'll also choose a PCP from this contracting Medical Group, which you will need to indicate on your enrollment form and submit to our Plan. You can find a list of all contracting Medical Groups (and their affiliated PCP's and hospital affiliations) from the Provider Directory. To confirm the availability of a provider, or to ask about a specific PCP, please contact Member Services at the phone number in back the cover of this booklet.

If there is a particular Plan specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist, or uses that hospital. The name and office telephone number of your PCP is printed on your membership card.

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

Changing your PCP

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

You may change your PCP for any reason, and your request will be effective on the first day of the month following the date our Plan receives your request. To change your PCP, call Member Services or you may visit our website at www.healthnet.com/uc.

When you contact us, be sure to let us know if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP, and tell you when the change to your new PCP will take effect.

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

Section 2.2	What kinds of medical care can you get without getting approval in advance from your PCP?
--------------------	--

You can get the services listed below without getting approval in advance from your PCP.

- Routine women’s health care, which include breast exams, mammograms (x-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider.
- Flu shots and pneumonia vaccinations as long as you get them from a network provider
- Emergency services **from network providers or from non-network providers.**
- Urgently needed care from in-network providers or from out-of-network providers when network providers are temporarily unavailable or, e.g., when you are temporarily outside of the plan’s service area.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside the plan’s service area. ***If possible, please let us know before you leave the service area where you are going to be so we can help arrange for you to have maintenance dialysis while outside the service area.***

Section 2.3	How to get care from specialists and other network providers
--------------------	---

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

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

For some types of referrals, your PCP may need to get approval in advance from our Plan (this is called getting “prior authorization”). Please refer to Chapter 3 for specific benefits that require prior authorization.

It is very important to get a referral (approval in advance) from your PCP before you see a plan specialist or certain other providers (there are a few exceptions, including routine women’s health care that we explain later in this section). **If you don’t have a referral (approval in advance) before you get services from a specialist, you may have to pay for these services yourself.**

If the specialist wants you to come back for more care, check first to be sure that the referral (approval in advance) you got from your PCP for the first visit covers more visits to the specialist.

If there are specific specialists you want to use find out whether your PCP sends patients to these specialists. Each plan PCP has certain plan specialists they use for referrals. This means that the PCP you select may determine the specialists you may see. You may generally change your PCP at any time if you want to see a Plan specialist that your current PCP can’t refer you to. Later in this section, under “How can you switch to another PCP,” we tell you how to change your PCP. If there are specific hospitals you want to use, you must first find out whether your PCP uses these hospitals.

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

Sometimes a specialist, clinic, hospital or other network provider you are using might leave the plan. If this happens, and it is a provider you see on a regular basis, you will be sent notification at least 30 days prior to the provider's termination effective date. If you continue seeing the provider after the termination effective date, the services may not be covered by the plan. Should you decide to switch to another contracted provider. Member Services can assist you in finding and selecting provider. Phone numbers are located on the back cover of this Evidence of Coverage.

SECTION 3 How to get covered services when you have an emergency or an urgent need for care

Section 3.1 Getting care if you have a medical emergency
--

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

When you have a “medical emergency,” you believe that your health is in serious danger. A medical emergency can include severe pain, a bad injury, a sudden illness, or a medical condition that is quickly getting much worse.

If you have a medical emergency:

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

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories.. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 3 of this booklet.

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

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

What if it wasn't a medical emergency?

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

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

- You go to a network provider to get the additional care.
- – *or* – the additional care you get is considered “urgently needed care” and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

Section 3.2 Getting care when you have an urgent need for care
--

What is “urgently needed care”?

“Urgently needed care” is a non-emergency situation when:

- you need medical care right away because of an illness, injury, or condition that you did not expect or anticipate, but your health is not in serious danger.

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

Whenever possible, you must use our network providers when you are in the plan's service area and you have an urgent need for care. (For more information about the plan's service area, see Chapter 1, Section 2.3 of this booklet.)

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

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

Suppose that you are temporarily outside our plan's service area, but still in the United States. If you have an urgent need for care, you probably will not be able to find or get to one of the providers in our plan's network. In this situation (when you are outside the service area and cannot get care from a network provider), our plan will cover urgently needed care that you get from any provider.

SECTION 4 What if you are billed directly for the full cost of your covered services?

Section 4.1	You can ask the plan to pay our share of the cost of your covered services
--------------------	---

In limited instances, you may be asked to pay the full cost of the services. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you will want our plan to pay our share of the costs by reimbursing you for payments you have already made.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us so that we can pay our share of the costs for your covered medical services.

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 10 (*Asking the plan to pay its share of a bill you have received for medical services or drugs*) for information about what to do.

Section 4.2	If services are not covered by our plan, you must pay the full cost
--------------------	--

Your plan covers all medical services that are medically necessary, are covered under Medicare, and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services, or they were obtained out-of-network where not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. Chapter 12.

The (*What to do if you have a problem or complaint*) has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services at the number on the back cover of this booklet to get more information about how to do this.

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

SECTION 5 How are your medical services covered when you are in a “clinical research study”?

Section 5.1 What is a “clinical research study”?
--

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

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

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

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

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

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

1. We can let you know whether the clinical research study is Medicare-approved.
2. We can tell you what services you will get from clinical research study providers instead of from our plan.
3. We can keep track of the health care services that you receive as part of the study.

If you plan on participating in a clinical research study, contact Member Services (see Chapter 5, Section 1 of this *Evidence of Coverage*).

Section 5.2 When you participate in a clinical research study, who pays for what?

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

- Room and board for a hospital stay that Medicare would pay for even if you weren’t in a study.
- An operation or other medical procedure if it is part of the research study.

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

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs. We will pay the difference between the cost-sharing in Original Medicare and your cost-sharing as a member of our plan. This means your costs for the services you receive as part of the study will not be higher than they would be if you received these services outside of a clinical research study.

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

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

Do you want to know more?

To find out what your coinsurance would be if you joined a Medicare-approved clinical research study, please call us at Member Services (phone numbers are on the cover of this booklet). You can get more information about joining a clinical research study by reading the publication “Medicare and Clinical Research Studies” on the Medicare website (<http://www.medicare.gov>). You can also call 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 6 Rules for getting care in a “religious non-medical health care institution”

Section 6.1 What is a religious non-medical health care institution?

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

Section 6.2 What care from a religious non-medical health care institution is covered by our plan?

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

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

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

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

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

Chapter 7. Medical Benefits Chart (what is covered and what you pay)

SECTION 1	Understanding your out-of-pocket costs for covered services.....	98
Section 1.1	What types of out-of-pocket costs do you pay for your covered services?	98
Section 1.2	What is the maximum amount you will pay for Medicare Part A and Part B covered medical services?	98
SECTION 2	What is covered for you and how much you will pay	99
Section 2.1	Your medical benefits and costs as a member of the plan.....	99
SECTION 3	What types of benefits are not covered by the plan?	100
Section 3.1	Types of benefits we do <i>not</i> cover (exclusions).....	100

SECTION 1 Understanding your out-of-pocket costs for covered services

This chapter focuses on your covered services. Refer to Chapter 3, Section 1 (*Medical Benefits Chart*) for a list of your covered services and tells how much you will pay for each covered service as a member of our plan. Later in this section, you can find information about medical services that are not covered. It also tells about limitations on certain services. Information about how much you pay for your Part D Prescription Drug Benefits is later in this section. Further exclusions can also be found in this section for members who have additional benefits.

Section 1.1 What types of out-of-pocket costs do you pay for your covered services?

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

- A **“copayment”** means that you pay a fixed amount each time you receive a medical service. You pay a copayment at the time you get the medical service.
- **“Coinsurance”** means that you pay a percent of the total cost of a medical service. You pay a coinsurance at the time you get the medical service.

Some people qualify for State Medicaid programs to help them pay their out-of-pocket costs for Medicare. If you are enrolled in one of these programs, you may still have to pay a copayment for the services, depending on the rules in your state.

Section 1.2 What is the maximum amount you will pay for Medicare Part A and Part B covered medical services?
--

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

As a member of our plan, the most you will have to pay out-of-pocket for covered Part A and Part B services in 2011 is \$1,500. (The amount you pay for your plan premium does not count toward your out-of-pocket maximum.) If you reach the maximum out-of-pocket payment amount of \$1,500, you will not have to pay any out-of-pocket costs for the remainder of the year for covered Part A and Part B services. (You will have to continue to pay your plan premium and the Medicare Part B premium.)

SECTION 2 What is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of the plan

The Medical Benefits Chart in Chapter 3, Section 1 lists the services our plan covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following requirements are met:

- Except for Employer-Sponsored benefits, your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Except in the case of preventive services and screening tests, your services (including medical care, services, supplies, and equipment) *must* be medically necessary. Medically necessary means that the services are used for the diagnosis, direct care and treatment of your medical condition and are not provided mainly for your convenience or that of your doctor.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 6 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in the plan's network. This is called giving you a "referral." Chapter 6 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart an asterisk ("*").
- Our plan covers all Medicare-covered preventive services at no cost to you.

SECTION 3 What types of benefits are not covered by the plan?

Section 3.1 Types of benefits we do <i>not</i> cover (exclusions)

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

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

If you get benefits that are excluded, you must pay for them yourself. We won’t pay for the medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3 in this booklet.)

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

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as a covered services.
- Experimental medical and surgical procedures, equipment and medications, unless covered by Original Medicare. However, certain services may be covered under a Medicare-approved clinical research study. See Chapter 6, Section 5 for more information on clinical research studies.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Full-time nursing care in your home.
- Custodial care, unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. Custodial care, or non-skilled care, is care that helps you with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by your immediate relatives or members of your household.
- Meals delivered to your home.

- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance), except when medically necessary.
- Cosmetic surgery or procedures, unless because of an accidental injury or to improve a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
- Routine dental care, such as cleanings, filings or dentures. However, non-routine dental care received at a hospital may be covered.
- Routine foot care, except for the limited coverage provided according to Medicare guidelines.
- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.
- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.
- Hearing aids.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies.
- Acupuncture.
- Naturopath services (uses natural or alternative treatments).
- Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at VA hospital and the VA cost-sharing is more than the cost-sharing under our plan. We will reimburse veterans for the difference. Members are still responsible for our cost-sharing amounts.
- Prenatal, maternity or post-partum care for a non-Health Net Seniority Plus Member acting as a surrogate.
- Services related to educational and professional purposes are not covered, including ancillary services such as: Vocational rehabilitation; Employment counseling, training or educational therapy for learning disabilities; Investigations required for employment; Education for obtaining or maintaining employment, or for professional certification; Education for personal or professional growth, development or training; or Academic education during residential treatment.
- Services that are not reasonable and necessary under Original Medicare Plan standards unless otherwise listed as a Covered Service. As noted in this section, we provide all Covered Services according to Medicare guidelines.
- Services that do not meet national standards for professional medical or mental health practice, including, but not limited to, Erhard/The Forum, primal therapy, bioenergetic therapy, sleep therapy, biofeedback, hypnotherapy and crystal healing therapy are not covered.
- Services that you get from Non-Plan Providers, except for care for a Medical Emergency and Urgently Needed Care, renal (kidney) dialysis services that you get when you are temporarily outside the Plan's Service Area, and care from Non-Plan Providers that is

arranged or approved by a Plan Provider. See other parts of this booklet "Use providers in the plan's network to get medical care" and "How to get covered services when you have an emergency or an urgent need for care" for information about using Plan Providers and the exceptions that apply.

- Services that you get without a Referral from your PCP, when a Referral from your PCP is required for getting that service.
- Services that you get without Prior Authorization from Health Net or your Medical Group, when Prior Authorization is required for getting that service. (Please refer to the "Definitions of Important words" section for a definition of Prior Authorization.)
- Stem cell harvesting and storage not associated with an approved transplant.
- Supportive devices for the feet. There is an exception: orthopedic or therapeutic shoes for people with diabetic foot disease (as shown in this section).
- The following types of treatment are only covered when provided in connection with covered treatment for a Mental Disorder or Chemical Dependency:
 1. Treatment for co-dependency.
 2. Treatment for psychological stress.
 3. Treatment of marital or family dysfunction.

