EVIDENCE OF COVERAGE

A complete explanation of your plan

Health Net Prescription Drug Plan (Employer Group PDP) - UC

For University of California Medicare members in Madera, Nevada or Ventura Counties

Effective 1/1/2012

Important benefit information – please read

Schedule changes in 2012

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

- **For all covered Part D drugs and covered non-Part D drugs that are listed on the Formulary, beginning January 1, 2012, you will receive additional coverage for these drugs under your supplemental pharmacy benefit. Please refer to your Commercial Pharmacy Plan Certificate of Insurance for coverage and benefit information for these drugs. This combined benefit ensures your copayment is always consistent with UC's plan design. You will experience NO change in the way you receive your drugs or the copays that you pay. A Certificate will arrive under separate cover.**

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

January 1, 2012

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

ELIGIBILITY

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

Subscriber

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

* Lecturers - see your benefits office for eligibility.

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

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

You may continue University medical plan coverage as a Retiree when you start collecting retirement or disability benefits from a University-sponsored defined benefit Plan 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 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, court documentation confirming a child's status as a legal ward Federal Income Tax Return, or other official documentation.

Eligible Adult: You may enroll one eligible adult Family Member, in addition to yourself

Spouse: Your legal spouse.

Domestic Partner:

You may enroll your same-sex domestic partner if your partnership is registered with the State of California or otherwise meets criteria as a domestic partnership as set forth in the University of California Group Insurance Regulations. Same-sex domestic partners from jurisdictions other than California will be covered to the extent required by law. You may enroll your opposite-sex domestic partner only if either you or your domestic partner is age 62 or older and eligible to receive Social Security benefits based on age. Your domestic partner (same-sex or opposite sex) must be at least 18 years of age.

Note: An adult dependent relative is not eligible for coverage in UC plans (unless enrolled prior to December 31, 2003 and continuously eligible and enrolled since that date [e.g., continues to be ineligible for Medicare PartA)].

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 unmarried, 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 unmarried, 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 for support and maintenance (50% or more); and
- the child is claimed as your, your spouse's, 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 , adoption, or domestic partnership), 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: The University complies with federal and state law in administering its group insurance programs. Health and welfare benefits and eligibility requirements, including dependent eligibility requirements are subject to change (e.g., for compliance with applicable laws and regulations). The University also complies with federal and state income tax laws which are subject to change. Requirements may include laws mandating that the employer contribution for coverage provided to certain Family Members be treated as imputed income to the Employee. See At Your Service online for related information. Contact your tax advisor for additional information.

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 if you are enrolling with paper 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) For a legal ward, the effective date of the legal guardianship
(f) 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

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. Coverage under another health plan for you and/or your eligible Family Members ended because you/they lost eligibility under the other plan or employer contributions toward coverage under the other plan terminated, your coverage under COBRA or Cal-COBRA continuation was exhausted, or coverage under CHIP or Medicaid was lost because you/they 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 in the UC-sponsored medical coverage 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 if you are enrolling with paper forms.

3. A court has ordered coverage be provided for a dependent child under your UC-sponsored medical plan pursuant to applicable law and an application is filed within the PIE which begins the date the court order is issued. The child 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.

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). 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 and continue 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 deenrolled 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 deenrolled from this health plan.

Medicare Secondary Payer Law (MSP)

The Medicare Secondary Payer (MSP) Law affects the order in which claims are paid by Medicare and an employer group health plan. 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.

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 monthly retirement payments covered by a University-sponsored defined benefit plan, your coverage and that of any enrolled Family Member stops at the end of the last month in which you are eligible for the retirement income.

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

Contract Termination

Coverage under the Plan is terminated when the group contract between the University and the Plan Vendor is terminated. Benefits will cease to be provided as specified in the contract and you may have to pay for the cost of those benefits yourself. You may be entitled to continued benefits under terms which are specified elsewhere in this document. (If you apply for an individual HIPAA or conversion plan, the benefits may not be the same as you had under this Plan.)

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 applicable 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 the President of the University (or his/her delegates) is the 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 91410-0198
1-800-539-4072

Group Contract Number

The Group Contract Number for this Plan is: 5047RD, H, N, S, W, 5047SA, E, K, P, T, X, 5047TD, J, N, T, Y, 5047UD, H, P, U, Z, 5047VD, J

Type of Plan

This Plan provides group medical care benefits. This Plan is one of the benefit plans offered under the University of California Health and Welfare Programs for eligible Faculty and Staff.

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 Standardized Contract .

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 Standardized Contract , 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.

Evidence of Coverage:

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

This booklet gives you the details about your Medicare prescription drug coverage for your 2012 benefit period. It explains how to get the prescription drugs you need covered. This is an important legal document. Please keep it in a safe place.

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

This plan, Health Net Prescription Drug Plan (Employer Group PDP), is offered by Health Net Life Insurance Company. (When this *Evidence of Coverage* says "we," "us," or "our," it means Health Net Life Insurance Company. When it says "plan" or "our plan," it means Health Net Prescription Drug Plan (Employer PDP).

A stand-alone prescription drug plan with a Medicare contract.

Member Services has free language interpreter services available for non-English speakers (phone numbers are on the back cover of this booklet).

This information is also available in a different format, including large print and audio tape, or non-English translations. Please call Member Services if you need plan information in another format (phone numbers are on the back cover of this booklet).

Benefits, formulary, pharmacy network, premium and/or copayments/coinsurance may change for the 2013 plan year.

Material ID # S5678_EG_2012_0010 Compliance Approved 08042011

Plan PWZ

Plan Benefit Chart

Deductible Stage

This plan does not have a deductible. You move directly into the Initial Coverage Stage.

Initial Coverage Stage

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

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 tier your drug is in. Please note:

If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay *either* the full price of the drug *or* the copayment amount, *whichever is lower*.

We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see the "When can you use a pharmacy that is not in the plan's network?" portion of the "Using the plan's coverage for your prescription drugs" section of this booklet for information about when we will cover a prescription filled at an out-of-network pharmacy.

You will pay the following for your covered prescription drugs when you are in the initial coverage stage:

Drug Tier	Network Retail Pharmacy (30-day supply)	Network Retail Pharmacy (90-day Supply)	Preferred Mail-Order Pharmacy or UC Walk-Up Service (90-day supply)	Non-Preferred Mail-Order Pharmacy (90-day supply)	Network long-term care pharmacy (up to a 34-day supply)	Out of Network Retail Pharmacy (30-day supply)
Tier 1 (Includes preferred generic drugs)	$5	$15	$10	$15	$5	$5
Tier 2 (Includes preferred brand drugs.)	$20	$60	$40	$60	$20	$20
Tier 3 (Includes non-preferred brand drugs.)	$35	$105	$70	$105	$35	$35
Tier 4 (Includes injectable drugs that do not meet the Centers for Medicare & Medicaid Services (CMS) minimum cost threshold required to be placed on Specialty Tier (Tier 5). These drugs may be limited to a maximum 30-day supply per fill.)	25%	25%	25%	25%	25%	25%
Tier 5 (Includes high cost drugs. Some of these drugs may be limited to a maximum 30-day supply per fill. Specialty Tier (Tier 5) drugs are not eligible for exceptions for payment at a lower tier.)	25%	25%	25%	25%	25%	25%

Once your total Part D drug costs reach$2,930, you will reach your **initial coverage limit**. Your initial coverage limit is calculated by adding payments made by this Plan and you. If other individuals, organizations, current or former employer/union, and another insurance plan or policy help pay for your drugs under this Plan, the amount they spend may count towards your initial coverage limit. When you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

Coverage Gap Stage

During the Coverage Gap Stage, you are eligible to receive a discount on covered Part D brand name and generic drugs

After your total Part D drug costs reach $2,930, you, or others on your behalf, will receive the following discounts for covered Part D drugs:

- **Generic Part D drugs:** 14% of the drug cost
- **Brand Name Part D drugs eligible for a discount as determined by Medicare:** A 50% discount off of the drug cost (excluding the dispensing fee and vaccine administration fee, if any).

For more information on these discounts, see the "Medicare Coverage Gap Discount Program" portion below.

In addition to the Medicare Coverage Gap Discounts, your Employer Group or Benefits Administrator is also providing additional supplementary coverage to your benefit during the Coverage Gap stage for covered Part D drugs. This means that with these discounts and the supplemental coverage, you will generally pay the same amount (your copayment or coinsurance) for your covered drugs as stated in the Initial Coverage Stage.

For all other covered Drugs (not Part D Drugs) you continue to pay your copayment or coinsurance.

Medicare Coverage Gap Discount Program

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on covered Part D brand name drugs. You receive a 50% discount of the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) for covered Part D brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You are also eligible to receive a discount for covered Part D generic drugs. You receive a 14% discount of the cost for covered Part D generic drugs. For covered Part D generic drugs, only the amount you pay counts and moves you through the coverage gap.

You continue receving these discounts for covered Part D brand name and Part D generic drugs until your yearly out-of-pocket payments reach $2,000.

In addition to the Medicare Coverage Gap Discounts, your Employer Group or Benefits Administrator is also providing additional supplementary coverage to your benefit during the Coverage Gap stage for covered Part D drugs. This means that with these discounts and the supplemental coverage, you will generally pay the same amount (your copayment or coinsurance) for your covered drugs as stated in the Initial Coverage Stage. See the "Plan Benefit Chart" at the beginning of this section that tells what you pay for drugs during the Initial Coverage Stage.

Out-of-Pocket Maximum for Outpatient Prescription Drugs

There is a yearly out-of-pocket maximum of $2,000 for covered outpatient prescription drugs. Once your out-of-pocket costs for covered outpatient prescription drugs (excluding Part B drugs and products) reach $2,000 in the calendar year, you will not pay any more copayment/coinsurance for covered outpatient prescription drugs for the rest of the year. All expenses that apply to the $2,000 out-of-pocket maximum will automatically be calculated by Health Net.

Catastrophic Coverage Stage

Because your plan has an out-of-pocket maximum of $2,000, this stage does not apply to you. After your out-of-pocket costs reach $2,000, you pay no copayments or coinsurance for all covered drugs for the remainder of the year.

Additional Information

- When there is a generic version of a brand name drug available, our network pharmacies will usually dispense the generic version.
- We offer additional coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards your total out of pocket costs (that is, the amount you pay does not help you move through the benefit or qualify for catastrophic coverage).
- Part D prescription drugs for the treatment of diabetes (including insulin) are covered as stated in the formulary.
- Your provider must get prior authorization from Health Net for certain prescription drugs. Contact Health Net for details.
- Prescription drugs for sexual and erectile dysfunction are limited to 4 doses per month.

Table of Contents

GETTING STARTED AS A MEMBER

Introduction

You are enrolled in Health Net Prescription Drug Plan (Employer PDP) which is a Medicare Prescription Drug Plan

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

There are different types of Medicare plans. Health Net Prescription Drug Plan (Employer PDP) is a Medicare prescription drug plan (PDP). Like all Medicare plans, this Medicare prescription drug plan is approved by Medicare and run by a private company.

What is the *Evidence of Coverage* booklet about?

This *Evidence of Coverage* booklet tells you how to get your Medicare prescription drug coverage through our plan. This booklet explains your rights and responsibilities, what is covered, and what you pay as a member of the plan.

This plan, Health Net Prescription Drug Plan (Employer PDP), is offered by Health Net Life Insurance Company. (When this Evidence of Coverage says "we," "us," or "our," it means Health Net Life Insurance Company. When it says "plan" or "our plan," it means Health Net Prescription Drug Plan (Employer PDP).)

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

What does this section tell you?

Look through this section of the *Evidence of Coverage* to learn:

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

What if you are new to our plan?