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

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

- Therapy intended to change behavior by inducing a dislike for the behavior through association with a noxious stimulus is not covered.
- Treatment or consultations provided by telephone are not covered.
- Any services listed above that aren't covered will remain not covered even if received at an emergency facility.

Chapter 8. Using the plan’s coverage for your Part D prescription drugs

SECTION 1	Introduction.....	105
Section 1.1	This chapter describes your coverage for Part D drugs	105
Section 1.2	Basic rules for the plan’s Part D drug coverage	105
SECTION 2	Fill your prescription at a network pharmacy or through the plan’s mail-order service	106
Section 2.1	To have your prescription covered, use a network pharmacy	106
Section 2.2	Finding network pharmacies.....	106
Section 2.3	Using the plan’s mail-order services.....	107
Section 2.4	How can you get a long-term supply of drugs?	107
Section 2.5	When can you use a pharmacy that is not in the plan’s network?	108
SECTION 3	Your drugs need to be on the plan’s “Drug List”	108
Section 3.1	The “Drug List” tells which Part D drugs are covered	108
Section 3.2	There are different “cost-sharing tiers” for drugs on the Drug List.....	109
Section 3.3	How can you find out if a specific drug is on the Drug List?.....	109
SECTION 4	There are restrictions on coverage for some drugs	110
Section 4.1	Why do some drugs have restrictions?	110
Section 4.2	What kinds of restrictions?	110
Section 4.3	Do any of these restrictions apply to your drugs?.....	111
SECTION 5	What if one of your drugs is not covered in the way you’d like it to be covered?	111
Section 5.1	There are things you can do if your Part D drug is not covered in the way you’d like it to be covered.....	111
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?.....	111

2011 Evidence of Coverage for Health Net Seniority Plus (Employer HMO)	104
Section 5.3 What can you do if your Part D drug is in a cost-sharing tier you think is too high?	113
SECTION 6 What if your coverage changes for one of your drugs?	114
Section 6.1 The Drug List can change during the year	114
Section 6.2 What happens if coverage changes for a drug you are taking?.....	114
SECTION 7 What types of drugs are <i>not</i> covered by the plan?	115
Section 7.1 Types of drugs we do not cover	115
SECTION 8 Show your plan membership card when you fill a prescription	116
Section 8.1 Show your membership card	116
Section 8.2 What if you don't have your membership card with you?.....	117
SECTION 9 Part D drug coverage in special situations	117
Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by the plan?.....	117
Section 9.2 What if you're a resident in a long-term care facility?	117
SECTION 10 Programs on drug safety and managing medications	118
Section 10.1 Programs to help members use drugs safely.....	118
Section 10.2 Programs to help members manage their medications	118



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

The “Extra Help” program helps people with limited resources pay for their drugs. For more information, see Chapter 5, Section 7.

Are you currently getting help to pay for your Part D 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 Member Services and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Member Services are on the back cover.

SECTION 1 Introduction

Section 1.1	This chapter describes your coverage for Part D drugs
--------------------	--

This chapter explains rules for using your coverage for Part D drugs. The next chapter tells what you pay for Part D drugs (Chapter 9, *What you pay for your Part D prescription drugs*).

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

- The plan covers drugs you are given during covered stays in the hospital or in a skilled nursing facility. Chapter 3 (*Plan Benefits Chart*) tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 3 (*Plan Benefits Chart*) tells about the benefits and costs for Part B drugs.

The two examples of drugs described above are covered by the plan’s medical benefits. The rest of your prescription drugs are covered under the plan’s Part D benefits. **This chapter explains rules for using your coverage for Part D drugs.** The next chapter tells what you pay for Part D drugs (Chapter 9, *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. (For more information, see Section 2, *Your prescriptions should be written by a network provider.*)
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See Section 4, *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 injury or illness. 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. (See the "When can you use a pharmacy that is not in the plan's network?" portion of this section for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with the plan to provide your covered prescription drugs. The term "covered drugs" means all of the 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 Member Services (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 Member Services (phone numbers are on the cover) or use the *Pharmacy Directory*.

What if you need a specialized pharmacy?

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

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term-care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our

network. If your long-term care pharmacy is not in our network, please contact Member Services.

- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense 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 specialized pharmacy, look in your *Pharmacy Directory* or call Member Services.

Section 2.3 Using the plan's mail-order services

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

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

To get order forms and information about filling your prescriptions by mail contact Member Services (phone numbers are on the back cover).

If you use a **non-preferred** mail-order pharmacy, you may pay more than when you use a preferred mail-order pharmacy.

Usually a mail-order pharmacy order will get to you in no more than 14 days. If your order is delayed, call Member Services at phone numbers are 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.)

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

2. For certain kinds of drugs, you can use the plan's network **mail-order services**. Our plan's mail-order service requires you to order at least a 30 day supply of the drug and no more than a 90-day supply. See 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 may be covered in certain situations

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

- If you are unable to obtain a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide services 24-hours a day, seven days a week.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail order pharmacy (including high cost and unique drugs).
- If you are getting a vaccine that is medically necessary but not covered by Medicare Part B or other covered drugs that are administered in your doctor's office.
- If you need a prescription filled that is related to care for a medical emergency or urgent care.
- If you are evacuated or otherwise displaced from your home because of a federal disaster or other public health emergency declaration.

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

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 7, 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.

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 injury or illness. It also needs to be an accepted treatment for your medical condition.

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 information about this, see Section 8.1 in this chapter).
- In other cases, we have decided not to include a particular drug on the Drug List.

Section 3.2	There are different “cost-sharing tiers” for drugs on the Drug List
--------------------	--

Every drug on the plan’s Drug List is in one of the cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug. To find out what type of drugs are covered under each drug tier and your cost-sharing for each tier, refer to Chapter 3 (*Plan benefits chart*). To find out which cost-sharing tier your drug is in, look it up in the plan’s *Drug List*.

- Cost-Sharing Tier 3 includes non-preferred generic and non preferred brand drugs.]
- Cost-Sharing Tier 4 (Injectable Tier) includes injectable drugs that do not meet the Centers for Medicare & Medicaid Services (CMS) minimum cost threshold required to be placed on Tier 5 (Specialty Tier). Some drugs are limited to a maximum 30-day supply per fill.
- For 5 Tier Plans: Cost-Sharing Tier 5 (Specialty Tier) is the highest tier and includes high cost drugs. Some drugs are limited to a maximum 30-day supply per fill and Part D drugs on this tier not eligible for exceptions for payment at a lower tier.

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

The amount you pay for drugs in each cost-sharing tier is shown the “Plan Benefit Chart” section at the beginning of this Evidence of Coverage.

Section 3.3	How can you find out if a specific drug is on the Drug List?
--------------------	---

You have three ways to find out:

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

SECTION 4 There are restrictions on coverage for some drugs

Section 4.1 Why do some drugs have restrictions?

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

In general, our rules encourage you 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 information below tells you more about the types of restrictions we use for certain drugs.

Restricting brand name drugs when a generic version is available

A "generic" drug works the same as a brand name drug, but usually costs less. **When a generic version of a brand name drug is available, our network pharmacies will usually provide you the generic version.** The brand name drug will usually be available for your Tier-3 copayment.

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, check the website (www.healthnet.com/uc) or call Member Services (phone numbers are on the back cover).

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 Part D 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 5, 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 five different cost-sharing tier. 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 6.2 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 6.3 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?

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).
- You can change to another drug.

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 5 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 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 the implementation of a new formulary at the beginning of each year (January 1) or after the Group's effective date**. This temporary supply will be for a maximum of a 30-days, or less if your prescription is written for fewer days..

- **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.

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

We will cover a temporary supply of your Part D drug **during the first 90 days of your membership** in the plan. The first supply will be for a maximum 34-day, 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-days of your drug, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

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

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

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

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

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

During the time when you are getting a temporary supply of a Part D drug, you should talk with your doctor 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 Part D 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. Perhaps there is a different Part D drug covered by the plan that might work just as well for you. You can call Member Services to ask for a list of covered Part D drugs that treat the same medical condition. This list can help your doctor to find a covered drug that might work for you.

You can file an exception

You and your doctor can ask the plan to make an exception for you and cover the Part D drug in the way you would like it to be covered. **If your 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 Part D drug even though it is not on the plan's Drug List. Or you can ask the plan to make an exception and cover the drug without restrictions.

If you and your doctor or other prescriber want to ask for an exception, Chapter 9, Section 6.2 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 Part D drug is in a cost-sharing tier you think is too high?
--------------------	---

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

You can change to another Part D drug

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

You can file an exception

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

If you and your doctor want to ask for an exception, Chapter 9, Section 6.2 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?

Section 6.1	The Drug List can change during the year
--------------------	---

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

- **Add or remove drugs from the Drug List.** New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or we might remove a drug from the list because it has been found to be ineffective.
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug** (for more information about restrictions to coverage, see Section 5 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 Part D drug you are taking, the change will not affect you until January 1 of the next year if you stay in the plan:

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

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

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

- If a Part D **brand-name drug you are taking is replaced by a new generic drug**, the plan must give you at least 60 days' notice or give you a 60-day refill of your Part D brand-name drug at a network pharmacy.
 - During this 60-day period, you should be working with your doctor to switch to the generic or to a different Part D 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 Part D brand-name drug for you. For information on how to ask for an exception, see Chapter 12 “*(What to do if you have a problem or complaint) (coverage decisions, appeals, complaints)*” section of this booklet.
- Again, if a drug is **suddenly recalled** because it's been found to be unsafe or for other reasons, the plan will immediately remove the drug from the Drug List. We will let you know of this change right away.
 - Your doctor 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
--

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

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section. 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, Section 6.5 in this booklet.)

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

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan will not cover a drug purchased outside the United States and its territories.

- Our plan usually will not cover off-label use. “Off-label use” is any use of the drug other than those indicated on a drug’s label as approved by the Food and Drug Administration.
 - Generally, coverage for “off-label use” is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its “off-label use.”

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

- Non-prescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale
- Drugs that the law does not allow any Medicare plans to cover

We offer additional coverage of some prescription drugs not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards qualifying you for the Catastrophic Coverage Stage.

In addition, if you are **receiving Extra Help from Medicare** to pay for your Part D prescriptions, the Extra Help will not pay for the drugs not normally covered by a Medicare prescription drug plan. (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 7, 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 or to a skilled nursing facility for a stay covered by the plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, the plan will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. Chapter 9 (*What you pay for your Part D prescription drugs*) gives more information about drug coverage and what you pay.

Please Note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage at any time. (Chapter 10, *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 Member Services.

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

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

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

During the time when you are getting a temporary supply of a 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 9, Section 6.2 tells what to do.**

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 your employer or retiree plan’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

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

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 9. What you pay for your Part D prescription drugs

	A table that shows your costs for a one-month (30-day) supply of a drug.....	37
	A table that shows your costs for a long-term (90-day) supply of a drug	40
SECTION 1	Introduction.....	122
Section 1.1	Use this chapter together with other materials that explain your drug coverage	122
SECTION 2	What you pay for a drug depends on which “drug payment stage” you are in when you get the drug.....	123
Section 2.1	What are the different drug payment stages?.....	123
SECTION 3	We send you reports that explain payments for your Part D drugs and which payment stage you are in.....	123
Section 3.1	We send you a monthly report called the “Explanation of Benefits”	123
Section 3.2	Help us keep our information about your Part D drug payments up to date.....	123
	During the Deductible Stage, you pay the full cost of your drugs.....	124
	This plan does not have a Deductible. You move directly into the Initial Coverage Stage. See the next portion of this section for details.	
Section 3.2	During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share	124
Section 3.4	You stay in the Initial Coverage Stage until your total drug costs for the year reach \$2840.00	125
SECTION 4	During the Coverage Gap Stage, you may receive a discount on Part D drugs.	126
Section 4.1	You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$4,550.....	126
SECTION 5	During the Catastrophic Coverage Stage, the plan pays most of the cost for your Part D drugs.....	129
Section 5.1	Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year	129

2011 Evidence of Coverage for Health Net Seniority Plus (Employer HMO)	121
SECTION 6 What you pay for Part D vaccinations depends on how and where you get them	129
Section 6.1 Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot	129
You may want to call us at Member Services before you get a vaccination	131
SECTION 7 Do you have to pay the Part D “late enrollment penalty”?	131
Section 7.1 What is the Part D “late enrollment penalty”?	131
Section 7.2 How much is the Part D late enrollment penalty?	131
Section 7.3 In some situations, you can enroll late and not have to pay the penalty	132
Section 7.4 What can you do if you disagree about your late enrollment penalty?	132
SECTION 8 We send you reports that explain payments for your drugs and which payment stage you are in	133
Section 8.1 We send you a monthly report called the “Explanation of Benefits”	133
Section 8.2 Help us keep our information about your drug payments up to date	133
SECTION 9 What you pay for vaccinations depends on how and where you get them	134
Section 9.1 Our plan has separate coverage for the vaccine medication itself and for the cost of giving you the vaccination shot	134
Section 9.2 You may want to call us at Member Services before you get a vaccination	135
SECTION 10 Do you have to pay the Part D “late enrollment penalty”?	136
Section 10.1 What is the Part D “late enrollment penalty”?	136
Section 10.2 How much is the Part D late enrollment penalty?	136
Section 10.3 In some situations, you can enroll late and not have to pay the penalty	137
Section 10.4 What can you do if you disagree about your late enrollment penalty?	137



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

The “Extra Help” program helps people with limited resources pay for their drugs. For more information, see Chapter 5, 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 Member Services and ask for the “Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs” (LIS Rider). Phone numbers for Member Services 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 5, 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 different “cost-sharing tiers” the drug is in and whether there are any restrictions on your coverage for the drug.
 - If you need a copy of the Drug List, call Member Services (phone numbers are 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 8 of this booklet.** Chapter 8 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 8 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 8 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?

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.

As shown in the different payment stages below, whether you move on to the next payment stage depends on how much **you and/or the plan spends** for your drugs while you are in each stage.

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

Section 3.1 We send you a monthly report called the “Explanation of Benefits”

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

- We keep track of how much you have paid. This is called your “**out-of-pocket**” cost.
- We keep track of your “**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 Part D prescriptions you have filled during the previous month. It shows the total Part D drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called “year-to-date” information. It shows you the total Part D drug costs and total Part D payments for your drugs since the year began.

Section 3.2 Help us keep our information about your Part D drug payments up to date

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

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for Part D prescription drugs when we will not automatically get the information we need. To help us keep track of your Part D out-of-pocket costs, you may give us copies of receipts for Part D drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to the “How to ask us to pay you back or to pay a bill you have received” portion of the “Asking the plan to pay its share of a bill you have received for covered services or drugs” section of this Evidence of Coverage.) Here are some types of situations when you may want to give us copies of your Part D drug receipts to be sure we have a complete record of what you have spent for your Part D drugs:
 - When you purchase a covered Part D drug at a network pharmacy at a special price or using a discount card that is not part of our plan’s benefit.
 - When you pay a copayment for Part D drugs that are provided under a drug manufacturer patient assistance program.
 - Any time you have purchased covered Part D drugs at out-of-network pharmacies or other times you have paid the full price for a covered Part D drug under special circumstances.
- **Send us information about the payments for Part D drugs others have made for you.** Payments made by certain other individuals and organizations for Part D drugs also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive an *Explanation of Benefits* in the mail, please look it over to be sure the information is complete and correct. If you think a Part D drug is missing from the report, or you have any questions, please call us at Member Services (phone numbers are on the cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

During the Deductible Stage, you pay the full cost of your drugs

This plan does not have a Deductible. You move directly into the Initial Coverage Stage. See the next portion of this section for details. Section 3.2 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 Chapter 3, Section 2 (***Prescription drugs (Part D) benefits chart***). In general, the higher the cost-sharing tier, the higher your cost for the drug:

- Cost-Sharing Tier 1 is the lowest tier and generally includes preferred generic drugs. It may include some preferred brand drugs.
- Cost-Sharing Tier 2 generally includes preferred brand drugs. It may include some generic drugs.
- Cost-Sharing Tier 3 includes non-preferred generic and non-preferred brand drugs.
- Tier 4 (Injectable Drugs) includes injectable drugs that do not meet the Centers for Medicare & Medicaid Services (CMS) minimum cost threshold required to be placed on Tier 5 (Specialty Tier). Some drugs are limited to a maximum 30-day supply per fill.
- Tier 5 Specialty Drugs is the highest tier and includes high cost drugs. Some drugs are limited to a maximum 30-day supply per fill and Part D drugs on this tier are not eligible for exceptions for payment at a lower tier.

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

Your pharmacy choices

How much you pay for a drug depends on 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

For more information about these pharmacy choices and filling your prescriptions, see Chapter 8 in this booklet and the plan's ***Pharmacy Directory***.

Section 3.4 You stay in the Initial Coverage Stage until your total drug costs for the year reach \$2840.00

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **\$2840.00 limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what the plan has paid:

- **What you have paid** for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 6.2 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
 - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- **What the plan has paid** as its share of the cost for your drugs during the Initial Coverage Stage.

We offer additional coverage on some prescription drugs that are not normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs will not count towards your initial coverage limit or total out-of-pocket costs.

The *Explanation of Benefits* that we send to you will help you keep track of how much you and the plan have spent for your drugs during the year. Many people do not reach the \$2840.00 limit in a year.

We will let you know if you reach this \$2840.00 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

SECTION 4 During the Coverage Gap Stage, you may receive a discount on Part D drugs.

Section 4.1 You stay in the Coverage Gap Stage until your out-of-pocket costs reach \$4,550

After your total Part D drug costs reach \$2840.00, you, or others on your behalf, will pay the following:

- **Generic Part D drugs:** The applicable coinsurance/copayment as shown in the Initial Coverage Stage.
- **Brand Name Part D drugs eligible for a discount as determined by Medicare:** Two times (2X) the applicable coinsurance/copayment as shown in the Initial Coverage Stage. These drugs are subject to the Medicare Coverage Gap Discount Program, which helps lower your drug cost. (Refer to “Medicare Coverage Gap Discount Program For Part D Brand Name Drugs” below for more information.)
- **All Other Covered Drugs:** The applicable coinsurance/copayment as described in the Initial Coverage Stage.

Once your yearly out-of-pocket payments for Part D drugs reach \$4,550, you move on to the Catastrophic Coverage Stage.

Medicare Coverage Gap Discount Program For Part D Brand Name Drugs

Beginning in 2011, the Medicare Coverage Gap Discount Program will provide manufacturer discounts on Part D brand name drugs as determined by Medicare to enrollees who have reached the coverage gap and are not already receiving “Extra Help.” A discount will be applied to your share of the cost for Part D brand name drugs from manufacturers that have agreed to pay the discount.

We will automatically apply the discount when your pharmacy charges you for your drug and your Explanation of Benefits will show any discount provided. The amount discounted by the manufacturer counts toward your out-of-pocket costs as if you had paid this amount and moves you through the coverage gap.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Member Services (phone numbers are on the back cover).

*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 8 of this booklet):*

- The amount you pay for drugs when you are in any of the following drug payment stages:
 - The Deductible Stage (if applicable to your plan).
 - The Initial Coverage Stage.
 - The Coverage Gap 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 Part D drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by the Indian Health Services, or by a State Pharmaceutical Assistance Program that is qualified by Medicare. Payments made by Medicare's "Extra Help" and the Medicare coverage Gap Discount Program 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 from the Coverage Gap Stage to the Catastrophic Coverage Stage.

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

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

- The amount you pay for your monthly premium.
- 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.
- Non-Part D drugs, including prescription drugs covered by Part A or Part B and other drugs excluded from coverage by Medicare.
- 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 certain insurance plans and government-funded health programs such as TRICARE and, the Veteran's Administration.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Worker's Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Member Services to let us know (phone numbers are 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 left the Coverage Gap Stage and 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.

SECTION 5 During the Catastrophic Coverage Stage, the plan pays most of the cost for your Part D drugs

Section 5.1	Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year
--------------------	--

You qualify for the Catastrophic Coverage Stage when your Part D out-of-pocket costs have reached the \$4,550.00 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 Part D drugs.

- **Your share** of the cost for a covered Part D drug will be either coinsurance or a copayment, whichever is the *larger* amount:
 - *–either–* coinsurance of 5% of the cost of the drug
 - *–or–* \$2.50 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 6 What you pay for Part D vaccinations depends on how and where you get them

Section 6.1	Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot
--------------------	--

Our plan provides coverage of a number of Part D vaccines. There are two parts to our coverage of vaccinations:

- The first part of coverage is the cost of **the Part D vaccine medication itself**. The vaccine is a prescription medication.
- The second part of coverage is for the cost of **giving you the Part D vaccination shot**. (This is sometimes called the “administration” of the vaccine.)

What do you pay for a vaccination?

What you pay for a vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
 - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to the “Medical Benefits Chart (what is covered and what you pay)” section of this booklet. Other vaccines are considered Part D drugs. You can find these vaccines listed in the plan’s *List of Covered Drugs*.
2. **Where you get the vaccine medication.**

3. Who gives you the vaccination shot.

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

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

To show how this works, here are three common ways you might get a Part D vaccination shot. Remember you are responsible for all of the costs associated with Part D vaccines (including their administration) during the Deductible Stage and/or Coverage Gap Stage of your benefit.

Situation 1: You buy the Part D vaccine at the pharmacy and you get your vaccination shot at the network pharmacy. (Whether you have this choice depends on where you live. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your copayment for the Part D vaccine itself.
- Our plan will pay for the cost of giving you the Part D vaccination shot.

Situation 2: You get the Part D vaccination at your doctor's office.

- When you get the Part D vaccination, you will pay for the entire cost of the Part D vaccine and its administration.
- You can then ask our plan to pay our share of the cost by using the procedures that are described in the "Asking the plan to pay its share of a bill you have received for medical services or drugs" section of this booklet.
- You will be reimbursed the amount you paid less your normal copayment for the Part D 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 Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the Part D vaccination shot.

- You will have to pay the pharmacy the amount of your copayment for the Part D vaccine itself.
- When your doctor gives you the Part D vaccination shot, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in the "Asking the plan to pay its share of a bill you have received for medical services or drugs" section of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the Part D vaccine less any difference between the amount the doctor charges and what we normally pay. (If you are in Extra Help, we will reimburse you for this difference.)

You may want to call us at Member Services before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Member Services whenever you are planning to get a vaccination (phone numbers 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 7 Do you have to pay the Part D “late enrollment penalty”?

Section 7.1 What is the Part D “late enrollment penalty”?

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.

Your late enrollment penalty is considered to be part of your plan premium. If you do not pay the part of your premium that is the late enrollment penalty you could be disenrolled for failure to pay your plan premium.

Section 7.2 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 was \$32.34. 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 \$32.44, which equals \$4.53, 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 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 7.3	In some situations, you can enroll late and not have to pay the penalty
--------------------	--

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the late enrollment penalty.

You will not have to pay a 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 7.4	What can you do if you disagree about your late enrollment penalty?
--------------------	--

If you disagree about your late enrollment penalty, you can ask us to review the decision about your late enrollment penalty. Call Member Services at the number on the back of this booklet to find out more about how to do this.

Important: Do not stop paying your late enrollment penalty while you're waiting for us to review the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.

SECTION 8 We send you reports that explain payments for your drugs and which payment stage you are in

Section 8.1 We send you a monthly report called the “Explanation of Benefits”

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 drug 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 8.2 Help us keep our information about your drug payments up to date
--

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 7, 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 Member Services (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 9 What you pay for vaccinations depends on how and where you get them

Section 9.1 Our plan has separate coverage for the vaccine medication itself and for the cost of giving you the vaccination shot
--

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 medical benefits. You can find out about your coverage of these vaccines by going to Chapter 4, *Medical Benefits Chart (what is covered and what you pay)*.
 - Other 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. Remember you are responsible for all of the costs associated with vaccines (including their administration) during the Coverage Gap Stage of your benefit.

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. Some states do not allow pharmacies to administer a vaccination.)

- You will have to pay the pharmacy the amount of your coinsurance or copayment for the vaccine itself.
- Our plan will pay for the cost of giving you the vaccination shot.

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 10 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 10 of this booklet.
- You will be reimbursed the amount charged by the doctor less any cost-sharing amount that you need to pay for 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 9.2	You may want to call us at Member Services before you get a vaccination
--------------------	--

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Member Services whenever you are planning to get a vaccination (phone numbers 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 10 Do you have to pay the Part D “late enrollment penalty”?