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

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

Legal information about the *Evidence of Coverage*

It's part of our contract with you

This *Evidence of Coverage* is part of our contract with you about how our plan covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs (Formulary)*, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The contract is in effect for months in which you are enrolled in our plan.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. 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.

What makes you eligible to be a plan member?

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

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

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 institutional 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) and certain items (such as durable medical equipment and supplies).

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 remain a member of our plan, you must keep living in this service area. The service area is described below.

Our service area includes:

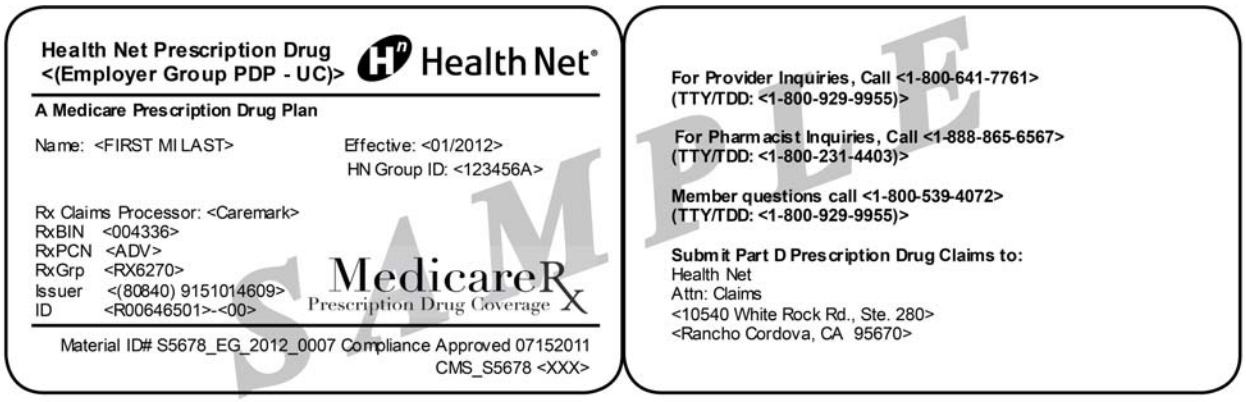
Madera, Nevada, and Ventura Counties

If you plan to move out of the service area, please contact Member Services. When you move, you will have a Special Enrollment Period that will allow you to enroll in a Medicare health or drug plan that is available in your new location.

What other materials will you get from us?

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

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



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

You may need to use your red, white, and blue Medicare card to get covered medical care and services under Original Medicare.

The *Pharmacy Directory*: Your guide to pharmacies in our network

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

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.

If you don't have the *Pharmacy Directory*, you can get a copy from Member Services (phone numbers are on the back cover of this booklet). 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.

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

The Drug List also tells you if there are any rules that restrict coverage for your drugs.

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

The *Explanation of Benefits* (the "EOB"): Reports with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary 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* (or the "EOB").

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. The "What you pay for your prescription drugs" section 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.

Your monthly premium for our plan

How much is your plan premium?

Please see your Group or Benefits Administrator for information about the premium payment for this plan.

In addition, you must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

In some situations, your plan premium could be <u>less</u>

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. The "Information about programs to help people pay for their prescription drugs" portion of the "Important phone numbers and

resources," section 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, **the information about premiums in this *Evidence of Coverage* may not apply to you**. We send you 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 of this booklet.

In some situations, your plan premium could be more

These situations are described below.

- Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, you must pay an extra amount for your Medicare Part D coverage. If you have to pay an extra amount, the Social Security Administration, not your Medicare plan, will send you a letter telling you what that extra amount will be. For more information about Part D premiums based on income go to the "Do you have to pay an extra Part D amount because of your income?" portion of the "What you pay for your prescription drugs" section of this booklet. You can also 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. Or 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 have "creditable" prescription drug coverage. ("Creditable" means the drug coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug 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. The "Do you have to pay the Part D 'late enrollment penalty'?" portion of the "What you pay for your prescription drugs" section 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. Please contact your Employer Group or Benefit Administrator for information about your plan premium.

Many members are required to pay other Medicare premiums

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 Part D plan premium.

- Your copy of *Medicare & You 2012* gives information about these premiums in the section called "2012 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 2012* 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.

What to do if you are having trouble paying your plan premium

If you are having trouble paying your premium on time, please contact Member Services to see if we can direct you to programs that will help with your plan premium.

Can your monthly plan premium change 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 the Extra Help program or if you lose your eligibility for the Extra Help program during the year. If a member qualifies for Extra Help with their prescription drug costs, the Extra Help program 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 the Extra Help program in the "Information about programs to help people pay for their prescription drugs" portion of the "Important phone numbers and resources" section of this *Evidence of Coverage.*

Please keep your plan membership record up to date

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

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

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

Call Member Services to let us know about these changes or contact the University of California Benefits Customer 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 medical or drug insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid)
- If you have any liability claims, such as claims from an automobile accident
- If you have been admitted to a nursing home
- If your designated responsible party (such as a caregiver) changes

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. (For more information about how our coverage works when you have other insurance, see the "How other insurance works with our plan" portion in this section.)

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 back cover of this booklet).

How other insurance works with our plan

Which plan pays first when you have other insurance?

When you have other insurance (like employer group health coverage), there are rules set by Medicare that decide whether our plan or your other insurance pays first. The insurance that pays first is called the "primary payer" and pays up to the limits of its coverage. The one that pays second, called the "secondary payer," only pays if there are costs left uncovered by the primary coverage. The secondary payer may not pay all of the uncovered costs.

These rules apply for employer or union group health plan coverage:

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends on your age, the size of the employer, and whether you have Medicare based on age, disability, or End-stage Renal Disease (ESRD):

  - If you're under 65 and disabled and you or your family member is still working, your plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
  - If you're over 65 and you or your spouse is still working, the plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.

- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

These types of coverage usually pay first for services related to each type:

- No-fault insurance (including automobile insurance)
- Liability (including automobile insurance)
- Black lung benefits
- Workers' compensation

Medicaid and TRICARE never pay first for Medicare-covered services. They only pay after Medicare, employer group health plans, and/or Medigap have paid.

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are on the back cover of this booklet.) You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.

We protect the privacy of your personal health information

We make sure that your health information is protected

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.

For more information about how we protect your personal health information, please go to the "We must protect the privacy of your personal health information"portion of the "Your rights and responsibilities" section in this booklet.

IMPORTANT PHONE NUMBERS AND RESOURCES

Our plan 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 Health Net Prescription Drug Plan (Employer PDP - UC) Member Services. We will be happy to help you.

Member Services	
CALL	**1-800-539-4072** Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. During the Medicare annual enrollment period (between October 15 and December 7) through February 14, our plan operates a toll-free call center for both current and prospective members that is staffed seven days a week from 8:00 a.m. to 8:00 p.m. Pacific time. During this time period, current and prospective members are able to speak with a Member Service representative. If you call outside these hours, when leaving a message, you should include your name, phone number and the time you called, and a representative will return your call no later than one business day after you leave a message. However, after February 14, 2012, your call will be handled by our automated phone system, Saturdays, Sundays, and holidays. When leaving a message, please include your name, phone number and the time that you called, and a representative will return your call no later than one business day after you leave a message Member Services also has free language interpreter services available for non-English speakers.
TTY/TDD	**1-800-929-9955** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.

FAX	**1-888-268-2393**
WRITE	Health Net Medicare P.O. Box 6501 Rensselaer, NY 12144-6501
WEBSITE	www.healthnet.com/uc

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Part D prescription drugs. For more information on asking for coverage decisions 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.

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

Coverage Decisions for Prescription Drugs	
CALL	**1-800-539-4072** Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
TTY/TDD	**1-800-929-9955** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	**1-916-463-9754**
WRITE	Health Net Pharmaceutical Services Attn: Pharmacy Service Center 10540 White Rock Road, Suite 280 Rancho Cordova, CA 95670
WEBSITE	www.healthnet.com/uc

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

An appeal is a formal way of asking us to review and change a coverage decision we have made. 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.

Appeals for Prescription Drugs	
CALL	**1-800-539-4072** Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
TTY/TDD	**1-800-929-9955** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	**1-800-977-1959**
WRITE	Health Net Appeals & Grievances Department P.O. Box 10450 Van Nuys, CA 91410-0450
WEBSITE	www.healthnet.com/uc

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

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint 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.

Complaints about prescription drugs	
CALL	**1-800-539-4072** Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
TTY/TDD	**1-800-929-9955** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week
FAX	**1-800-977-1959**
WRITE	Health Net Appeals & Grievances Department P.O. Box 10450 Van Nuys, CA 91410-0450

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

The coverage determination process includes determining requests that asks us to pay for our share of the costs of a drug that you have received. For more information on situations in which you may need to ask the plan for reimbursement or to pay a bill you have received from a provider, see the "Asking us to pay our share of the cost for covered drugs" section of this *Evidence of Coverage*.

Payment Requests	
CALL	**1-800-539-4072** Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
TTY/TDD	**1-800-929-9955** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	**1-916-463-9754**

WRITE	Health Net Pharmaceutical Services Attn: Claims 10540 White Rock Road, Suite 280 Rancho Cordova, CA 95670
WEBSITE	www.healthnet.com/uc

Medicare
(How to get help and information directly from the Federal Medicare program)

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

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

Medicare	
CALL	1-800-MEDICARE, or 1-800-633-4227 Calls to this number are free. 24 hours a day, 7 days a week.
TTY	1-877-486-2048 This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.

WEBSITE	http://www.medicare.gov 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. You can also find Medicare contacts in your state by selecting "Help and Support" and then clicking on "Useful Phone Numbers and Websites." The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. Select "Find Out if You're Eligible." • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select "Health & Drug Plans" and then "Compare Drug and Health Plans" or "Compare Medigap Policies." These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans. 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.

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. You can find contact information for the SHIP in your state in Exhibit 4 "State Health Insurance Assistance Program (SHIP)," located at the end of this *Evidence of Coverage*. You may also find the website for your local SHIP at www.medicare.gov under "Help and Support" by selecting "Useful Phone Numbers and Websites."

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

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

can also help you understand your Medicare plan choices and answer questions about switching plans.

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. You can find contact information for the QIO in your state in Exhibit 1 "Quality Improvement Organization (QIO)," located at the end of this *Evidence of Coverage*.

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

You should contact the QIO if you have a complaint about the quality of care you have received. For example, you can contact your state's QIO if you were given the wrong medication or if you were given medications that interact in a negative way.

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. 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 Social Security's 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

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.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These programs help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost sharing (like deductibles, coinsurance, and copayments).
- **Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI):** Helps pay Part B premiums.

- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, refer to Exhibit 5 located at the end of this *Evidence of Coverage* for a list of state Medicaid programs.

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 (if applicable to your plan), and Part D prescription copayments and coinsurance. 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 in this section.)

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 Part D 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.

- Call Member Services at the number on the back cover of this booklet and tell the representative that you think you qualify for extra help (Best Available Evidence). You may be required to provide one of the following types of documentation:
    - 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, call Member Services at the number on the back cover of this booklet and tell the representative that you believe you qualify for extra help. You may be required to provide one of the following types of documentation:

- 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.

If you are unable to provide the documentation described above and you believe that you may qualify for extra help, call Member Services at the number on the back cover of this booklet and a representative will assist you.

- 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 Part D 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

The Medicare Coverage Gap Discount Program provides manufacturer discounts on Part D brand name drugs to Part D enrollees who have reached the coverage gap threshold and are not already receiving "Extra Help." A discount on the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) is available for those Part D brand name drugs from manufacturers that have agreed to pay the discount.

If you reach the coverage gap threshold, we will automatically apply the discount when your pharmacy bills you for your prescription. Your *Explanation of Benefits (EOB)* will show any discount provided. Both the amount you pay and 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.