Section 10.1 What is the Part D “late enrollment penalty”?

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 10.2 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,
- 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 10.3	In some situations, you can enroll late and not have to pay the penalty
---------------------	--

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the late enrollment penalty.

You will not have to pay a 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 10.4	What can you do if you disagree about your late enrollment penalty?
---------------------	--

If you disagree about your late enrollment penalty, you can ask us to review the decision about your late enrollment penalty. Call Member Services at the number on the back of this booklet to find out more about how to do this.

Chapter 10. Asking the plan to pay its share of a bill you have received for covered services or drugs

SECTION 1	Situations in which you should ask our plan to pay our share of the cost of your covered services or drugs.....	139
Section 1.1	If you pay our plan’s share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment	139
SECTION 2	How to ask us to pay you back or to pay a bill you have received.....	141
Section 2.1	How and where to send us your request for payment.....	141
SECTION 3	We will consider your request for payment and say yes or no	141
Section 3.1	We check to see whether we should cover the service or drug and how much we owe	141
Section 3.2	If we tell you that we will not pay for the medical care or drug, you can make an appeal	142
SECTION 4 to the plan	Other situations in which you should save your receipts and send them	142
Section 4.1	In some cases, you should send your receipts to the plan to help us track your out-of-pocket drug costs	142

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

Section 1.1	If you pay our plan's share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment
--------------------	--

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called “reimbursing” you). It is your right to be paid back by our plan whenever you’ve paid more than your share of the cost for medical services or drugs that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

Here are examples of situations in which you may need to ask our plan to pay you back or to pay a bill you have received.

1. When you’ve received emergency or urgently needed medical care from a provider who is not in our plan’s network

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed care from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill the plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
 - If the provider is owed anything, we will pay the provider directly.
 - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill the plan directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.

- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under the plan.

3. 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.

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

If you do not have your plan membership card with you, you can ask the pharmacy to call the plan or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

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

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

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

- For example, the drug may not be on the plan's *List of Covered Drugs (Formulary)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it.
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 12 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, complaints)*) has information about how to make an appeal.

SECTION 2 How to ask us to pay you back or to pay a bill you have received

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

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

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

- You don't have to use the form, but it'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 Member Services and ask for the form. The phone numbers for Member Services are on the cover of this booklet.

For medical services, mail your request for payment together with any bills or receipts to us at this address:

Health Net Medicare Claims

P.O. Box 14703
Lexington, KY 40512

For Prescription Drugs, mail your request for payment together with any bills or receipts to us at this address:

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

Please be sure to contact Member Services if you have any questions. If you don't know what you owe, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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 service or drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and decide whether to pay it and how much we owe.

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If

you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 6 explains the rules you need to follow for getting your medical services. Chapter 8 explains the rules you need to follow for getting your Part D prescription drugs.)

- If we decide that the medical care or drug is *not* covered, or you did *not* follow all the rules, we will not reimburse you. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

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

If you think we have made a mistake in turning down your request for payment, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to Chapter 12 of this booklet (*What to do if you have a problem or complaint (coverage decisions, appeals, 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 9. 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 in Chapter 12 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.4 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 6.6 of Chapter 9.

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 are two situations when you should send us receipts to let us know about payments you have made for your drugs:

1. When you buy the drug for a price that is lower than the plan’s price

Sometimes when you are in the: Deductible stage and/or Coverage Gap Stage you can buy your drug **at a network pharmacy** for a price that is lower than the plan’s price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside the plan's benefit that offers a lower price.
- Unless special conditions apply, you must use a network pharmacy in these situations and your drug must be on our Drug List.
- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** If you are in the Deductible stage and/or Coverage Gap Stage, the plan will not pay for any share of these drug costs. But sending the receipt allows us to calculate your Part D out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

2. When you get a Part D drug through a patient assistance program offered by a drug manufacturer

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

- Save your receipt and send a copy to us so that we can have your Part D out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through the plan's benefits, the plan will not pay for any share of these drug costs. But sending the receipt allows us to calculate your Part D out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

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

Chapter 11. Your rights and responsibilities

SECTION 1	Our plan must honor your rights as a member of the plan.....	145
Section 1.1	We must provide information in a way that works for you (in Braille, in large print, or other alternate formats, etc.)	145
Section 1.2	We must treat you with fairness and respect at all times	145
Section 1.3	We must ensure that you get timely access to your covered services and drugs.....	145
Section 1.4	We must protect the privacy of your personal health information	146
Section 1.5	We must give you information about the plan, its network of providers, and your covered services.....	151
Section 1.6	We must support your right to make decisions about your care.....	152
Section 1.7	You have the right to make complaints and to ask us to reconsider decisions we have made.....	154
Section 1.8	What can you do if you think you are being treated unfairly or your rights are not being respected?.....	155
Section 1.9	How to get more information about your rights	155
SECTION 2	You have some responsibilities as a member of the plan	155
Section 2.1	What are your responsibilities?.....	155

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 Braille, in large print, or other alternate formats, etc.)
--

To get information from us in a way that works for you, please call Member Services (phone numbers are 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 large print, or other alternate formats if you need it. If you are eligible for Medicare because of disability, we are required to give you information about the plan's benefits that is accessible and appropriate for you.

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

Section 1.2 We must treat you with fairness and respect at all times
--

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 Member Services (phone numbers are on the cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Section 1.3 We must ensure that you get timely access to your covered services and drugs
--

As a member of our plan, you have the right to choose a provider in the plan's network to provide and arrange for your covered services (Chapter 6 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are on the cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from the plan's network of providers *within a reasonable amount of time*. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or drugs within a reasonable amount of time, Chapter 12 of this booklet tells what you can do.

Section 1.4	We must protect the privacy of your personal health information
--------------------	--

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

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

How do we protect the privacy of your health information?

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

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

You have the right to look at your medical records held at the plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will 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 Member Services (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 coverage or expenses. For example, we may use your protected health information to process claims, to be reimbursed by another insurer that may be responsible for payment or for premium billing.
- **Health Care Operations.** We use and disclose your protected health information in order to perform our plan activities, such as quality assessment activities or administrative activities, including data management or Member Services.
- **Treatment.** We may use and disclose your protected health information to assist your health care providers (doctors, pharmacies, hospitals and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.
- **Plan Sponsor.** If you are enrolled through a group health plan, we may provide non-identifiable summaries of claims and expenses for enrollees in your group health plan to the plan sponsor, which is usually the employer.

If the plan sponsor provides plan administration services, we may also provide access to identifiable health information to support its performance of such services which may include but are not limited to claims audits or Member Services functions. Health Net will only share health information upon a certification from the plan sponsor representing there are

restrictions in place to ensure that only plan sponsor employees with a legitimate need to know will have access to health information in order to provide plan administration functions.

We may also disclose protected health information to a person, such as a family member, relative, or close personal friend, who is involved with your care or payment. We may disclose the relevant protected health information to these persons if you do not object or we can reasonably infer from the circumstances that you do not object to the disclosure; however, when you are not present or are incapacitated, we can make the disclosure if, in the exercise of professional judgment, we believe the disclosure is in your best interest.

Other permitted or required disclosures

- **As Required by Law.** We must disclose protected health information about you when required to do so by law.
- **Public Health Activities.** We may disclose protected health information to public health agencies for reasons such as preventing or controlling disease, injury or disability.
- **Victims of Abuse, Neglect or Domestic Violence.** We may disclose protected health information to government agencies about abuse, neglect or domestic violence.
- **Health Oversight Activities.** We may disclose protected health information to government oversight agencies (e.g., California Department of Health Services) for activities authorized by law.
- **Judicial and Administrative Proceedings.** We may disclose protected health information in response to a court or administrative order. We may also disclose protected health information about you in certain cases in response to a subpoena, discovery request or other lawful process.
- **Law Enforcement.** We may disclose protected health information under limited circumstances to a law enforcement official in response to a warrant or similar process; to identify or locate a suspect; or to provide information about the victim of a crime.
- **Coroners, Funeral Directors, Organ Donation.** We may release protected health information to coroners or funeral directors as necessary to allow them to carry out their duties. We may also disclose protected health information in connection with organ or tissue donation.
- **Research.** Under certain circumstances, we may disclose protected health information about you for research purposes, provided certain measures have been taken to protect your privacy.
- **To Avert a Serious Threat to Health or Safety.** We may disclose protected health information about you, with some limitations, when necessary to prevent a serious threat to your health and safety or the health and safety of the public or another person.

- **Special Government Functions.** We may disclose information as required by military authorities or to authorized federal officials for national security and intelligence activities.
- **Workers' Compensation.** We may disclose protected health information to the extent necessary to comply with state law for workers' compensation programs.

Other Uses or Disclosures with an Authorization

Other uses or disclosures of your protected health information will be made only with your written authorization unless otherwise permitted or required by law. You may revoke an authorization at any time in writing, except to the extent that we have already taken action on the information disclosed or if we are permitted by law to use the information to contest a claim or coverage under the Plan.

Your rights regarding your protected health information

You have certain rights regarding protected health information that the Plan maintains about you.

- **Right to Access Your Protected Health Information.** You have the right to review or obtain copies of your protected health information records, with some limited exceptions. Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.
- **Right to Amend Your Protected Health Information.** If you feel that protected health information maintained by the Plan is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by the Plan, as is often the case for health information in our records, or you ask to amend a record that is already accurate and complete.

If we deny your request to amend, we will notify you in writing. You then have the right to submit to us a written statement of disagreement with our decision and we have the right to rebut that statement.

- **Right to an Accounting of Disclosures by the Plan.** You have the right to request an accounting of disclosures we have made of your protected health information. The list will not include our disclosures related to your treatment, our payment or health care operations, or disclosures made to you or with your authorization. The list may also exclude certain other disclosures, such as for national security purposes.

Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you

request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.

- **Right to Request Restrictions on the Use and Disclosure of Your Protected Health Information.** You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. *We may not agree to your request.* If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.
- **Right to Receive Confidential Communications.** You have the right to request that we use a certain method to communicate with you about the Plan or that we send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.
- **Right to a Paper Copy of This Notice.** You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.
- **Contact Information for Exercising Your Rights.** You may exercise any of the rights described above by contacting our Privacy Office. See the end of this Notice for the contact information.

Health information security

Health Net requires its employees to follow the Health Net security policies and procedures that limit access to health information about members to those employees who need it to perform their job responsibilities. In addition, Health Net maintains physical, administrative and technical security measures to safeguard your protected health information.

Changes to this notice

We reserve the right to change the terms of this Notice at any time, effective for protected health information that we already have about you as well as any information that we receive in the future. We will provide you with a copy of the new Notice whenever we make a material change to the privacy practices described in this Notice. We also post a copy of our current Notice on our website at www.healthnet.com/uc. Any time we make a material change to this Notice, we will promptly revise and issue the new Notice with the new effective date.

Complaints

If you believe that your privacy rights have been violated, you may file a complaint with us and/or with the Secretary of the Department of Health and Human Services. All complaints to the Plan must be made in writing and sent to the Privacy Office listed at the end of this Notice.

We support your right to protect the privacy of your protected health information. ***We will not retaliate against you or penalize you for filing a complaint.***

***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, please contact:

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 providers, and your covered services

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 large print or other alternate formats)

If you want any of the following kinds of information, please call Member Services (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 Advantage health plans.
- **Information about our network providers including our network pharmacies.**
 - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
 - For a list of the providers in the plan's network, see the Provider Directory.
 - For a list of the pharmacies in the plan's network, see the *Pharmacy Directory*.
 - For more detailed information about our providers or pharmacies, you can visit our website at www.healthnet.com/uc or call Member Services (phone numbers are on the back cover of this booklet).

- **Information about your coverage and rules you must follow in using your coverage.**
 - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
 - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 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 Member Services (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 medical service or 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 medical service or drug from an out-of-network provider or pharmacy.
 - If you are not happy or if you disagree with a decision we make about what medical care or 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 12 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 12 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
 - If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 10 of this booklet.

Section 1.6	We must support your right to make decisions about your care
--------------------	---

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices *in a way that you can understand*.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say “no”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 12 of this booklet tells how to ask the plan for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

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

- Fill out a written form to give **someone the legal authority to make medical decisions for you** if you ever become unable to make decisions for yourself.
- **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. You can also contact Member Services to ask for the forms (phone numbers are on the cover of this booklet).
- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. 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 your local Office for Civil Rights.

Office for Civil Rights
U.S. Department of Health & Human Services
90 7th Street, suite 4-100
San Francisco, CA 94103

The telephone number is 1-415-437-8310.

Section 1.7	You have the right to make complaints and to ask us to reconsider decisions we have made
--------------------	---

If you have any problems or concerns about your covered services or care, Chapter 12 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 9, what you need to do to follow up on a problem or concern depends on the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – **we are required to treat you fairly.**

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Member Services (phone numbers are 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?
--------------------	--

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 Member Services** (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 5, 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 Member Services** (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 5 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 Member Services (phone numbers are on the cover of this booklet). We're here to help.

- ***Get familiar with your covered services and the rules you must follow to get these covered services. Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.***
 - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
 - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.

- ***If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us. Please call Member Services to let us know.***
 - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called “**coordination of benefits**” because it involves coordinating the health and drug benefits you get from our plan with any other health and drug benefits available to you. We’ll help you with it.
- ***Tell your doctor and other health care providers that you are enrolled in our plan. Show your plan membership card whenever you get your medical care or 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.
- ***Be considerate. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor’s office, hospitals, and other offices.***
- ***Pay what you owe. As a plan member, you are responsible for these payments:***
 - You must pay your plan premiums to continue being a member of our plan.
 - In order to be eligible for our plan, you must maintain your eligibility for Medicare Part A and Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of the plan.
 - For some of your medical services or drugs covered by the plan, you must pay your share of the cost when you get the service or drug. This will be a copayment or coinsurance (a percentage of the total cost). Chapter 3 tells what you must pay for your prescription drugs.
 - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
- ***Tell us if you move. If you are going to move, it’s important to tell us right away. Call Member Services (phone numbers are on the cover of this booklet).***
 - **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 Member Services for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.***
 - Phone numbers and calling hours for Member Services are on the cover of this booklet.
 - For more information on how to reach us, including our mailing address, please see Chapter 5.

**Chapter 12. What to do if you have a problem or complaint
(coverage decisions, appeals, complaints)**

SECTION 1	Introduction.....	161
Section 1.1	What to do if you have a problem or concern.....	161
Section 1.2	What about the legal terms?.....	161
SECTION 2	You can get help from government organizations that are not connected with us	162
Section 2.1	Where to get more information and personalized assistance.....	162
SECTION 3	To deal with your problem, which process should you use?	162
Section 3.1	Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?.....	162
SECTION 4	A guide to the basics of coverage decisions and appeals.....	164
Section 4.1	Asking for coverage decisions and making appeals: the big picture	164
Section 4.2	How to get help when you are asking for a coverage decision or making an appeal	164
SECTION 5	Your medical care: How to ask for a coverage decision or make an appeal	165
Section 5.1	This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care	165
Section 5.2	Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)	167
Section 5.3	Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)	169
Section 5.4	Step-by-step: How to make a Level 2 Appeal	172
Section 5.5	What if you are asking our plan to pay you for our share of a bill you have received for medical care?.....	173

SECTION 6	Your Part D prescription drugs: How to ask for a coverage decision or make an appeal	175
Section 6.1	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	175
Section 6.2	What is an exception?	176
Section 6.3	Important things to know about asking for exceptions	177
Section 6.4	Step-by-step: How to ask for a coverage decision, including an exception	178
Section 6.5	Step-by-step: How to make a Level 1 Appeal for a Part D drug (how to ask for a review of a coverage decision made by our plan)	181
Section 6.6	Step-by-step: How to make a Level 2 Appeal	183
SECTION 7	How to ask us to cover a longer hospital stay if you think the doctor is discharging you too soon	185
Section 7.1	During your hospital stay, you will get a written notice from Medicare that tells about your rights	185
Section 7.2	Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date	186
Section 7.3	Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date	189
Section 7.4	What if you miss the deadline for making your Level 1 Appeal?	190
SECTION 8	How to ask us to keep covering certain medical services if you think your coverage is ending too soon	193
Section 8.1	<i>This section is about three services:</i> Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services	193
Section 8.2	We will tell you in advance when your coverage will be ending	194
Section 8.3	Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time	195
Section 8.4	Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time	197

Section 8.5	What if you miss the deadline for making your Level 1 Appeal?	198
SECTION 9	Taking your appeal to Level 3 and beyond.....	201
Section 9.1	Levels of Appeal 3, 4, and 5 for Medical Service Appeals	201
Section 9.2	Levels of Appeal 3, 4, and 5 for Part D Drug Appeals.....	202
SECTION 10	How to make a complaint about quality of care, waiting times, Member Services, or other concerns.....	203
Section 10.1	What kinds of problems are handled by the complaint process?.....	203
Section 10.2	The formal name for “making a complaint” is “filing a grievance”	206
Section 10.3	Step-by-step: Making a complaint.....	206
Section 10.4	You can also make complaints about quality of care to the Quality Improvement Organization	208
	Appeals Procedures for your Employer-Sponsored Benefits	208
	Appeals Procedures for your Employer-Sponsored Benefits	217

SECTION 1 Introduction

Section 1.1 What to do if you have a problem or concern

This chapter explains two types of processes for handling problems and concerns:

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

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

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

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

Section 1.2 What about the legal terms?

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 simpler 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 "organization determination" or "coverage determination," and "Independent Review Organization" instead of "Independent

Review Entity." It also uses abbreviations as little as possible.

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

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 with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with 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.

The services of SHIP counselors are free. You will find phone numbers in Chapter 5, 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?

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 coverage?

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

Yes

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

No

Skip ahead to **Section 10** 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

The process for coverage decisions and making appeals deals with problems related to your benefits and coverage for medical services and prescription drugs, including problems related to payment. This is the process you use for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or drugs. We make a coverage decision for you whenever you go to a doctor for medical care. You can also contact the plan and ask for a coverage decision. For example, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

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

In some cases we might decide the service or drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

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

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. 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

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You **can call us at Member Services** (phone numbers are 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).

- **Your doctor or other provider can make a request for you.** Your doctor or other provider can request a coverage decision or a Level 1 Appeal on your behalf. To request any appeal after Level 1, your doctor or other provider must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal.
 - There may be someone who is already legally authorized to act as your representative under State law.
 - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services 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 medical care: 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.

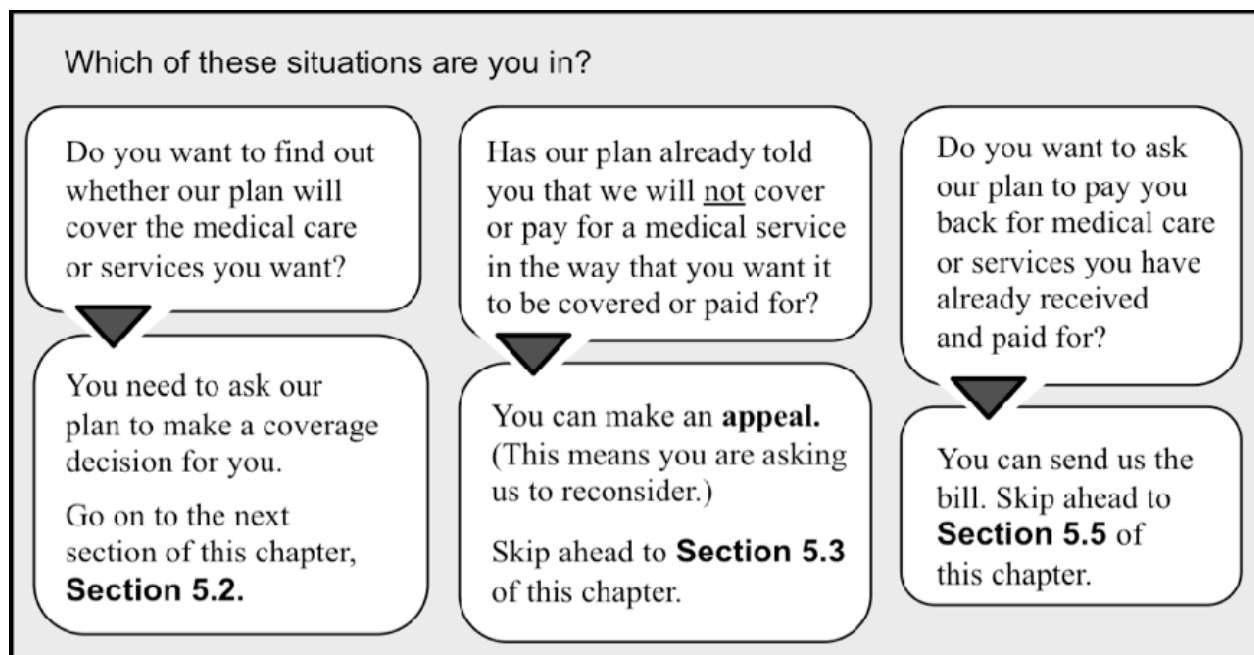
Section 5.1	This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care
--------------------	--

This section is about your benefits for medical care and services. These are the benefits described in Chapter 3, Section 1 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*. To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time. This section tells what you can do if you are in any of the five following situations:

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.
2. Our plan will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by the plan.

3. You have received medical care or services that you believe should be covered by the plan, but we have said we will not pay for this care.
4. You have received and paid for medical care or services that you believe should be covered by the plan, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care you have been getting will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

- **NOTE: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services,** you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:
 - Chapter 9, Section 7: The "*How to ask for a longer hospital stay if you think you are being asked to leave the hospital too soon*" portion of the The What to do if you have a problem or complaint (coverage decisions, appeals, complaints), section of this booklet.
 - Chapter 9, Section 8: The "*How to ask our plan to keep covering certain medical services if you think your coverage is ending too soon*" portion of the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)". This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.
- For *all other* situations that involve being told that medical care you have been getting will be stopped, see "Your medical care: How to ask for a coverage decision or make an appeal" portion in this section (Section 5) as your guide for what to do.



Section 5.2	Step-by-step: How to ask for a coverage decision (how to ask our plan to authorize or provide the medical care coverage you want)
--------------------	---

Legal Terms	When a coverage decision involves your medical care, it is called an “organization determination.”
--------------------	---

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a **“fast decision.”**

Legal Terms	A “fast decision” is called an “expedited decision.”
--------------------	---

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to provide coverage for the medical care you want. You, or your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 5, Section 1 and look for the section called, *How to contact our plan when you are asking for a coverage decision about your medical care.*

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. **A standard decision means we will give you an answer within 14 days** after we receive your request.

- **However, we can take up to 14 more days** if you ask for more time, or if we need information (such as medical records) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

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

- **A fast decision means we will answer within 72 hours.**
 - **However, we can take up to 14 more days** if we find that some information is missing that may benefit you, or if you need to get information to us for the review. If we decide to take extra days, we will tell you in writing.

- If you believe we should *not* take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.) We will call you as soon as we make the decision.
- **To get a fast decision, you must meet two requirements:**
 - You can get a fast decision only if you are asking for coverage for medical care *you have not yet received*. (You cannot get a fast decision if your request is about payment for medical care you have already received.)
 - 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 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 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 asks for the fast decision, we will automatically give a fast decision.
 - The letter will also tell how you can file a “fast complaint” about our decision to give you a standard decision instead of the fast decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 of this chapter.)

Step 2: Our plan considers your request for medical care coverage and we give you our answer.

Deadlines for a “fast” coverage decision

- Generally, for a fast decision, we will give you our answer **within 72 hours**.
 - As explained above, we can take up to 14 more days under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing. If we take extra days, it is called “an extended time period.”
 - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

Deadlines for a “standard” coverage decision

- Generally, for a standard decision, we will give you our answer **within 14 days of receiving your request.**
 - We can take up to 14 more days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing.
 - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells how to make an appeal.
- **If our answer is yes to part or all of what you requested,** we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period.
- **If our answer is no to part or all of what you requested,** we will send you a written statement that explains why we said no.