You are also eligible to receive a discount for covered Part D generic drugs. You receive a 14% discount of the cost for covered Part D generic drugs. For covered Part D generic drugs during the Coverage Gap Stage, only the amount you pay counts and moves you through the coverage gap.

You continue receving these discounts for covered Part D brand name drugs and Part D generic drugs until your yearly out-of-pocket payments reach $2,000.

In addition to the Medicare Coverage Gap Discounts, your Employer Group or Benefits Administrator is also providing additional supplementary coverage to your benefit during the Coverage Gap stage for covered drugs. This means that with these discounts and the supplemental coverage, you will generally pay the same amount (your copayment or coinsurance) for your covered drugs as stated in the Initial Coverage Stage.

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 of this booklet).

What if you have coverage from a State Pharmaceutical Assistance Program (SPAP)?

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than Extra Help), you still get the 50% discount on covered brand name drugs. The 50% discount is applied to the price of the drug before any SPAP or other coverage.

What if you get Extra Help from Medicare to help pay your prescription drug costs? Can you get the discounts?

No. If you get Extra Help, you already get coverage for your prescription drug costs during the coverage gap.

What if you don’t get a discount, and you think you should have?

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand name drug, you should review your next *Explanation of Benefits* (EOB) notice. If the discount doesn’t appear on your *Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don’t agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Exhibit 4 at the end of this *Evidence of Coverage*) or by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

State Pharmaceutical Assistance Programs

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

These programs provide limited income and medically needy seniors and individuals with disabilities financial help for prescription drugs.

You can contact the SPAP in your state. Please refer to Exhibit 2 at the end of this *Evidence of Coverage* to locate the Qualified SPAP(s) in your state.

How to contact the Railroad Retirement Board

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

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

USING THE PLAN'S COVERAGE FOR YOUR PRESCRIPTION DRUGS

?

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

There are programs to help people with limited resources pay for their Part D drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see the "Information about programs to help people pay for their prescription drugs" portion of the "Important phone numbers and resources" section of this booklet.

Are you currently getting help to pay for your Part D drugs?

If you are in a program that helps pay for your Part D drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We send you 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 Part D 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 of this booklet.

Introduction

This section describes your coverage for drugs

This section of the *Evidence of Coverage* explains rules for using your coverage for drugs. The next section of this booklet, "What you pay for your prescription drugs," and the "Plan Benefit Chart" at the beginning of this booklet tells what you pay for drugs.

In addition to your coverage for Part D drugs, our plan covers some drugs not covered by Part D. These drugs are included on our Drug List.

Original Medicare (Medicare Part A and Part B) also covers some drugs:

- Medicare Part A covers drugs you are given during Medicare-covered stays in the hospital or in a skilled nursing facility.

- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility.

The two examples of drugs described above are covered by Original Medicare. (To find out more about this coverage, see your *Medicare & You* Handbook.) Your Part D prescription drugs are covered under our plan.

This section of the *Evidence of Coverage* explains rules for using your coverage for drugs under our plan. The next section of this booklet, "What you pay for your prescription drugs," and the "Plan Benefit Chart" at the beginning of this booklet tell what you pay for drugs.

Basic rules for the plan's drug coverage

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

- You must have a provider (a doctor or other prescriber) write your prescription
- You must use a network pharmacy to fill your prescription. (See the next portion of this section, "Fill your prescriptions at a network pharmacy or through the plan's mail-order service.")
- Your drug must be on the plan's *List of Covered Drugs (Formulary)* (we call it the "Drug List" for short). (See the "Your drugs need to be on the plan's 'Drug List'" portion of this section.)
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See the "Your drugs need to be on the plan's 'Drug List'" portion of this section for more information about a medically accepted indication.)

Fill your prescription at a network pharmacy, through the plan's mail-order service, or through the UC Walk-Up Service

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 prescription drugs that are covered on the plan's Drug List.

Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Pharmacy Directory*, visit our website (www.healthnet.com/uc), or call Member Services (phone numbers are on the back cover of this booklet). 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 either to have a new prescription written by a provider 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 back cover of this booklet) or use the *Pharmacy Directory*. You can also find information on our website at www.healthnet.com/uc.

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 drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. (Note: This scenario should happen rarely.)

To locate a specialized pharmacy, look in your *Pharmacy Directory* or call Member Services.

Using the plan's mail-order services

For certain kinds of drugs, you can use the plan's preferred 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. The drugs available through our plan's mail-order service are marked as **"mail-order" drugs** in our Drug List.

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**.

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

To get order forms and information about filling your prescriptions by mail, visit our website (www.healthnet.com/uc), or call Member Services (phone numbers are on the back cover of this booklet) for assistance.

Usually a mail-order pharmacy order will get to you in no more than 14 days. If your mail order is delayed, call Member Services (phone numbers are on the back cover of this booklet) for assistance.

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 mail-order services, you can obtain up to a 90-day supply at UC-designated Medical Center Pharmacies for the same cost-sharing that you would pay for a 90-day supply from a preferred mail-order pharmacy.

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 "mail-order" drugs on our plan's Drug List. (Mail-order 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 mail-order drugs. Other retail pharmacies may not agree to accept the lower cost-sharing amounts for a long-term supply of mail-order 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 mail-order drugs. You can also call Member Services for more information.

2. For certain kinds of drugs, you can use the plan's preferred **mail-order services.** The drugs available through our plan's mail-order service are marked as "**mail-order" drugs** in our Drug List. 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 the "Using the plan's mail-order services" portion of this section for more information about using our mail-order services.
3. 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 mail-order services, you can obtain up to a 90-day supply for only two copays at one of the UC-designated Medical Center Pharmacies.

When can you use a pharmacy that is not in the plan's network?

Your prescription may be covered in certain situations

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

- If you are unable to obtain a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provides service 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 your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (The "How to ask us to pay you back" portion of the "Asking us to pay our share of the costs for covered drugs" section of this *Evidence of Coverage* explains how to ask the plan to pay you back.)

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

The "Drug List" tells which 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 use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is *either*:

- approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- -- *or* -- 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.)

The Drug List includes both brand name and generic drugs

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

What is *not* on the Drug List?

The plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more about this, see the "What types of drugs are *not* covered by the plan?" portion later in this section).
- In other cases, we have decided not to include a particular drug on our Drug List.

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:

- Tier 1 includes preferred generic drugs.
- Tier 2 includes preferred brand drugs.
- Tier 3 includes non-preferred brand drugs.

- 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 Specialty Tier (Tier 5). These drugs may be limited to a maximum 30-day supply per fill.
- Tier 5 (Specialty Tier) includes high cost drugs. Some of these drugs may be limited to a maximum 30-day supply per fill. Specialty Tier (Tier 5) drugs 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*.

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

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 of this booklet

There are restrictions on coverage for some drugs

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 to get a drug that works for your medical condition and is safe and effective. 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 provider to use that lower-cost option. For Part D drugs, we also need to comply with Medicare's rules and regulations for drug coverage and cost sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to ask us to make an exception. We may or may not agree to waive the restriction for you. (See the What is an exception?" portion of the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" section of this *Evidence of Coverage* for information about asking for exceptions.)

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

Generally, a "generic" drug works the same as a brand name drug, and usually costs less. **In most cases, when a generic version of a brand name drug is available, our network pharmacies will provide you the generic version** However, if your provider has told us the medical reason that the generic drug will not work for you or has written "No substitutions" on your prescription for a brand name drug, then we will cover the brand name drug. (Your share of the cost may be greater for the brand name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from the plan before we will agree to cover the drug for you. This **is called "prior authorization."** 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 less costly but just as 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.

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 our website (www.healthnet.com/uc) or call Member Services (phone numbers are on the back cover of this booklet).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you

want to take, you should contact Member Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to ask us to make an exception. We may or may not agree to waive the restriction for you. (See the What is an exception?" portion of the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" section of this *Evidence of Coverage* for information about asking for exceptions.)

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

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

Suppose there is a prescription drug you are currently taking, or one that you and your provider 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 the "There are restrictions on coverage for some drugs" portion of this section, 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. In some cases, you may want us to waive the restriction for you. For example, you might want us to cover a certain drug for you without having to try other drugs first. Or you may want us to cover more of a drug (number of pills, etc.) than we normally will cover.
- **What if the Part D drug is covered, but it is in a cost-sharing tier that makes your cost sharing more expensive than you think it should be?** The plan puts each covered drug into one of the different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

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

- If your drug is not on the Drug List or if your drug is restricted, go to the "What can you do if your drug is not on the Drug List or if the drug is restricted in some way?" portion of this section to learn what you can do.
- If your Part D drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to the "What can you do if your drug is in a cost-sharing tier you think is too high?" portion of this section to learn what you can do.

What can you do if your Part D 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 Part D drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask the plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

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

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

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

- The Part D drug you have been taking is **no longer on the plan's Drug List**.
- -- or -- the Part D drug you have been taking is **now restricted in some way** (the "There are restrictions on coverage for some drugs" portion of this section 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 Part D drug **one time only during the first 90-days after the implementation of a new formulary at the beginning of each year (January 1)**. This temporary supply will be for a maximum of 30-day supply, 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). The prescription must be filled at a network pharmacy.

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

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

- **For those members who are new to the plan and resident 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 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.

- **For those members who have been in the plan for more than 90 days and reside in a long-term care facility and need a 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. 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 medication).

- **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 medication).

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

During the time when you are getting a temporary supply of a Part D drug, you should talk with your provider to decide what to do when your temporary supply runs out. You can either switch to a different Part D drug covered by the plan or ask the plan to make an exception for you and cover your current Part D drug. The information below tells you more about these options.

You can change to another drug

Start by talking with your provider. 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 provider find a covered drug that might work for you.

You can ask for an exception

You and your provider 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 provider says that you have medical reasons that justify asking us for an exception, your provider 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 Part D drug without restrictions.

If you and your provider want to ask for an exception, the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" section of this *Evidence of Coverage* 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.

What can you do if your Part D drug is in a cost-sharing tier you think is too high?

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

You can change to another Part D drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. 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 provider to find a covered Part D drug that might work for you.

You can ask for an exception

For drugs in Tier 3 (Non preferred brand drugs) and Tier 4 (Injectable Tier), you and your provider 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 provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" section of this *Evidence of Coverage* 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.

Drugs in some of our cost-sharing tiers are not eligible for this type of exception. We do not lower the cost-sharing amount for drugs in Tier 2 (Preferred brand dugs) or Tier 5 (Specialty Tier).

What if your coverage changes for one of your drugs?

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 the "There are restrictions on coverage for some drugs" portion of this section).
- **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.

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 negative 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 provider 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 happen 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 provider to switch to the generic or to a different Part D drug that we cover.
    - Or you and your provider 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 the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" section of this *Evidence of Coverage.*
- 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 provider will also know about this change, and can work with you to find another drug for your condition.

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

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 Part D drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" section of this *Evidence of Coverage*.

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 (or are limited 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, mineral products, prenatal vitamins, and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction are limited to four doses per month.
- 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

In addition, if you are receiving **Extra Help from Medicare t**o 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, if you have drug coverage through Medicaid, 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.

Show your plan membership card when you fill a prescription

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.

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 the "How to ask us to pay you back" portion of the "Asking us to pay our share of the costs for covered drugs" section of this *Evidence of Coverage* for information about how to ask the plan for reimbursement.)

Part D drug coverage in special situations

What if you're in a hospital or a skilled nursing facility for a stay that is covered by the Original Medicare?

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

If you are **admitted to a skilled nursing facility** for a stay covered by Original Medicare, Medicare Part A will generally cover your prescription drugs during all or part of your stay. If you are still in the skilled nursing facility, and Part A is no longer covering your drugs, our plan will cover your Part D 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.