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

- If our plan says no, you have the right to ask us to reconsider – and perhaps change – this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3 Step-by-step: How to make a Level 1 Appeal
(how to ask for a review of a medical care coverage decision made by our plan)

**Legal
Terms**

When you start the appeal 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 medical care coverage decision is called a plan “**reconsideration.**”

Step 1: You contact our plan and make your appeal. If your health requires a quick response, you must ask for a “**fast appeal.**”

What to do

- **To start an appeal you, your representative, or in some cases your doctor must contact our plan.** For details on how to reach us for any purpose related to

your appeal, go to Chapter 5, Section 1 look for section called, *How to contact us when you are making an appeal about your medical care.*

- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a signed request.**
- **If you are asking for a fast appeal, make your appeal in writing or call us at the phone number shown in the “Important phone numbers and resources” section of this booklet.**
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
 - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
 - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a “fast appeal” (you can make an oral request)

Legal Terms	A “fast appeal” is also called an “expedited appeal.”
------------------------	---

- If you are appealing a decision our plan made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal.”
- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast decision.” To ask for a fast appeal, follow the instructions for asking for a fast decision. (These instructions are given earlier in this section.)
- *If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal.*

Step 2: 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 request for coverage of medical care. We check to see if we were following all the rules when we said no to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a “fast” appeal

- When we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires us to do so.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, we **can take up to 14 more calendar days**. If we decide to take extra days to make the decision, we will tell you in writing.
 - If we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Deadlines for a “standard” appeal

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
 - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days**.
 - If we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.
- **If our answer is no to part or all of what you requested**, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

Step 3: If our plan says no to your appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your appeal, **our plan is required to send your appeal to the “Independent Review Organization.”**

When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4 Step-by-step: How to make a Level 2 Appeal

If our plan says no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision 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. ”
--------------------	---

Step 1: The Independent Review Organization reviews your appeal.

- **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 handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your “case file.” **You have the right to ask us for a copy of your case file.** 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.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

If you had a “fast” appeal at Level 1, you will also have a “fast” appeal at Level 2

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

If you had a “standard” appeal at Level 1, you will also have a “standard” appeal at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at level 2. the review organization must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal.
- However, if the Independent Review Organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days.**

Step 2: The Independent Review Organization gives you their answer.

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- **If the review organization says yes to part or all of what you requested**, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization.
- **If this organization says no to part or all of your appeal**, it means they agree with our plan that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
 - The notice you get from the Independent Review Organization will tell you in writing if your case meets the requirements for continuing with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final.

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 5.5	What if you are asking our plan to pay you for our share of a bill you have received for medical care?
--------------------	---

If you want to ask our plan for payment for medical care, start by reading Chapter 10 of this booklet: *Asking the plan to pay its share of a bill you have received for covered services or drugs*. Chapter 10. This section describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from our plan

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see Chapter 4: *Medical Benefits Chart (what is covered and what you pay)*). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 6 of this booklet: *Using the plan's coverage for your medical services*).

We will say yes or no to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or, if you haven't paid for the services, we will send the payment directly to the provider. When we send the payment, it's the same as saying *yes* to your request for a coverage decision.)
- If the medical care is *not* covered, or you did *not* follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why. (When we turn down your request for payment, it's the same as saying *no* to your request for a coverage decision.)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe in part 5.3 of this section. Go to this part for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days.

SECTION 6 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 6.1	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
--------------------	--

Your benefits as a member of our plan include coverage for many outpatient prescription 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 3 (*Plan benefit charts*), Chapter 8 (*Using our plan’s coverage for your Part D prescription drugs*) and Chapter 9 (*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. ”
--------------------	--

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 6.2 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.**”

- For 3 tier plan: 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.
- For 2 tier plan: 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 2*.
- If we agree to make an exception and cover Part D , you cannot ask for an exception to the copayment or co-insurance amount we require you to pay for the drug

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 8 and look for Section 5).

Legal Terms

Asking for removal of a restriction on coverage for a drug is sometimes called asking for a “**formulary exception.**”

- The extra rules and restrictions on coverage for certain drugs include:
 - *Being required to use the generic version* of a drug instead of the brand-name drug.

- **Getting plan approval in advance** before we will agree to cover the drug for you. (This is sometimes called “prior authorization.”)
- **Being required to try a different drug first** before we will agree to cover the drug you are asking for. (This is sometimes called “step therapy.”)
- **Quantity limits**. For some drugs, there are restrictions on the amount of the drug you can have.
- If 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. (this type of exception only applies to Part D drugs) Every drug on the plan’s Drug List is in one of five 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.”
--------------------	---

3-tier plan

- 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**

2-tier plan

- If your drug is in **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 6.3	Important things to know about asking for exceptions
--------------------	---

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a 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 6.5 tells how to make an appeal if we say no.

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

Section 6.4	Step-by-step: How to ask for a coverage decision, including an exception
--------------------	---

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 5, 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 10 of this booklet: *Asking the plan to pay its share of a bill you have received for covered services or drugs*. Chapter 10 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 6.2 and 6.3 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. ”
------------------------	---

- 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 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 10 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 about a drug you have not yet received

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

Deadlines for a “standard” coverage decision about payment for a drug you have already bought

- We must give you our answer **within 14 calendar days** after we receive your request.
 - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2.
 - **If our answer is yes to part or all of what you requested**, we are also required to make payment to you within 14 calendar days after we receive your request.
- **If our answer is no to part or all of what you requested**, we will send you a written statement that explains why we said no.

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

- If 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 6.5	Step-by-step: How to make a Level 1 Appeal for a Part D drug (how to ask for a review of a coverage decision made by our plan)
--------------------	--

Legal Terms	<p>When you start the appeals process by making an appeal, it is called the “first level of appeal” or a “Level 1 Appeal.”</p> <p>An appeal to the plan about a Part D drug coverage decision is called a plan “redetermination.”</p>
--------------------	--

Step 1: You contact our plan and make your Level 1 Appeal for a Part D drug. If your health requires a quick response, you must ask for a “**fast appeal.**”

What to do

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact 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 5, 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.*
- **If you are asking for a standard appeal, you make your appeal by submitting a written request.**
- **If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown in “Important phone numbers and resources” of this booklet, (How to contact our plan when you are making an appeal about your prescription drugs).**
- **You must make your appeal request within 60 calendar days** from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.
- **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. ”
------------------------	--

- 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 6.4 of this chapter.

Step 2: Our plan considers your appeal for a Part D drug and we give you our answer.

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

Deadlines for a “fast” appeal

- If we are using the fast deadlines, we must give you our answer **within 72 hours after we receive your appeal**. We will give you our answer sooner if your health requires it.
 - If we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process.
- **If our answer is yes to part or all of what you requested**, we must provide the coverage we have agreed to provide within 72 hours after we receive your approval.
- **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 for a Part D drug, 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 6.6	Step-by-step: How to make a Level 2 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 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. ”
--------------------	---

Step 1: To make a Level 2 Appeal for a Part D drug, you must contact the Independent Review Organization and ask for a review of your case.

- If 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 for a Part D drug 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 for a Part D drug?

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

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you 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 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7 How to ask us to cover a longer hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about the plan's coverage for your hospital care, including any limitations on this coverage, see Chapter 3, Section 1 of this booklet: *Medical Benefits Chart (what is covered and what you pay)*. During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your “**discharge date**.” Our plan's coverage of your hospital stay ends on this date.
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

<h3>Section 7.1 During your hospital stay, you will get a written notice from Medicare that tells about your rights</h3>
--

During your hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital is supposed to give it to you within two days after you are admitted.

- 1. Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:
 - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
 - Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
 - Where to report any concerns you have about quality of your hospital care.
 - What to do if you think you are being discharged from the hospital too soon.

Legal Terms

The written notice from Medicare tells you how you can “**make an appeal.**” Making an appeal is a formal, legal way to ask for a delay in your discharge date so that your hospital care will be covered for a longer time. (Section 7.2 below tells how to make this appeal.)

2. You must sign the written notice to show that you received it and understand your rights.

- You or someone who is acting on your behalf must sign the notice. (Section 4 of this chapter tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice **does not mean** you are agreeing on a discharge date.

3. Keep your copy of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.

- If you sign the notice more than 2 days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged.
- To look at a copy of this notice in advance, you can call Member Services or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at <http://www.cms.hhs.gov>

Section 7.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your hospital services to be covered by our plan for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Legal Terms	When you start the appeal process by making an appeal, it is called the “first level of appeal” or a “Level 1 Appeal.”
--------------------	--

Step 1: Contact the Quality Improvement Organization in your state and ask for a “fast review” of your hospital discharge. You must act quickly.

Legal Terms	A “fast review” is also called an “ immediate review ” or an “ expedited review. ”
--------------------	--

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the Federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare.

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 5, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization *before* you leave the hospital and **no later than your planned discharge date.** (Your “planned discharge date” is the date that has been set for you to leave the hospital.)
 - If you meet this deadline, you are allowed to stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision on your appeal from the Quality Improvement Organization.
 - If you do *not* meet this deadline, and you decide to stay in the hospital after your planned discharge date, *you may have to pay all of the costs* for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Ask for a “fast review”:

- You must ask the Quality Improvement Organization for a “**fast review**” of your discharge. Asking for a “fast review” means you are asking for the organization to use the “fast” deadlines for an appeal instead of using the standard deadlines.

**Legal
Terms**

A “fast review” is also called an “immediate review” or an “expedited review.”

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish.
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and our plan has given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives your planned discharge date and explains the reasons why your doctor, the hospital, and our plan think it is right (medically appropriate) for you to be discharged on that date.

**Legal
Terms**

This written explanation is called the “Detailed Notice of Discharge.” You can get a sample of this notice by calling Member Services or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.) Or you can get see a sample notice online at <http://www.cms.hhs.gov/BNI/>

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

- If the review organization says *yes* to your appeal, **our plan must keep providing your covered hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 3 of this booklet).

What happens if the answer is no?

- If the review organization says *no* to your appeal, they are saying that your planned discharge date is medically appropriate. (Saying *no* to your appeal is also called *turning down* your appeal.) If this happens, **our plan’s coverage for your hospital services will end** at noon on the day *after* the Quality Improvement Organization gives you its answer to your appeal.

- If the review organization says no to your appeal and you decide to stay in the hospital, then **you may have to pay the full cost** of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to “Level 2” of the appeals process.

Section 7.3	Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date
--------------------	--

If the Quality Improvement Organization has turned down your appeal, *and* you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 calendar days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 calendar days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

If the review organization says yes:

- **Our plan must reimburse you** for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. **Our plan must continue providing coverage** for your hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

If the review organization says no:

- It means they agree with the decision they made to your Level 1 Appeal and will not change it. This is called “upholding the decision.” It is also called “turning down your appeal.”
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to our plan instead

As explained above in Section 7.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. (“Quickly” means before you leave the hospital and no later than your planned discharge date). If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, *the first two levels of appeal are different.*

Step-by-Step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our plan, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Legal Terms	A “fast” review (or “fast appeal”) is also called an “ expedited ” review (or “ expedited appeal ”).
--------------------	--

Step 1: Contact our plan and ask for a “fast review.”

- For details on how to contact our plan, go to Chapter 5, Section 1 and look for the section called, *How to contact our plan when you are making an appeal about your medical care.*
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

Step 2: Our plan does a “fast” review of your planned discharge date, checking to see if it was medically appropriate.

- During this review, our plan takes a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: Our plan gives you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- **If our plan says yes to your fast appeal**, it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If our plan says no to your fast appeal**, we are saying that your planned discharge date was medically appropriate. Our coverage for your hospital services ends as of the day we said coverage would end.
- If you stayed in the hospital *after* your planned discharge date, then **you may have to pay the full cost** of hospital care you received after the planned discharge date.

Step 4: If our plan says *no* to your fast appeal, your case will *automatically* be sent on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **our plan is required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 Alternate Appeal

If our plan says no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the “Independent Review Organization” is the “Independent Review Entity.” It is sometimes called the “IRE.”
--------------------	---

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 10 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an 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 handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- **If this organization says *yes* to your appeal,** then our plan must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue the plan’s coverage of your hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with our plan that your planned hospital discharge date was medically appropriate. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8 How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1	<i>This section is about three services:</i> Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services
--------------------	--

This section is about the following types of care *only*:

- **Home health care services** you are getting.

- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a “skilled nursing facility,” see Chapter 12, *Definitions of important words*.)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually, this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, *Definitions of important words*” section in this booklet.)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 3, Section 1 of this booklet: *Medical Benefits Chart* (what is covered and what you pay)” section in this booklet.