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. (The "Ending your membership in the plan" section of this *Evidence of Coverage* tells when you can leave our plan and join a different Medicare plan.)

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 a 34-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in the plan.

If you have been a member of the plan for more than 90 days and need a 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 Part D drug, you should talk with provider to decide what to do when your temporary supply runs out. Perhaps there is a different Part D drug covered by the plan that might work just as well for you. Or you and your provider 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 you and your provider want to ask for an exception, the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" section of this *Evidence of Coverage* tells you what to do.

What if you are taking drugs covered by Original Medicare?

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

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

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

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

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

Special note about "creditable coverage":

Each year your employer or retiree group should send you a notice 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 the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

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

Programs on drug safety and managing medications

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 provider to correct the problem.

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 same time, or they could have very high drug costs.

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

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Member Services (phone numbers are on the back cover of this booklet).

WHAT YOU PAY FOR YOUR PRESCRIPTION DRUGS

?

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

There are programs to help people with limited resources pay for their Part D drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see the "Information about programs to help people pay for their prescription drugs" portion of the "Important phone numbers and resources" section of this booklet.

Are you currently getting help to pay for your Part D drugs?

If you are in a program that helps pay for your Part D drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs may not apply to you.** We send you a separate insert, called the "*Evidence of Coverage* Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider), which tells you about your Part D 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 of this booklet.

Introduction

Use this section together with other materials that explain your drug coverage

This section of the *Evidence of Coverage* focuses on what you pay for your prescription drugs. To keep things simple, we use "drug" in this section to mean a prescription drug. As explained in the "Using the plan's coverage for your prescription drugs" section of this *Evidence of Coverage*, some drugs are covered under Original Medicare or are excluded by law.

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

- **The plan's *List of Covered Drugs (Formulary).*** To keep things simple, we call this the "Drug List."
  - This Drug List tells which drugs are covered for you.
  - It also tells which of the "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.

  - If you need a copy of the Drug List, call 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.

- **The "Using the plan's coverage for your prescription drugs" section of this *Evidence of Coverage*.** This section gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. This section 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 the "Using the plan's coverage for your prescription drugs" section of this *Evidence of Coverage* for the details). The *Pharmacy Directory* has a list of pharmacies in the plan's network. 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).

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

What are the different drug payment stages for our members?

As shown in the "Plan Benefit Chart" at the beginning of the *Evidence of Coverage*, there are different "drug payment stages" for your prescription drug coverage under our plan. 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.

Stage 1 *Yearly Deductible Stage*	**Stage 2** *Initial Coverage Stage*	**Stage 3** *Coverage Gap Stage*	**Stage 4** *Catastrophic Coverage Stage*
Because there is no deductible for the plan, this payment stage does not apply to you.	You begin in this stage when you fill your first prescription of the year. During this stage, the plan pays its share of the cost of your drugs and **you pay your share of the cost.** You stay in this stage until your year-to-date **"total drug costs"** (your payments plus any Part D plan's payments) total $2,930. (Details are in the "During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share" portion of this section.)	When you are in the Coverage Gap Stage (after your total Part D drug costs reach $2,930), the Medicare Coverage Gap Discount Program provides discounts on covered Part D brand name and Part D generic drugs. In addition to the Medicare Coverage Gap Discounts, your Employer Group or Benefits Administrator is also providing additional supplementary coverage to your benefit during the Coverage Gap stage for covered Part D drugs. This means that with these discounts and the supplemental coverage, you will generally pay the same amount (your copayment or coinsurance) for your covered drugs as stated in the Initial Coverage Stage. For all other covered drugs (not Part D Drugs) you continue to pay your copayment or	Because your plan has an out-of-pocket maximum of $2,000, this payment stage does not apply to you.

		coinsurance. (Details are in the "During the Coverage Gap Stage, you receive a discount on Part D brand name and Part D generic drugs" portion of this section.) You stay in this stage until your **"out-of-pocket costs"** (your payments) reach a total of $2,000. After your out-of-pocket costs reach $2,000, you pay no copayments or coinsurance for all covered drugs for the remainder of the year.	

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

We send you a monthly report called the "Explanation of Benefits" (EOB)

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 Part D "**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 through the plan during the previous month. 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 drugs costs, what the plan paid, and what you and others on your behalf paid.

- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total Part D drug costs and total Part D payments for your drugs since the year began.
- **The EOB indicates at what stage of the Part D benefit you are in.** During the Coverage Gap stage (regardless of whether or not you have coverage in this stage) you are eligible for certain discounts.

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 keep track of your Part D out-of-pocket costs. 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" portion of the "Asking us to pay our share of the costs for covered drugs" section of this booklet.) 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 (EOB)* 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 back cover of this booklet). Be sure to keep these reports. They are an important record of your drug expenses.

There is no deductible for our plan.

You do not pay a deductible for your drugs

There is no deductible for our plan. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See the "During the Initial Coverage Stage, the plan pays its share of your drug costs and you pay your share" portion of this section for information about your coverage in the Initial Coverage Stage.

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

What you pay for a drug depends on the drug and where you fill your prescription

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

The plan has five Cost-Sharing Tiers

Every drug on the plan's Drug List is in one of the cost-sharing tiers. In general, the higher the cost-sharing tier number, the higher your cost for the drug:

- Tier 1 includes preferred generic drugs.
- Tier 2 includes preferred brand drugs.
- Tier 3 includes non-preferred brand drugs.
- 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 Specialty Tier (Tier 5). These drugs may be limited to a maximum 30-day supply per fill.
- Tier 5 (Specialty Tier) includes high cost drugs. Some of these drugs may be limited to a maximum 30-day supply per fill. Specialty Tier (Tier 5) drugs 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*. To find out how much you pay for drugs in each of the cost-sharing Tiers during the Initial Coverage Stage, please refer to the "Plan Benefit Chart" in the beginning of this *Evidence of Coverage*.

Your pharmacy choices

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

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

For more information about these pharmacy choices and filling your prescriptions, see the "Using your plan's coverage for your prescription drugs" section of this booklet and the plan's *Pharmacy Directory*.

You stay in the Initial Coverage Stage until your total Part D drug costs for the year reach $2,930

You stay in the Initial Coverage Stage until the total amount for the Part D prescription drugs you have filled and refilled reaches the **$2,930 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 <u>you</u> have paid** for all the covered Part D drugs you have gotten since you started with your first drug purchase of the year. (see the "How Medicare calculates your out-of-pocket costs for prescription drugs" portion of this section for more information about how Medicare calculates your out-of-pocket costs) This includes:
  - The deductible you paid for Part D drugs during the Deductible Stage if your plan has a deductible.
  - The total you paid as your share of the cost for your Part D drugs during the Initial Coverage Stage.

What the <u>plan</u> has paid as its share of the cost for your Part D drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2012, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

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 (EOB)* that we send to you will help you keep track of how much you and the plan have spent for your Part D drugs during the year. Many people do not reach the $2,930 limit in a year.

We will let you know if you reach this $2,930 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

During the Coverage Gap Stage, you receive a discount on Part D brand name drugs and Part D generic drugs

You stay in the Coverage Gap Stage until your out-of-pocket costs reach $2,000

During the Coverage Gap Stage, you are eligible to receive a discount on covered Part D brand name and generic drugs

After your total Part D drug costs reach $2,930, you, or others on your behalf, will receive the following discounts for covered Part D drugs:

- **Generic Part D drugs:** 14% of the drug cost
- **Brand Name Part D drugs eligible for a discount as determined by Medicare:** A 50% discount off of the drug cost (excluding the dispensing fee and vaccine administration fee, if any).

For more information on these discounts, see the "Medicare Coverage Gap Discount Program" portion below.

In addition to the Medicare Coverage Gap Discounts, your Employer Group or Benefits Administrator is also providing additional supplementary coverage to your benefit during the Coverage Gap stage for covered Part D drugs. This means that with these discounts and the supplemental coverage, you will generally pay the same amount (your copayment or coinsurance) for your covered drugs as stated in the Initial Coverage Stage.

For all other covered drugs (not Part D Drugs) you will continue to pay your copayment or coinsurance in the Coverage Gap Stage.

Medicare Coverage Gap Discount Program

When you are in the Coverage Gap Stage, the Medicare Coverage Gap Discount Program provides manufacturer discounts on covered Part D brand name drugs. You receive a 50% discount of the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) for covered Part D brand name drugs. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them and moves you through the coverage gap.

You are also eligible to receive a discount for covered Part D generic drugs. You receive a 14% discount of the cost for covered Part D generic drugs. For covered Part D generic drugs, only the amount you pay counts and moves you through the coverage gap.

You continue receving these discounts for covered Part D brand name and Part D generic drugs until your yearly out-of-pocket payments reach $2,000.

In addition to the Medicare Coverage Gap Discounts, your Employer Group or Benefits Administrator is also providing additional supplementary coverage to your benefit during the Coverage Gap stage for covered Part D drugs. This means that with these discounts and the supplemental coverage, you will generally pay the same amount (your copayment or coinsurance) for your covered drugs as stated in the Initial Coverage Stage. See the "Plan Benefit Chart" at the beginning of this section that tells what you pay for drugs during the Initial Coverage Stage.

Out-of-Pocket Maximum for Outpatient Prescription drugs

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

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

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

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

*When you add up your out-of-pocket costs, **you can include** the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in the "Using the "Using the plan's coverage for your prescription drugs" section 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 Service, 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:

Because your plan has an out-of-pocket maximum of $2,000, this stage does not apply to you. After your out-of-pocket costs reach $2,000, you pay no copayments or coinsurance for all covered drugs for the remainder of the year.

*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 made by the plan for your generic drugs while in the Coverage Gap.
- 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 back 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 (The "We send your reports that explain payments for your Part D Drugs and which payment stage you are in" portion of this section tells about this report).

Make sure we have the information we need. The "We send you reports that explain payments for your Part D drugs and which payment stage you are in" portion tells what you can do to help make sure that our records of what you have spent are complete and up to date.

Catastrophic Coverage Stage

Because your plan has an out-of-pocket maximum of $2,000, this stage does not apply to you. After your out-of-pocket costs reach $2,000, you pay no copayments or coinsurance for all covered drugs for the remainder of the year.

What you pay for Part D vaccinations depends on how and where you get them

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 vaccination shot**. (This is sometimes called the "administration" of the vaccine.)

What do you pay for a Part D vaccination?

What you pay for a vaccination depends on three things:

1. **The type of vaccine** (what you are being vaccinated for).
    - Some vaccines are considered Part D drugs. You can find these vaccines listed in the plan's *List of Covered Drugs (Formulary).*
    - Other vaccines are considered medical benefits. They are covered under Original Medicare.
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 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 Part D vaccination shot.

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 and administration of the vaccine.

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 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 us to pay our share of the costs for covered 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 get 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 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 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 us to pay our share of the costs for covered 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 get 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 back 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.

Do you have to pay the Part D "late enrollment penalty"?

What is the Part D "late enrollment penalty"?

Note: If you receive "Extra Help" from Medicare to pay for your prescription drugs, the late enrollment penalty rules do not apply to you. You will not pay a late enrollment penalty, even if you go without "creditable" prescription drug coverage.

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 have creditable prescription drug coverage. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage.

The penalty is added to your monthly premium. When you first enroll in our plan, we let you know the amount of the penalty. Please contact your Group or Benefits Administrator for more information about the premium payment for this plan.

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.

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 creditable 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, if you go 14 months without coverage, the penalty 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 2011, this average premium amount was $32.34. This amount may change for 2012.
- To get your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would

be 14% times $32.34, which equals $4.53. This 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.

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:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription 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. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information, because you may need it if you join a Medicare drug plan later.
        - Please note: "The certificate of creditable coverage" you may receive when your health coverage ends does not mean the prescription drug coverage was "creditable" coverage. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
    - The following are *not* creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites
    - For additional information about creditable coverage, please look in your *Medicare & You* 2012 Handbook or call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

- If you were without creditable coverage, but you were without it for less than 63 days in a row.
- If you are receiving "Extra Help" from Medicare.

What can you do if you disagree about your late enrollment penalty?

If you disagree about your late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** from the date on the letter you receive stating you have to pay a late enrollment penalty. Call Member Services at the number on the back cover 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 a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums. Please contact your Group or Benefits Administrator for more information about the premium payment for this plan.

Do you have to pay an extra Part D amount because of your income?

Who pays an extra Part D amount because of income?

Most people pay a standard monthly Part D premium. However, some people pay an extra amount because of their yearly income. If your income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, you must pay an extra amount for your Medicare Part D coverage.

If you have to pay an extra amount, the Social Security Administration, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. The extra amount must be paid separately and cannot be paid with your monthly plan premium.

How much is the extra Part D amount?

If your modified adjusted gross income as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your monthly plan premium.

The chart below shows the extra amount based on your income.

If you filed an individual tax return and your income in 2010 was:	If you were married but filed a separate tax return and your income in 2010 was:	If you filed a joint tax return and your income in 2010 was:	This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)
Equal to or less than $85,000	Equal to or less than $85,000	Equal to or less than $170,000	$0
Greater than $85,000 and less than or equal to $107,000		Greater than $170,000 and less than or equal to $214,000	$11.60
Greater than $107,000 and less than or equal to $160,000		Greater than $214,000 and less than or equal to $320,000	$29.90
Greater than $160,000 and less than or equal to $214,000	Greater than $85,000 and less than or equal to $129,000	Greater than $320,000 and less than or equal to $428,000	$48.10
Greater than $214,000	Greater than $129,000	Greater than $428,000	$66.40

What can you do if you disagree about paying an extra Part D amount?

If you disagree about paying an extra amount because of your income, you can ask the Social Security Administration to review the decision. To find out more about how to do this, contact the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778).

ASKING US TO PAY OUR SHARE OF THE COSTS FOR COVERED DRUGS

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

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

Sometimes when you get a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of the plan. In either case, you can ask our plan to pay you back (paying you back is often called "reimbursing" you).

Here are examples of situations in which you may need to ask our plan to pay you back All of these examples are types of coverage decisions (for more information about coverage decisions, go to the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" section of this booklet).

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

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to the" When can you use a pharmacy that is not in the plan's network?" portion of the "Using the plan's coverage for your prescription drugs " section of this booklet to learn more.)

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

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

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

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

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

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

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

4. If you are retroactively enrolled in our plan.

Sometimes a person's enrollment in the plan is retroactive. (Retroactive means that the first day of their enrollment has already past. The enrollment date may even have occurred last year.)

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

- Please call Member Services for additional information about how to ask us to pay you back and deadlines for making your request.

How to ask us to pay you back

How and where to send us your request for payment

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

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

- You don't have to use the form, but it will help us 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 back cover of this booklet.

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

Health Net Pharmaceutical Services
Attn: Claims
10540 White Rock Road, Suite 280
Rancho Cordova, CA 95670

You must submit your claim to us within three years of the date you received the drug.

Please be sure to contact Member Services if you have any questions. If you don't know what you should have paid, 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.

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

We check to see whether we should cover the 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 make a coverage decision.

- If we decide that the drug is covered and you followed all the rules for getting the drug, we will pay for our share of the cost. We will mail your reimbursement of our share of the cost to you. (The "Using the plan's coverage for your prescription drugs" section of this *Evidence of Coverage* explains the rules you need to follow for getting your prescription drugs covered.) We will send payment within 30 days after your request was received.
- If we decide that the 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.

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

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying , you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment. The examples of situations in which you may need to ask our plan to pay you back:

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

For the details on how to make this appeal, go to the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" section of this booklet. The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading the "A guide to the basics of coverage decisions and appeals" portion of that section. "A guide to the basics of coverage decisions and appeals" explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read "A guide to the basics of coverage decisions and appeals," you can go to the "Your prescription drugs: How to ask for a coverage decision or make an appeal" portion of that section for a step-by-step explanation of how to file an appeal.

Other situations in which you should save your receipts and send copies to the plan

In some cases, you should send copies of your receipts to us to help us track your Part D out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your Part D 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 Part D 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 copies of receipts to let us know about payments you have made for your drugs:

1. When you buy a Part D drug for a price that is lower than our price

Sometimes when you are in the Deductible Stage and/or Coverage Gap Stage, you can buy your Part D drug **at a network pharmacy** for a price that is lower than our price.

- For example, a pharmacy might offer a special price on the drug. Or you may have a discount card that is outside our 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 Part D out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** If you are in the Deductible Stage and Coverage Gap Stage, we may not pay for any share of these drug costs. But sending a copy of 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, we will not pay for any share of these drug costs. But sending a copy of 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.

YOUR RIGHTS AND RESPONSIBILITIES

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

We must provide information in a way that works for you (in languages other than English, 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 of this booklet).

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. This information is available for free in other languages. Please contact our Member Services at 1-800-539-4072 for additional information. (TTY/TDD users should call 1-800-929-9955) 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. We can also give you information in Braille, in large print, or other alternate formats if you need it. If you are eligible for Medicare because of a 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.

We must treat you with fairness and respect at all times

You have the right to be treated with respect and recognition of your dignity. Our plan must obey laws that protect you from discrimination or unfair treatment. **We do not discriminate** based on a person's race, ethnicity, national origin, religion, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area

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 back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

We must ensure that you get timely access to your covered drugs

As a member of our plan, you also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays. If you think that you are not getting your drugs within a reasonable amount of time, the "How to make a complaint about quality of care, waiting

times, customer service, or other concerns" portion of the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" section this booklet tells what you can do. If we have denied coverage for your prescription drugs and you don't agree with our decision, the "A guide to the basics of coverage decisions and appeals" portion of the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" section of this booklet tells what you can do.)

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 work with your healthcare provider to 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 back cover of this booklet).

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

As a member of our plan, you have the right to get several kinds of information from us. This includes information about Health Net, its services, its providers and member rights and responsibilities. (As explained above in the "We must provide information in a way that works for you (in Braille, in large print, or other alternate formats, etc.)" portion above, 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 back cover of this booklet):

- **Information about our plan**. This includes, for example, information about the plan's financial condition. It also includes information about the number of appeals made by members and the plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare prescription drug plans.
- **Information about our network pharmacies.**
  - For example, you have the right to get information from us about the pharmacies in our network.
  - For a list of the pharmacies in the plan's network, see the *Pharmacy Directory.*
  - For more detailed information about our pharmacies, you can 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.**
  - To get the details on your prescription drug coverage, see the "Using the plan's coverage for your prescription drugs" and "What you pay for your prescription drugs" sections of this booklet plus the plan's *List of Covered Drugs (Formulary).* These sections, together with the *List of Covered Drugs (Formulary)*, 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 back cover of this booklet).

- **Information about why something is not covered and what you can do about it.**
    - If a drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the drug from an out-of-network pharmacy.
    - If you are not happy or if you disagree with a decision we make about what drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" section of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (That section also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
    - If you want to ask our plan to pay our share of the cost for a prescription drug, see the "Asking us to pay our share of the costs for covered drugs" of this booklet.

We must support your right to make decisions about your care

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 back 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 the Office of Civil Rights. Please refer to Exhibit 3 "Office for Civil Rights," at the end of this *Evidence of Coverage* to locate the Office for Civil Rights for your state.

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, the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" section 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 the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" section of this booklet, 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 back cover of this booklet).

Evaluation of new technologies

New technologies include procedures, drugs, biological product, or devices that have recently been developed for the treatment of specific diseases or conditions, or are new applications of existing procedures, drugs, biological products, and devices. New technologies are considered investigational if there is no conclusive medical and scientific evidence in published peer-reviewed medical literature that the drug, biological product, device, or procedure has a beneficial effect on health outcomes, there is no clearance from a federal, governmental regulatory body, or other governmental agency (e.g., U.S. Food and Drug Administration (FDA)) for final and unrestricted market approval for use in the treatment of a specified condition, and not generally accepted by the medical community.

Health Net, Inc. assesses technology through an established process for recognizing and evaluating advances in new technologies and new applications of existing technologies which should be included in applicable benefit plans and to ensure members have access to safe and effective care. Health Net, Inc. may rely upon published evaluations and clinical recommendations of recognized experts (e.g., national medical associations, independent medical panels, technology assessment organizations, and practicing physicians). Such experts base their evaluations and findings on the scientific quality of the supporting evidence and rationale for the new technologies or new applications. Health Net, Inc.'s Medical Advisory Council has the responsibility for assessing new technology and new applications and for medical policy decisions. Medicare's National and Local Coverage Determinations, when applicable, are also followed.

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 back 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 the "State Health Insurance Assistance Program" portion of the "Important phone numbers and resources" section of this booklet.

- Or, **you can call 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.

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 back 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 the "State Health Insurance Assistance Program" portion of the "Important phone numbers and resources" section of this booklet.
- You can contact **Medicare**.
    - You can visit the Medicare website (to read or download the publication "Your Medicare Rights & Protections." (The publication is available at: http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf.)
    - 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.

You have some responsibilities as a member of the plan

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 back cover of this booklet). We're here to help.

- ***Get familiar with your covered drugs and the rules you must follow to get these covered drugs.*** *Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered drugs.*
    - The "Using the plan's coverage for your prescription drugs" and "What you pay for your prescription drugs" sections of this booklet give the details about your coverage for prescription drugs.

- ***If you have any other 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 drugs from our plan. This is called "**coordination of benefits**" because it involves coordinating the drug benefits you get from our plan with any other drug benefits available to you. We'll help you with it. (For more information about coordination of

benefits, go to the "How other insurance works with our plan" portion of the "Getting started as a member" section of this *Evidence of Coverage*.)

- ***Tell your doctor and pharmacist that you are enrolled in our plan.*** *Show your plan membership card whenever you get your 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, give them the information they need about you and your health, and work with them to develop mutually agreed upon goals. 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.
    - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
- ***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. Please contact your Group or benefits administrator for information about your plan premium.
    - For most of your drugs covered by the plan, you must pay your share of the cost when you get the drug. This will be a copayment or coinsurance. The "What you pay for your prescription drugs" and "Plan Benefit Chart" sections of this booklet tell what you must pay for your prescription drugs.
    - If you get any drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
        - If you disagree with our decision to deny coverage for a drug, you can make an appeal. Please see the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" section of this booklet for information about how to make an appeal.
    - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of the plan.
- ***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 back cover of this booklet).*
    - **If you move *outside* of our plan service area, you cannot remain a member of our plan.** (The "Getting started as a member" section of this booklet 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 or our member rights and responsibilities policy.*
  - Phone numbers and calling hours for Member Services are on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see the "Important phone numbers and resources" section of this *Evidence of Coverage*.

WHAT TO DO IF YOU HAVE A PROBLEM OR COMPLAINT (COVERAGE DECISIONS, APPEALS, COMPLAINTS)

BACKGROUND

Introduction

What to do if you have a problem or concern

This section 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 the "To deal with your problem, which process should you use" portion of this section will help you identify the right process to use.

What about the legal terms?

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

To keep things simple, this section explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this section generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "coverage determination," and "Independent Review Organization" instead of "Independent Review Entity." It also uses abbreviations as little as possible.