When our plan decides it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, ***our plan will stop paying its share of the cost for your care.***

If you think we are ending the coverage of your care too soon, **you can appeal or decision.** This section tells you how to ask.

Section 8.2 We will tell you in advance when your coverage will be ending

1. **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice.
 - The written notice tells you the date when our plan will stop covering the care for you.

Legal Terms

In this written notice, we are telling you about a “**coverage decision**” we have made about when to stop covering your care. (For more information about coverage decisions, see Section 4 in this chapter.)

- The written notice also tells what you can do if you want to ask our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms

In telling what you can do, the written notice is telling how you can “**make an appeal.**” Making an appeal is a formal, legal way to ask our plan to change the coverage decision we have made about when to stop your care. (Section 8.3 below tells how you can make an appeal.)

Legal Terms

The written notice is called the “**Notice of Medicare Non-Coverage.**” To get a sample copy, call Member Services or 1-800-MEDICARE (1-800-633-4227, 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.). Or see a copy online at <http://www.cms.hhs.gov/BNI/>

2. You must sign the written notice to show that you received it.

- You or someone who is acting on your behalf must sign the notice. (Section 4 tells how you can give written permission to someone else to act as your representative.)
- Signing the notice shows *only* that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with the plan that it’s time to stop getting the care.

Section 8.3	Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time
--------------------	--

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 of this chapter tells you how to file a complaint.)
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Legal Terms

When you start the appeal process by making an appeal, it is called the “first level of appeal” or “Level 1 Appeal.”

Step 1: Make your Level 1 Appeal: contact the Quality Improvement Organization in your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the Federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care.

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 5, Section 4, of this booklet.)

What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for our plan to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal ***no later than noon of the day after you receive the written notice telling you when we will stop covering your care.***
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 8.4.

Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers informed our plan of your appeal, you will also get a written notice from the plan that gives our reasons for wanting to end the plan's coverage for your services.

**Legal
Terms**

This notice explanation is called the
“Detailed Explanation of Non-Coverage.”

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

What happens if the reviewers say yes to your appeal?

- If the reviewers say *yes* to your appeal, then **our plan must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 3 of this booklet).

What happens if the reviewers say no to your appeal?

- If the reviewers say *no* to your appeal, then **your coverage will end on the date we have told you.** Our plan will stop paying its share of the costs of this care.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* this date when your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal.

- This first appeal you make is “Level 1” of the appeals process. If reviewers say *no* to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal.
- Making another appeal means you are going on to “Level 2” of the appeals process.

Section 8.4	Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time
--------------------	--

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review.

- You must ask for this review **within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

What happens if the review organization says yes to your appeal?

- **Our plan must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **Our plan must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

What happens if the review organization says no?

- It means they agree with the decision they made to your Level 1 Appeal and will not change it. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to our plan instead

As explained above in Section 9.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, *the first two levels of appeal are different*.

Step-by-Step: How to make a Level 1 Alternate Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our plan, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms	A “fast” review (or “fast appeal”) is also called an “ expedited ” review (or “ expedited appeal ”).
--------------------	--

Step 1: Contact our plan and ask for a “fast review.”

- For details on how to contact our plan, go to Chapter 5, Section 1 and look for the section called, *How to contact our plan when you are making an appeal about your medical care.*
- **Be sure to ask for a “fast review.”** This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines.

Step 2: Our plan does a “fast” review of the decision we made about when to stop coverage for your services.

- During this review, our plan takes another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending the plan’s coverage for services you were receiving.
- We will use the “fast” deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a “fast review,” we are allowed to decide whether to agree to your request and give you a “fast review.” But in this situation, the rules require us to give you a fast response if you ask for it.)

Step 3: Our plan gives you our decision within 72 hours after you ask for a “fast review” (“fast appeal”).

- **If our plan says yes to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If our plan says no to your fast appeal,** then your coverage will end on the date we have told you and our plan will not pay after this date. Our plan will stop paying its share of the costs of this care.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would your coverage ends, then **you will have to pay the full cost** of this care yourself.

Step 4: If our plan says *no* to your fast appeal, your case will *automatically* go on to the next level of the appeals process.

- To make sure we were following all the rules when we said no to your fast appeal, **our plan is required to send your appeal to the “Independent Review Organization.”** When we do this, it means that you are *automatically* going on to Level 2 of the appeals process.

Step-by-Step: How to make a Level 2 *Alternate Appeal*

If our plan says no to your Level 1 Appeal, your case will *automatically* be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision our plan made when we said no to your “fast appeal.” This organization decides whether the decision we made should be changed.

Legal Terms	The formal name for the “Independent Review Organization” is the “Independent Review Entity.” It is sometimes called the “IRE.”
--------------------	---

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. Section 1 of this chapter tells how to make a complaint.)

Step 2: The Independent Review Organization does a “fast review” of your appeal. The reviewers give you an answer within 72 hours.

- **The Independent Review Organization is an 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 handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says yes to your appeal,** then our plan must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says no to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it. (This is called “upholding the decision.” It is also called “turning down your appeal.”)
 - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further.

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9 Taking your appeal to Level 3 and beyond

Section 9.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals

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

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

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

<p>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.”</p>

- **If the Administrative Law Judge says yes, to your appeal, the appeals process *may* or *may not* be over** - We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the judge’s decision.
 - If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.
- **If the Administrative Law Judge says no, to your appeal the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.
 -

<p>Level 4 Appeal The Medicare Appeals Council will review your appeal and give you</p>
--

an answer. The Medicare Appeals Council works for the Federal government.

- **If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process *may* or *may not* be over -** We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
 - If we decide *not* to appeal the decision, we must authorize or provide you with the service within 60 days after receiving the Medicare Appeals Council’s decision.
 - If we decide to appeal the decision, we will let you know in writing.
- **If the answer is no or if the Medicare Appeals Council denies the review request, the appeals process *may* or *may not* be over.**
 - If you decide to accept this decision that turns down your appeal, the appeals process is over.
 - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal A judge at the **Federal District Court** will review your appeal.

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

Section 9.2 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 law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

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

- **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved.
- **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. 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 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 10 How to make a complaint about quality of care, waiting times, Member Services, 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 10.1 What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems *only*. This includes problems related to quality of care,

waiting times, and the Member Services you receive. Here are examples of the kinds of problems handled by the complaint process.

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

Quality of your medical care

- Are you unhappy with the quality of the care you have received (including care in the hospital)?

Respecting your privacy

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

Disrespect, poor customer service, or other negative behaviors

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

Waiting times

- Are you having trouble getting an appointment, or waiting too long to get it?
- Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by Member Services or other staff at our plan?
- Examples include waiting too long on the phone, in the waiting room, in the exam room, or when getting a prescription.

Cleanliness

- Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

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 understand?

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

Possible complaints (continued)

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

The process of asking for a coverage decision and making appeals is explained in sections 4-9 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 medical services or 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 10.2	The formal name for “making a complaint” is “filing a grievance”
---------------------	---

Legal Terms	<ul style="list-style-type: none"> • 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 10.3	Step-by-step: Making a complaint
---------------------	---

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

Usually, **calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. **1-800-539-4072** Calls to this number are free. Hours of Operation: 8:00 am to 8:00 p.m., Pacific Time, seven days a week. TTY: **1-800-929-9955.**

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

You or your representative may contact us at the above phone number to make a complaint about your medical care or Part D prescription drugs. We will try to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or if your complaint is related to quality of care, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this the Grievance procedure.** To make a complaint – or if you have questions about this procedure – please call Member Services at the phone number in Chapter 5 of this booklet. Or you may send or fax us a written request to the address or fax number listed under Appeals & Grievances for Medicare Prescription Drugs in Chapter 5 of this booklet.

You need to file your complaint within 60 calendar days after the event. We can give you more time if you have a good reason for missing the deadline. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.

In certain cases, you have the right to ask for a fast review of your grievance. This is called the Expedited Grievance procedure. You are entitled to a fast review of your complaint if you disagree with our decision in the following circumstances:

- We deny your request for a fast review of a request for medical care or Part D drugs.
- We deny your request for a fast review of an appeal of denied services or Part D drugs.
- We decide additional time is needed to review your request for medical care or Part D drugs.
- We decide additional time is needed to review your appeal of denial medical care or Part D drugs.

You may submit this type of complaint telephonically at the Member Services number shown in Section 2. You may also submit the complaint in writing or via facsimile to us at the address or fax number listed under Appeals & Grievances for Medicare Prescription Drugs in Chapter 5 of this booklet. Once the expedited grievance is received by us, a Clinical Practitioner will review the case to determine the circumstances surrounding the denial of your request for a fast review or if the case extension was appropriate. You will be notified of the outcome of the fast case orally and in writing within 24 hours of initial receipt of the case.

If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have.

- **Whether you call or write, you should contact Member Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a “fast 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.”
------------------------	---

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more 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 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to 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 5, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to our plan and also to the Quality Improvement Organization.

Appeals Procedures for your Employer-Sponsored Benefits

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

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

STEP 1: The Initial Decision

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

STEP 2: Appealing the Initial Decision

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an "**Appeal**." You can file the Appeal by calling Health Net Member Services Department at **1-800-539-4072** or by sending information to:

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

We will:

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

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

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

If you are not satisfied with the outcome of your Appeal in Step 2, you can request for an independent review organization to review your case. This organization will review your request and make a decision about whether we must give you the care or payment you want. You may call Health Net Member Services Department at **1-800-539-4072** to request the independent review or by sending the request to:

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

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

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

STEP 4: Binding Arbitration

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

Chapter 13. Ending your membership in the plan

How we may use and disclose your protected health information	147
Other permitted or required disclosures.....	148
Other Uses or Disclosures with an Authorization.....	149
Your rights regarding your protected health information	149
Health information security	150
Changes to this notice	150
Complaints	150
Contact the plan	151
Section 1.1 This chapter focuses on ending your membership in our plan	213
SECTION 2 When can you end your membership in our plan?	213
Section 2.1 You can end your membership during the Annual Enrollment Period.....	213
Section 2.2 In certain situations, you can end your membership during a Special Enrollment Period	214
Section 2.3 Where can you get more information about when you can end your membership?	214
SECTION 3 How do you end your membership in our plan?.....	215
Section 3.1 Usually, you end your membership by enrolling in another plan.....	215
SECTION 4 Until your membership ends, you must keep getting your medical services and drugs through our plan	216
Section 4.1 Until your membership ends, you are still a member of our plan.....	216
SECTION 5 We must end your membership in the plan in certain situations	216
Section 5.1 When must we end your membership in the plan?.....	216
Section 5.2 We <u>cannot</u> ask you to leave our plan for any reason related to your health.....	217

Section 5.3	You have the right to make a complaint if we end your membership in our plan	217
Section 7.2	Steps You Must Take.....	222
Section 7.3	How The Amount Of your Reimbursement Is Determined.....	223

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 medical care 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 and during the Medicare Advantage Open Enrollment Period. In certain situations, you may also be eligible to leave the plan at other times of the year.

Section 2.1 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	In certain situations, you can end your membership during a Special Enrollment Period
--------------------	--

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

- **Who is eligible for a Special Enrollment Period?** If any of the following situations apply to you, you are eligible to end your membership during a Special Enrollment Period. These are just examples, for the full list you can contact the plan, call Medicare, or visit the Medicare website (<http://www.medicare.gov>):
 - Usually, when you have moved.
 - If you have 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 Advantage plan. (You can choose a plan that covers prescription drugs or one that does not cover prescription drugs.)
 - Original Medicare *with* a separate Medicare prescription drug plan.
 - – *or* – Original Medicare *without* a separate Medicare prescription drug plan.

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 2.3	Where can you get more information about when you can end your membership?
--------------------	---

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

- You can **call Member Services** (phone numbers are on the cover of this booklet).
- You can find the information in the *Medicare & You 2011* 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	Usually, you end your membership by enrolling in another plan
--------------------	--

Usually, to end your membership in our plan, you simply enroll in another health plan during one of the enrollment periods (see Section 2 for information about the enrollment periods). 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 Plans Member Services and ask to be disenrolled from our plan.