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

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

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.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us 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 can find contact information for the SHIP in your state in "Exhibit 4 State Health Insurance Assistance Program (SHIP)" at the end of this *Evidence of Coverage*. You may also find the website for your local SHIP at www.medicare.gov under "Help and Support" by selecting "Useful Phone Numbers and Websites."

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).

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

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, you only need to read parts of this section that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help with your specific problem or concern, **START HERE**

Is your problem or concern about your benefits or 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. My problem is about benefits or coverage.	**No.** My problem is not about benefits or coverage.
Go on to the next portion of this section**, "A guide to the basics of coverage decisions and making appeals."**	Skip ahead to the portion at the end of this section: **"How to make a complaint about quality of care, waiting times, customer service or other concerns."**

COVERAGE DECISIONS AND APPEALS

A guide to the basics of coverage decisions and appeals

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 prescription drugs, including problems related to payment. This is the process you use for issues such as whether a drug is covered or not and the way in which the drug is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs.

We 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 a 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. Your appeal is handled by different reviewers than those who made the original unfavorable decision. 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 ask for a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected to us. 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.

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 back cover of this booklet).
- To **get free help from an independent organization** that is not connected with our plan, contact your State Health Insurance Assistance Program (see the "You can get help from government organizations that are not connected with us" portion of this section).
- **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 prescriber, or other person to be your representative, call Member Services and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at

http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf or on our website at www.healthnet.com/uc.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us 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.

Your prescription drugs: How to ask for a coverage decision or make an appeal

? Have you read the "A guide to 'the basics' of coverage decisions and appeals" portion of this section? If not, you may want to read it before you start this section.

This portion tells you what to do if you have problems getting a drug or you want us to pay you back for a 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 the use of the drug is a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See the "Your drugs need to be on the plan's "Drug List" portion of the "Using the plan's coverage for your prescription drugs" section of this *Evidence of Coverage* for more information about a medically accepted indication.)

- **This portion is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this portion, 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 (Formulary)*, rules and restrictions on coverage, and cost information, see the "Using our plan's coverage for your Part D prescription drugs" and the "What you pay for your Part D prescription drugs" sections of this booklet.

Coverage decisions and appeals

As discussed in the "A guide to the basics of coverage decisions and appeals" portion of this section, 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	An initial coverage decision drugs is called a **"coverage determination."**

Here are examples of coverage decisions you ask us to make about your drugs:

- You ask us to make an exception, including:
  - Asking us to cover a drug that is not on the plan's *List of Covered Drugs (Formulary)*
  - 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 Part D 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 (Formulary)* but we require you to get approval from us before we will cover it for you.)
  - *Please note:* If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- 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 portion tells you both how to ask for coverage decisions and how to request an appeal. Use this chart below to help you determine which part has information for your situation:

Which of these situations are you in?

Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you have already received and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
You can ask us to make an exception. (This is a type of coverage decision.) Start with the "**What is an exception?"** portion of this section.	You can ask us for a coverage decision. Skip ahead to the "**Step-by-step: How to ask for a coverage decision, including an exception"** portion of this section.	You can ask us to pay you back. (This is a type of coverage decision.) Skip ahead to the "**Step-by-step: How to ask for a coverage decision, including an exception"** portion of this section.	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to the "**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)"** portion of this section.

What is an exception?

If a drug is not covered in the way you would like it to be covered, you can ask us 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 drug for you that is not on our *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."**

   - 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 (Non-preferred brand drugs).
   - If we agree to make an exception and cover a Part D drug, you cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the Part D drug.

2. **Removing a restriction on our coverage for a covered drug**. There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs* (for more information, go to the "Using your plan's coverage for your prescription drugs" section of this booklet).

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 may 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 we agree to make an exception and waive a restriction on a Part D drug for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the Part D 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 our Drug List is in one of the cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms	Asking to pay a lower preferred price for a covered non-preferred Part D drug is sometimes called asking for a **"tiering exception."**

   - If your Part D drug is in Tier 3 (Non preferred brand drugs) or Tier 4 (Injectable Tier) you can ask us to cover it at the cost-sharing amount that applies to drugs in Tier 2 (Preferred brand). This would lower your share of the cost for the Part D drug.
   - You cannot ask us to change the cost-sharing tier for any drug in Tier 2 (Preferred Brand) or Tier 5 (Specialty Tier).

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 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.

We 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 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.

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

Step-by-step: How to ask for a coverage decision, including an exception

<u>Step 1:</u> You ask us 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 us to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to the "Important phone numbers and resources" section of this booklet and look for the portion called, "How to contact us when you are asking for a coverage decision about your prescription drugs." Or if you are asking us to pay you back for a drug, go to the portion called, "Where to send a request that asks us to pay for our share of the cost for a drug you have received."
- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. The "A guide to the basics of coverage decisions and appeals" portion of this section 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 us to pay you back for a drug,** start by reading the "Asking us to pay our share of the costs for covered drugs" section of this booklet. That section 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 us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See the "What is an exception?" and "Important things to know about asking for exceptions" portions of this section 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 coverage determination."**

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast decision means we will answer within 24 hours.
- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision only if you are asking for a *drug you have not yet received*. (You cannot get a fast decision if you are asking us to pay you back for a drug you are already bought.)
  - You can get a fast decision *only* if using the standard deadlines could *cause serious harm to your health or hurt your ability to function.*

- **If your doctor or other prescriber tells us that your health requires a "fast decision," we will automatically agree to give you a fast decision.**
- If you ask for a fast decision on your own (without your doctor's or other prescriber's support), we 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 the "How to make a complaint about quality of care, waiting times, customer service, or other concerns" portion of this section.)

Step 2: We consider 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 for a Part D drug, 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 for a Part D drug, 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 for a Part D drug, 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 30 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 we say no, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made.

The next section tells you how to ask for an appeal for a Part D drug.

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	An appeal to the plan about a drug coverage decision is called a plan **"redetermination."**

Step 1: You contact us and make your Level 1 Appeal for the 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, your doctor, or your representative, must contact us.**
    - For details on how to reach us by phone, fax, or mail for any purpose related to your appeal, go to the "Important phone numbers and resources" section of this booklet, and look for the portion called, "How to contact us when you are making an appeal about your prescription drugs."
- **If you are asking for a standard appeal, make your appeal by submitting a written request.** You may also ask for an appeal by calling us at the phone number in the "How to contact us when you are making an appeal about your prescription drugs" portion of the "Important phone numbers and resources" section of this booklet.
- **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 the "**How to contact us when you are making an appeal about your prescription drugs" portion of 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. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an 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 redetermination."**

- If you are appealing a decision we 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 the "Step-by-step: How to ask for a coverage decision, including an exception" portion of this section.

Step 2: We consider 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 appeal.
- **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 you believe your health requires it, you should ask for "fast" appeal.
    - 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).

Step-by-step: How to make a Level 2 Appeal for a Part D drug

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 independent organization that is hired by Medicare**. This organization is not connected with us 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 us.

- 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 s**end 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 the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting for a Part D drug 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. The "Taking your appeal to Level 3 and beyond" portion of this section tells more about Levels 3, 4, and 5 of the appeals process.

Taking your appeal for a Part D drug to Level 3 and beyond

Levels of Appeal 3, 4, and 5 for Part D Drugs

This part 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 Administrative Law Judge says yes to your appeal, the appeals process is over**. What you asked for in the appeal has been approved. We must **authorize provide the drug coverage** that was approved by the Administrative Law Judge **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **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.

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. We must authorize or **provide the drug coverage** that was approved by the Medicare Appeals Council **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we receive the decision.
- **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. If the Medicare Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you who to contact and what to do next if you choose to continue with your appeal.

Level 5 Appeal	A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

How to ask for an appeal for a drug that is excluded from coverage under Part D.

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 Medicare Part D Prescription 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 for Part D drugs.

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 our plan 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 8am to 8pm, 7 days a week, TTY/TDD users call: 1 800- 929-9955** or by sending information to:

Health Net
Appeals & Grievance Department
P.O. Box 10450
Van Nuys, CA 91410-0450

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 8am to 8pm, 7 days a week, TTY/TDD users call: 1-800-929-9955** to request the independent review or by sending the request to:

Health Net
Appeals & Grievance Department
P.O. Box 10450
Van Nuys, CA 91410-0450

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.

MAKING COMPLAINTS

How to make a complaint about quality of care, waiting times, customer service, or other concerns

?

If your problem is about decisions related to benefits, coverage, or payment, then this section is *not for you*. Instead, you need to use the process for coverage decisions and appeals. Go to the "A guide to the basics of coverage decisions and appeals" portion of this section.

What kinds of problems are handled by the complaint process?

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

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

Quality of your medical care

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

Respecting your privacy

- Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be 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 treated you?
- Do you feel you are being encouraged to leave the plan?

Waiting times

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

Cleanliness

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

Information you get from us

- 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 the following portions of this section:

"A guide to the basics of coverage decisions and appeals"

"Your prescription drugs: How to ask for a coverage decision or make an appeal"

"Taking your appeal for a Part D Drug to Level 3 and beyond"

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 us for a coverage decision or made an appeal, and you think that we are 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 we are 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 we are told that we must cover or reimburse you for certain drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do 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.

The formal name for "making a complaint" is "filing a grievance"

Legal Terms

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

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, TTY/TDD users call 1-800-929-9955.

  Hours of Operation: 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week

- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us** If you put your complaint in writing, we will respond to your complaint in writing.
- Upon receipt of your complaint, we will initiate the Grievance procedure and acknowledge receipt of your request within 5 business days of receipt.
- If you ask for a written response, file a written complaint (grievance), or if your complaint is related to quality of care, we will respond to you in writing. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaint. 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 above. Or, you may mail or fax us a written request to the address or fax number listed under Appeals for Prescription Drugs or Complaints about Prescription Drugs, in the "Important phone numbers and resources" section 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. You can submit your Grievance, formally, in writing or via fax at the address or fax number listed under Appeals for Prescription Drugs or Complaints about

Prescription Drugs, in the "Important phone numbers and resources" section of this booklet.

- We must notify you of our decision about your complaint (grievance) as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame by up to 14 calendar days if you 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 complaint. 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 situations
  - We deny your request for a fast review of a request for drug benefits.
  - We deny your request for a fast review of an appeal of denied drug benefits.
- You may submit this type of complaint by phone by calling Member Services at the number on the back cover of this booklet. You may also submit the complaint to us in writing or by fax at the address or fax number listed under Appeals for Prescription Drugs or Complaints about Prescription Drugs the "Important phone numbers and resources" section of this booklet. Once we receive the expedited grievance (complaint), a Clinical Practitioner will review the case to determine the reasons for the denial of your request for a fast review or if the case extension was appropriate. We will notify you of the decision of the fast case orally and in writing within 24 hours of receiving your complaint.
- **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 portion calls a **"fast complaint"** is also called an **"expedited 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 calendar days (44 calendar 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.

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 us 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 us).

- The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients

- To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Exhibit 1 "Quality Improvement Organization" portion at the end 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 us and also to the Quality Improvement Organization

.

ENDING YOUR MEMBERSHIP IN THE PLAN

Introduction

This section 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. The "When can you end your membership in our plan?" portion of this section 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. The "How do you end your membership in our plan" portion of this section 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. The "Our plan must end your membership in the plan in certain situations" portion of this section tells you about situations when we must end your membership.

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

When can you end your membership in our plan?

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

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

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

- Please contact your employer/union benefits administrator for information regarding other plan options and/or questions about your employer/union open enrollment season.
- From October 15 through December 7 in 2011, during the Annual Enrollment Period (AEP), anyone with Medicare may switch from one way of getting Medicare to another

for the following year. 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) 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. Or, visit www.medicare.gov to learn more about your options.

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):
    - If you have moved out of your plan's service area.
    - If you have Medicaid.
    - If you are eligible for Extra Help with paying for your Medicare prescriptions.
    - If we violate our contract with you.
    - If you are getting care in an institution, such as a nursing home or long-term care hospital.
    - If you enroll in the Program of All-inclusive Care for the Elderly (PACE). PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Member Services (phone numbers are on the back cover of this booklet

- **When are Special Enrollment Periods?** The enrollment periods vary depending on your situation.

- **What can you do?** To find out if you are eligible for a Special Enrollment Period, please call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048. If you are eligible to end your membership because of a special situation, you can choose to change both your Medicare health coverage and prescription drug coverage. This means you can choose any of the following types of plans:
    - Another Medicare prescription drug plan.
    - Original Medicare *without* a separate Medicare prescription drug plan.
        - **If you receive Extra Help from Medicare to pay for your prescription drugs: If you switch to Original Medicare and do not enroll in a separate Medicare prescription drug plan, Medicare**

may enroll you in a drug plan, unless you have opted out of automatic enrollment.

- – *or* – A Medicare health plan. A Medicare health plan is a plan offered by a private company that contracts with Medicare to provide all of the Medicare Part A (Hospital) and Part B (Medical) benefits. Some Medicare health plans also include Part D prescription drug coverage.
    - If you enroll in most Medicare health plans, you will automatically be disenrolled from our plan when your new plan's coverage begins. However, if you choose a Private Fee-for-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that plan and keep our plan for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or to drop Medicare prescription drug coverage.

  Note: If you disenroll from Medicare prescription drug coverage 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 expected to pay, at least as much 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.

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 back cover of this booklet).
- You can find the information in the ***Medicare & You 2012*** 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.

How do you end your membership in our plan?

Usually, you end your membership by enrolling in another plan

Usually, to end your membership in our plan, you simply enroll in another Medicare plan during one of the enrollment periods (see the "When can you end your membership in our plan" portion earlier in this section for information about the enrollment periods). However, there two situations in which you will need to end your membership in a different way:

- If you want to switch from our plan to Original Medicare *without* a Medicare prescription drug plan, you must ask to be disenrolled from our plan.
- If you join a Private Fee-for-Service plan without prescription drug coverage, a Medicare Medical Savings Account Plan, or a Medicare Cost Plan, enrollment in the new plan will not end your membership in our plan. In this case, you can enroll in that plan and keep our plan for your drug coverage. If you do not want to keep our plan, you can choose to enroll in another Medicare prescription drug plan or ask to be disenrolled from our plan.

If you are in one of these two situations and want to leave our plan, there are two ways you can ask to be disenrolled:

- You can make a request in writing to us. (Contact Member Services if you need more information on how to do this.)
- --*or*--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.

Note: If you disenroll from Medicare prescription drug coverage 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 expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See the "Do you have to pay the Part D "late enrollment penalty"?" portion of the "What you pay for your prescription drugs" section of this booklet for more information about the late enrollment penalty.

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:
• Another Medicare prescription drug plan.	• Enroll in the new Medicare prescription drug plan. You will automatically be disenrolled from our plan when your new plan's coverage begins.
• A Medicare health plan.	• Enroll in the Medicare health plan. With most Medicare health plans, you will automatically be disenrolled from our plan when your new plan's coverage begins. However, if you choose a Private Fee-For-Service plan without Part D drug coverage, a Medicare Medical Savings Account plan, or a Medicare Cost Plan, you can enroll in that new plan and keep our plan for your drug coverage. If you want to leave our plan, you must *either* enroll in another Medicare prescription drug plan *or* ask to be disenrolled. To ask to be disenrolled, you must send us a written request (contact Member Services if you need more information on how to do this) or 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).
• Original Medicare *without* a separate Medicare prescription drug plan. • **Note:** If you disenroll from a Medicare prescription drug plan and go without	• **Send us a written request to disenroll. Contact Member Services** if you need more information on how to do this **(phone numbers are on the back cover of this booklet).** • You can also contact **Medicare** at 1-

If you would like to switch from our plan to:	This is what you should do:
	creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See the "Do you have to pay the Part D "late enrollment penalty"?" portion in the "What you pay for your prescription drugs" section of this booklet for more information about the late enrollment penalty.
	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.

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

Until your membership ends, you are still a member of our plan

If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See the "When can you end your membership in our plan" portion earlier in this section for information on when your new coverage begins.) During this time, you must continue to get your prescription drugs through our plan.

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

Our plan must end your membership in the plan in certain situations

When must we end your membership in the plan?

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

- If you do not stay continuously enrolled in Medicare Part A or Part B (or both).

- If you move out of our service area for more than 12 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 (go to prison).
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide care for you and other members of our plan.
    - We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get prescription drugs.
    - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
- If you do not pay the plan premiums for 90-days.
    - We must notify you in writing that you have 90-days to pay the plan premium before we end your membership. Please contact your Group or Benefits Administrator for more information about the premium payment for this plan.

When Coverage Ends

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

Involuntarily ending your membership due to termination of the Group Policy

All Group Members

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

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

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

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

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

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

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

- The Member no longer meets the eligibility requirements established by the Group and Health Net. This will include a child subject to a Medical Child Support Order, according to state or federal law, who becomes ineligible on the earlier of:
  1. The date established by the order.
  2. The date the order expired.
- The Member establishes primary residency outside the continental United States.
- The Member establishes primary residency outside the Health Net Service Area.

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

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

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

- Disruptive or Threatening Behavior: Your coverage may be terminated upon the date the notice of termination is mailed if you threaten the safety of the health care provider, his or her office staff, the contracting Physician Group or Health Net if such behavior does not arise from a diagnosed illness or condition. In addition, your coverage may be terminated upon 15 days prior written notice if you repeatedly or materially disrupt the operations of the Physician Group or Health Net to the extent that your behavior substantially impairs Health Net's ability to furnish or arrange services for you or other Health Net Members, or substantially impairs the Physician's office or contracting Physician Group's ability to provide services to other patients.
- Misrepresentation or Fraud: Your coverage may be terminated at midnight on the date the notice of termination is mailed if you knowingly omit or misrepresent a meaningful fact on your enrollment form or fraudulently or deceptively use services or facilities of Health Net, its contracting Physician Groups or other contracting providers, (or knowingly allow another person to do so), including altering a prescription.

If coverage is terminated for any of the above reasons, you forfeit all rights to enroll in the federal Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) plan or any plan that is owned or operated by Health Net's parent company or its subsidiaries and lose the right to re-enroll in Health Net in the future.

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

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

Coverage Options Following Termination
If coverage through this Plan ends as a result of the Group's non-payment of subscription charges, see "All Group Members" portion of "Involuntarily ending your membership due to termination of the Group Policy" in this section for coverage options following termination. If

coverage through this Plan ends for reasons other than the Group's non-payment of subscription charges, the terminated Member may be eligible for additional coverage.

COBRA Continuation Coverage: Many groups are required to offer continuation coverage by COBRA. For most Groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside California. Please check with your Group to determine if you and your covered dependents are eligible.

Where can you get more information?

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

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

We cannot 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.

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 the "How to make a complaint about quality of care, waiting times, customer service, or other concerns" portion of the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" section of this booklet for information about how to make a complaint.

LEGAL NOTICES

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.

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 prescription drug 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.

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.

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.

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.

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.

Recovery of benefits paid by Health Net under your Health Net Prescription Drug Plan (Employer PDP)

When you are injured

If you are ever injured through the actions of another person, or yourself (responsible party), Health Net will provide benefits for all covered prescription drugs that you receive through this Plan. However, if you receive money or are entitled to receive money because of your injuries, whether through a settlement, judgment or any other payment associated with your injuries, Health Net or the pharmacy retain the right to recover the value of any prescription drugs provided to you through this Plan.

As used throughout this provision, the term responsible party means any party actually or potentially responsible for making any payment to a Member due to a Member's injury, illness or condition. The term responsible party includes the liability insurer of such party or any insurance coverage.

Some examples of how you could be injured through the actions of a responsible party are:

- You are in a car accident;
- You slip and fall in a store.

Health Net's rights of recovery apply to any and all recoveries made by you or on your behalf from the following sources, including but not limited to:

- Payments made by a third party or any insurance company on behalf of a third party;
- Uninsured or underinsured motorist coverage;
- Personal injury protection, no fault or any other first party coverage;
- Workers Compensation or Disability award or settlement;
- Medical payments coverage under any automobile policy, premises or homeowners' insurance coverage, umbrella coverage;
- Medical expenses incurred as a result of medical malpractice; and
- Any other payments from any other source received as compensation for the responsible party's actions.

By accepting benefits under this Plan, you acknowledge that Health Net has a first priority right of subrogation and reimbursement that attaches when this Plan has paid for health care benefits for expenses incurred due to the actions of a responsible party and you or your representative recovers or is entitled to recover any amounts from a responsible party.

By accepting benefits under this Plan, you also grant Health Net an assignment of your right to recover pharmaceutical expenses from any coverage available to the extent of the full cost of all covered prescription drugs provided by the Plan and you specifically direct such carriers to directly reimburse the Plan on your behalf.

By accepting benefits under this Plan, you also grant Health Net a first priority lien on any recovery, settlement or judgment, or other source of compensation and all reimbursement due Health Net for the full cost of benefits paid under the Plan that are associated with injuries through a responsible party regardless of whether specifically identified as recovery for pharmaceutical expenses and regardless of whether you are made whole or fully compensated for your loss. Health Net may recover the full cost of all benefits provided by this Plan without regard to any claim of fault on the part of the Member, whether by comparative negligence or otherwise. No attorney fees may be deducted from Health Net's recovery, and Health Net is not required to pay or contribute to paying court costs or attorney's fees for the attorney hired by you to pursue the claim or lawsuit against any responsible party.

Steps you must take

If you are injured because of a responsible party, you must cooperate with Health Net and/or the pharmacys' efforts to recover its expenses, including:

- Telling Health Net and the pharmacy the name and address of the responsible party, if you know it, the name and address of your lawyer, if you are using a lawyer, the name and address of any insurance company involved with your injuries and describing how the injuries were caused.
- Completing any paperwork that Health Net or the pharmacy may reasonably require to assist in enforcing the lien.
- Promptly responding to inquiries from Health Net about the status of the case and any settlement discussions.
- Notifying Health Net immediately upon you or your lawyer receiving any money from the responsible parties, any insurance companies, or any other source.
- Pay the health care lien from any recovery, settlement or judgment, or other source of compensation and all reimbursement due Health Net for the full cost of benefits paid under the Plan that are associated with injuries through a responsible party regardless of whether specifically identified as recovery for pharmaceutical expenses and regardless of whether you are made whole or fully compensated for your loss;
- Do nothing to prejudice Health Net's rights as set forth above. This includes, but is not limited to, refraining from any attempts to reduce or exclude from settlement or recovery the full cost of all benefits paid by the plan; and
- Hold any money that you or your lawyer receive from the responsible parties, or from any other source, in trust, and reimbursing Health Net and the pharmacy for the amount of the lien as soon as you are paid.

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.

***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.

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.***

Contact the plan

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

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

You may also contact us at:

Telephone: **1-800-522-0088**
Fax: **1-818-676-8314**

Email: Privacy@healthnet.com

Binding Arbitration

This binding 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 the constitutional right 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 arbitrations 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 the 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 and the reasons for the award. 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.

DEFINITIONS OF IMPORTANT WORDS

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of prescription drugs or payment for drugs you already received. For example, you may ask for an appeal if we don't pay for a drug you think you should be able to receive. The "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" section of this booklet explains appeals, including the process involved in making an appeal.

Annual Enrollment Period – A set time each fall when members can change their health or drugs plans or switch to Original Medicare. The Annual Enrollment Period is from October 15 until December 7, 2011.