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 Advantage plan. 	<ul style="list-style-type: none"> ● Enroll in the new Medicare Advantage plan. <p>You will automatically be disenrolled from our plan when your new plan’s coverage begins.</p>
<ul style="list-style-type: none"> ● Original Medicare <i>with</i> a separate Medicare prescription drug plan. 	<ul style="list-style-type: none"> ● Enroll in the new Medicare prescription drug plan. <p>You will automatically be disenrolled from our plan when your new plan’s coverage begins.</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 Member Services and ask to be disenrolled from the plan (phone numbers are on the cover of this booklet).

If you would like to switch from our plan to:

This is what you should do:

- You can also contact **Medicare**, at 1-800-MEDICARE (1-800-633-4227) 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call 1-877-486-2048.
- You will be disenrolled from our when your coverage in Original Medicare begins.

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

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave your 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 medical care and prescription drugs through our plan.

- **You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends.** Usually, your prescription drugs are only covered if they are filled at a network pharmacy including through our mail-order pharmacy services.
- **If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged** (even if you are discharged after your new health coverage begins).

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 and Part B.

- 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 Member Services to find out if the place you are moving or traveling to is in our plan's area.
- If you become incarcerated.
- 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 medical care for you and other members of our plan.
 - We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get medical care.
 - 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.

Section 5.2	We <u>cannot</u> ask you to leave our plan for any reason related to your health
--------------------	---

What should you do if this happens?

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

Section 5.3	You have the right to make a complaint if we end your membership in our plan
--------------------	---

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 10 for information about how to make a complaint.

Appeals Procedures for your Employer-Sponsored Benefits
--

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

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

STEP 1: The Initial Decision

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

STEP 2: Appealing the Initial Decision

If you disagree with the decision we make in Step 1, you may ask us to reconsider our decision. This is called an "**Appeal.**" You can file the Appeal by calling Health Net Member Services Department at **1-800-539-4072** or by sending information to:

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

We will:

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

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

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

If you are not satisfied with the outcome of your Appeal in Step 2, you can request for an independent review organization to review your case. This organization will review your request and make a decision about whether we must give you the care or payment you want. You may

call Health Net Member Services Department at **1-800-539-4072** to request the independent review or by sending the request to:

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

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

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

STEP 4: Binding Arbitration

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

Chapter 14. Legal notices

SECTION 1

Notice about governing law221

SECTION 2

Notice about nondiscrimination.....221

SECTION 3

Health Care Plan Fraud.....222

SECTION 4

Circumstances Beyond Health Net's Control.....222

SECTION 5

When A Third Party Causes A Member Injuries.....222

SECTION 6

Binding Arbitration.....224

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 Membership card

A membership card issued by Health Net under this Evidence of Coverage is for identification purposes only. Possession of a membership card does not confer any right to services or other benefits under this Evidence of Coverage. To be entitled to services or benefits under this Evidence of Coverage, the holder of the card must be eligible for coverage and be a member under this Evidence of Coverage. Any person receiving services to which he or she is not then entitled under this Evidence of Coverage will be responsible for payment for those services. A Member must present their Health Net membership card, not their Medicare card, when receiving services. Please call Member Services at the number located on the back cover of this booklet if you need your membership card replaced.

Note: Any member knowingly permitting abuse or misuse of the membership card may be disenrolled for cause. Health Net is required to report a disenrollment that results from membership card abuse or misuse to the Office of the Inspector General, which may result in criminal prosecution.

Section 4 Independent contractors

The relationship between Health Net and each participating provider is an independent contractor relationship. Participating providers are not employees or agents of Health Net and neither Health Net, nor any employee of Health Net, is an employee or agent of a participating provider. In no case will Health Net be liable for the negligence, wrongful act, or omission of any participating or other health care provider. Participating physicians, and not Health Net, maintain the physician-patient relationship with the member. Health Net is not a provider of care.

SECTION 5 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 6 Circumstances beyond Health Net's control

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

SECTION 7 When a third party causes a member injuries

If you are ever injured through the actions of another person (a third party), Health Net will provide benefits for all covered services that you receive under this *Evidence of Coverage*. However, if you receive any money from a third party because of your injuries, you must reimburse Health Net for the value of any medications provided to you by Health Net. 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 7.2 Steps You Must Take
--

Health Net's legal right to reimbursement is called a lien. If you are injured because of the actions of a third party, you must cooperate with Health Net'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.
- Responding promptly to inquiries from Health Net about the status of the case and any settlement discussions.
- Notifying Health Net immediately when you or your lawyer receives any money from a third party or their insurance company.

- Holding any money that you or your lawyer receives from a third party or their insurance company in trust, and reimbursing Health Net for the amount of the lien as soon as you are paid by the third party.

Section 7.3 How The Amount Of your Reimbursement Is Determined

Your reimbursement to Health Net under this lien is based on the value of the covered services you receive and the costs of perfecting this lien. For purposes of determining the lien amount, the value of the covered services depends on how the provider was paid and will be determined as permitted by law. Unless the money that you receive came from a workers' compensation claim amount of the reimbursement that you owe Health Net 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.
- be reduced by a pro rata share for any legal fees or costs that you paid from the money you received.
- 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.

SECTION 8 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.

SECTION 9 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.

SECTION 9 Contact the plan

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

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

You may also contact us at:

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

SECTION 9 Binding Arbitration

This bind arbitration provision does not apply to disputes that are subject to the Medicare appeals process as described in the section ‘What to do if you have a problem or complaint (coverage decisions, appeals, complaints?’.

Sometimes disputes or disagreements may arise between you (including your enrolled Family Members, heirs or personal representatives) and Health Net regarding the construction, interpretation, performance or breach of this Evidence of Coverage or regarding other matters relating to or arising out of your Health Net membership. Typically such disputes are handled and resolved through the Health Net Grievance, Appeal and Independent Medical Review process described above. However, in the event that a dispute is not resolved in that process, Health Net uses binding arbitration as the final method for resolving all such disputes, whether stated in tort, contract or otherwise, and whether or not other parties such as employer groups, health care providers, or their agents or employees, are also involved. In addition, disputes with Health Net involving alleged professional liability or medical malpractice (that is, whether any medical services rendered were unnecessary or unauthorized or were improperly, negligently or incompetently rendered) also must be submitted to binding arbitration.

As a condition to becoming a Health Net Member, you agree to submit all disputes you may have with Health Net, except those described below, to final and binding arbitration. Likewise, Health Net agrees to arbitrate all such disputes. This mutual agreement to arbitrate disputes means that both you and Health Net are bound to use binding arbitration as the final means of

resolving disputes that may arise between the parties, and thereby the parties agree to forego any right they may have to a jury trial on such disputes. However, no remedies that otherwise would be available to either party in a court of law will be forfeited by virtue of this agreement to use and be bound by Health Net's binding arbitration process. This agreement to arbitrate shall be enforced even if a party to the arbitration is also involved in another action or proceeding with a third party arising out of the same matter.

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

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

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

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

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

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

Effective July 1, 2002, Members who are enrolled in an employer's plan that is subject to ERISA, 29 U.S.C. § 1001 et seq., a federal law regulating benefit plans, are not required to submit disputes about certain "adverse benefit determinations" made by Health Net to mandatory binding arbitration. Under ERISA, an "adverse benefit determination" means a decision by

Health Net to deny, reduce, terminate or not pay for all or a part of a benefit. However, you and Health Net may voluntarily agree to arbitrate disputes about these "adverse benefit determinations" at the time the dispute arises.

Chapter 15. 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 12 explains appeals, including the process involved in making an appeal.

Benefit Period – For both our plan and Original Medicare, a benefit period is used to determine coverage for inpatient stays in hospitals and skilled nursing facilities. A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or a skilled nursing facility. The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 days in a row. If you go to the hospital (or SNF) after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods you can have.

The type of care that is covered depends on whether you are considered an inpatient for hospital and SNF stays. You must be admitted to the hospital as an inpatient, not just under observation. You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both.

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 \$4550.00 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs Medicare. Chapter 5 explains how to contact CMS.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services including physician's services, physical therapy, social or psychological services, and outpatient rehabilitation.

Cost-Sharing – Cost-sharing refers to amounts that a member has to paying addition to the plan's premium when services or drugs are received. It includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs or services are covered; (2) any fixed "copayment" amounts that a plan requires when a specific services or drugs is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug, that a plan requires when a specific service or drug is received.

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

Coverage Determination – A decision about whether a medical service or drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the service or 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.

Covered Services – The general term we use to mean all of the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to 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.

Custodial Care – Care for personal needs rather than medically necessary needs. Custodial care is care that can be provided by people who don't have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Medicare does not cover custodial care unless it is provided as other care you are getting in addition to daily skilled nursing care and/or skilled rehabilitation services.

Deductible – The amount you must pay before our plan begins to pay its share of your covered medical services or drugs.

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).

Durable Medical Equipment – Certain medical equipment that is ordered by your doctor for use in the home. Examples are walkers, wheelchairs, or hospital beds.

Emergency Care – Covered services that are: 1) rendered by a provider qualified to furnish emergency services; and 2) needed to evaluate or stabilize an emergency medical condition.

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

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a 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 providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

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

Initial Coverage Stage – This is the stage after you have met your deductible (if applicable to your plan) and before your total drug expenses have reached *the initial coverage limit* as described in the “What you pay for your prescription drugs” section in this booklet, including amounts you've paid and what our plan has paid on your behalf.

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.

Medicaid (or Medical Assistance) – A joint Federal and State program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See the “Important phone numbers and resources” section in this booklet for information about how to contact Medicaid in your state.

Medical Group - A group of Physicians, who are organized as a legal entity, that has an agreement in effect with our plan to provide medical care to our members.

Medically Necessary – Drugs, services, or supplies that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for 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). People with Medicare can get their Medicare health coverage through Original Medicare or a Medicare Advantage plan.

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 Medicare Advantage plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) 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 Coverage Gap Discount Program – A program that provides discounts on most covered Part D brand name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving “Extra Help.” Discounts are based on agreements between the Federal government and certain drug manufacturers. For this reason, most, but not all, brand name drugs are discounted.

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

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

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

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 5 for information about how to contact Member Services.

Network Pharmacy – A network pharmacy is a pharmacy where members of our Plan can get their prescription drug benefits. We call them “network pharmacies” because they contract with

our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Provider – “Provider” is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the State to provide health care services. We call them “**network providers**” when they accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as “plan providers.”

Organization Determination – The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services.

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

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

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our Plan. Out-of-network providers are providers that are not employed, owned, or operated by our Plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 6.

Out-of-Pocket Costs – See the definition for “cost-sharing” above. A member’s cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member’s “out-of-pocket” cost requirement.

Out-of-Pocket Maximum – The maximum amount that you pay out-of-pocket during the calendar year, usually at the time services are received, for covered Part A (Hospital Insurance) and Part B (Medical Insurance) services. Plan premiums and Medicare Part A and Part B premiums do not count toward the out-of-pocket maximum.

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.

Primary Care Physician (PCP) – A health care professional you select to coordinate your health care. Your PCP is responsible for providing or authorizing covered services while you are a plan member. See the “Using the plan’s coverage for your medical services” section of this booklet as it tells more about PCPs.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan. Covered services that need prior authorization are marked in the Benefits Chart in Chapter 4. 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 5 for information about how to contact the QIO in your state and Chapter 12 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.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

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.

Skilled Nursing Facility (SNF) Care – A level of care in a SNF ordered by a doctor that must be given or supervised by licensed health care professionals. It may be skilled nursing care, or skilled rehabilitation services, or both. Skilled nursing care includes services that require the skills of a licensed nurse to perform or supervise. Skilled rehabilitation services are physical therapy, speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment, such as how to use a walker or get in and out of a wheelchair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to perform usual daily activities, such as eating and dressing by yourself.

Special Needs Plan – A special type of Medicare Advantage plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

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

Supplemental Security Income (SSI) – A monthly benefit paid by 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.

Urgently Needed Care – Urgently needed care is a non-emergency situation when you need medical care right away because of an illness, injury, or condition that you did not expect or anticipate, but your health is not in serious danger.



Health Net Medicare Programs
Post Office Box 10198
Van Nuys, California, 91410-0198.

Member Services 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 Hearing and Speech impaired
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
1.800.275.4737
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.

WWW.HEALTHNET.COM/UC

EOCID 304576