Best Available Evidence – Documentation used by the Part D sponsor to support a favorable change to low-income subsidy eligible beneficiary's LIS status.

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

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit where you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,700 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that administers Medicare. The "Important phone numbers and resources" section of this *Evidence of Coverage* explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for prescription drugs after you pay any deductibles (if applicable to your plan). Coinsurance is usually a percentage (for example, 20%).

Copayment – An amount you may be required to pay as your share of the cost for a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $5 or $20 for a prescription drug.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when drugs are received (This is in addition to the plan's applicable monthly premium.) Cost sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a drug, that a plan requires when a specific drug is received.

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

Coverage Determination – A decision about whether a drug prescribed for you is covered by the plan and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. The "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" sectionof this booklet explains how to ask us for a coverage decision.

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

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, 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.

Deductible – The amount you must pay for prescription (if applicable to your plan) before our plan begins to pay.

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).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

***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).

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.

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, a "generic drugs" works the same as a brand name drug and usually costs less.

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

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

Initial Coverage Stage – This is the stage after you have met your deductible (if applicable to your plan, see the "Plan Benefit Chart" at the beginning of this document) and before your total drug expenses have reached $2,930, including amounts you've paid and what our plan has paid on your behalf.

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, if you're eligible for Part B when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Late Enrollment Penalty – An amount added to your monthly premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected 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. For example, if you receive Extra Help from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive Extra Help, you do not pay a penalty, even if you go without "creditable" prescription drug coverage.

List of Covered Drugs (Formulary or "Drug List") – A list of prescription drugs covered 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 – See "Extra Help."

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 "Medicaid" portion of the "Important phone numbers and resources" section of this booklet for information about how to contact Medicaid in your state.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See "'The Drug List' tells which drugs are covered" portion of the "Using the plan's coverage for your prescription drugs" section of this booklet for more information about a medically accepted indication.

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, a PACE plan, 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 and Part B 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. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. 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 Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

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 the "Important phone numbers and resources" section of this booklet 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.

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

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

Out-of-Pocket Costs – See the definition for "cost-sharing" above. A member's cost-sharing requirement to pay for a portion of drugs received is also referred to as the member's "out-of-pocket" cost requirement.

PACE plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan. *:* PACE is not available in all states. If you would like to know if PACE is available in your state, please contact Member Services (phone numbers are on the back cover of this booklet).

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.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

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

Quality Improvement Organization (QIO) – A Group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients. See the "Quality Improvement Organization" portion of the "Important phone numbers and resources" section and the Exhibit 1 "Quality Improvement Organization (QIO)" section of this booklet for information about how to contact the QIO for your state. For information about making complaints to the QIO, see the "What to do if you have a problem or complaint (coverage decisions, appeals, complaints)" section of this booklet.

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

Service Area – A geographic area where a prescription drug plan accepts members if it limits membership based on where people live. The plan may disenroll you if you move out of the plan's service area.

Special Enrollment Period – A set time when members can change their health or drugs plans or return to Original Medicare. Situations in which you may be eligible for a Special Enrollment Period include: if you move outside the service area, if you are getting "Extra Help" with your prescription drug costs, if you move into a nursing home, or if we violate our contract with you.

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.

Exhibit 1 Quality Improvement Organization (QIO)

State	Program Name & Address	Contact Number
Alabama	Alabama Quality Assurance Foundation Two Perimeter Park South, Suite 200 West Birmingham, AL 35243-2337 **www.aqaf.com**	1-800-760-4550 711 (National Relay Service)
Alaska	Mountain-Pacific Quality Health Foundation 4241 B Street, Suite 303 Anchorage, AK 99503 **www.mpqhf.org**	1-800-497-8232 711 (National Relay Service)
Arizona	Health Services Advisory Group 3133 E. Camelback Road, Suite 300 Phoenix, AZ 85016-4501 **www.hsag.com**	1-800-359-9909 711 (National Relay Service)
Arkansas	Arkansas Foundation for Medical Care 1020 W. 4th Street, Suite 300 Little Rock, AR 72201 **www.afmc.org**	1-800-272-5528 711 (National Relay Service)
California	Health Services Advisory Group 700 N. Brand Blvd., Suite 370 Glendale, CA 91203 **www.hsag.com**	1-866-800-8749 711 (National Relay Service)
Colorado	Colorado Foundation for Medical Care 23 Inverness Way East, Suite 100 Englewood, CO 80112-5708 **www.cfmc.org**	1-800-727-7086 711 (National Relay Service)
Connecticut	Qualidigm 1111 Cromwell Avenue, Suite 201 Rocky Hill, CT 06067-3454 **www.qualidigm.org**	1-800-553-7590 711 (National Relay Service)

State	Program Name & Address	Contact Number
Delaware	Quality Insights of Delaware Baynard Bldg, Suite 100 3411 Silverside Road Wilmington, DE 19810-4812 **www.wvmi.org**	1-866-475-9669 711 (National Relay Service)
Florida	FMQAI 5201 W. Kennedy Blvd., Suite 900 Tampa, FL 33609-1822 **www.fmqai.com**	1-800-844-0795 711 (National Relay Service)
Georgia	Georgia Medical Care Foundation 1455 Lincoln Pkwy., Suite 800 Atlanta, GA 30346 **www.gmcf.org**	1-800-982-0411 711 (National Relay Service)
Hawaii	Mountain-Pacific Quality Health Foundation 1360 S. Beretania Street, Suite 501 Honolulu, HI 96814 **www.mpqhf.org**	1-800-524-6550 711 (National Relay Service)
Idaho	Qualis Health 720 Park Blvd., Suite 120 Boise, ID 83712-7756 **www.qualishealthmedicare.org**	1-800-445-6941 711 (National Relay Service)
Illinois	Illinois Foundation for Quality Health Care 711 Jorie Blvd., Suite 301 Oak Brook, IL 60523-4425 **www.ifmc-il.org**	1-800-647-8089 711 (National Relay Service)
Indiana	Health Care Excel 2629 Waterfront Pkwy. East Drive, Suite 150 Indianapolis, IN 46214 **www.hce.org**	1-800-288-1499 711 (National Relay Service)

State	Program Name & Address	Contact Number
Iowa	IFMC 1776 West Lakes Pkwy. West Des Moines, IA 50266 **www.internetifmc.com**	1-800-752-7014 711 (National Relay Service)
Kansas	Kansas Foundation for Medical Care, Inc 2947 SW Wanamaker Drive Topeka, KS 66614-4193 **www.kfmc.org**	1-800-432-0770 711 (National Relay Service)
Kentucky	Health Care Excel 1941 Bishop Lane, Suite 400 Louisville, KY 40218 **www.hce.org**	1-800-288-1499 711 (National Relay Service)
Louisiana	eQHealth Solutions 8591 United Plaza Blvd., Suite 270 Baton Rouge, LA 70809 **http://louisianaqio.eqhs.org/**	1-800-433-4958 711 (National Relay Service)
Maine	Northeast Health Care Quality Foundation 15 Old Rollinsford Road, Suite 302 Dover, NH 03820-2830 **www.nhcqf.org**	1-800-772-0151 711 (National Relay Service)
Maryland	Delmarva Foundation for Medical Care 6940 Columbia Gateway Drive, Suite 420 Columbia, MD 21046-2788 **www.mdqio.org**	1-800-492-5811 711 (National Relay Service)
Massachusetts	MassPRO 245 Winter Street Waltham, MA 02451-1231 **www.masspro.org**	1-800-252-5533 711 (National Relay Service)

State	Program Name & Address	Contact Number
Michigan	MPRO 22670 Haggerty Road, Suite 100 Farmington Hills, MI 48335 **www.mpro.org**	1-800-365-5899 711 (National Relay Service)
Minnesota	Stratis Health 2901 Metro Drive, Suite 400 Bloomington, MN 55425-1525 **www.stratishealth.org**	1-800-444-3423 711 (National Relay Service)
Mississippi	Information & Quality Healthcare 385B Highland Colony Pkwy., Suite 504 Ridgeland, MS 39157 **www.iqh.org**	1-800-844-0600 711 (National Relay Service)
Missouri	Primaris 200 N. Keene Street, Suite 101 Columbia, MO 65201 **www.primaris.org**	1-800-347-1016 711 (National Relay Service)
Montana	Mountain-Pacific Quality Health Foundation 3404 Cooney Drive Helena, MT 59602 **www.mpqhf.org**	1-800-497-8232 711 (National Relay Service)
Nebraska	CIMRO of Nebraska 1230 O Street, Suite 120 Lincoln, NE 68508 **www.cimronebraska.org**	1-800-458-4262 711 (National Relay Service)
Nevada	HealthInsight 6830 W. Oquendo Road, Suite 102 Las Vegas, NV 89118 **www.healthinsight.org**	1-800-748-6773 711 (National Relay Service)

State	Program Name & Address	Contact Number
New Hampshire	Northeast Health Care Quality Foundation 15 Old Rollinsford Road, Suite 302 Dover, NH 03820-2830 **www.nhcqf.org**	1-800-772-0151 711 (National Relay Service)
New Jersey	Healthcare Quality Strategies, Inc. 557 Cranbury Road, Suite 21 East Brunswick, NJ 08816 **www.hqsi.org**	1-800-624-4557 711 (National Relay Service)
New Mexico	New Mexico Medical Review Association 5801 Osuna Road NE, Suite 200 Albuquerque, NM 87109 **www.nmmra.org**	1-800-663-6351 711 (National Relay Service)
New York	IPRO 1979 Marcus Avenue Lake Success, NY 11042-1002 **www.ipro.org**	1-800-331-7767 711 (National Relay Service)
North Carolina	The Carolinas Center for Medical Excellence 100 Regency Forest Drive, Suite 100 Cary, NC 27518-8598 **www.thecarolinascenter.org**	1-800-682-2650 1-800-735-2962 (TTY)
North Dakota	North Dakota Health Care Review, Inc. 800 31st Avenue, SW Minot, ND 58701 **www.ndhcri.org**	1-888-472-2902 711 (National Relay Service)
Ohio	Ohio KePRO Rock Run Center, Suite 100 5700 Lombardo Center Drive Seven Hills, OH 44131 **www.ohiokepro.com**	1-800-589-7337 711 (National Relay Service)

State	Program Name & Address	Contact Number
Oklahoma	Oklahoma Foundation for Medical Quality 14000 Quail Springs Pkwy., Suite 400 Oklahoma City, OK 73134-2600 **www.ofmq.com**	1-800-522-3414 711 (National Relay Service)
Oregon	Acumentra Health 2020 SW Fourth Avenue, Suite 520 Portland, OR 97201 **www.acumentra.org**	Beneficiary & Family-Centered Care National Coordinating Center: 1-855-472-4440 711 (National Relay Service)
Pennsylvania	Quality Insights of Pennsylvania 2601 Market Place Street, Suite 320 Harrisburg, PA 17110 **www.qipa.org**	1-800-322-1914 711 (National Relay Service)
Rhode Island	Quality Partners of Rhode Island 235 Promenade Street Suite 500, Box 18 Providence, RI 02908 **www.qualitypartnersri.org**	1-800-662-5028 711 (National Relay Service)
South Carolina	The Carolinas Center for Medical Excellence 246 Stoneridge Drive, Suite 200 Columbia, SC 29210 **www.thecarolinascenter.org**	1-800-922-3089 1-800-735-8583 (TTY)
South Dakota	South Dakota Foundation for Medical Care 2600 West 49th Street, Suite 300 Sioux Falls, SD 57105 **www.sdfmc.org**	1-800-658-2285 711 (National Relay Service)
Tennessee	QSource 3175 Lenox Park Blvd., Suite 309 Memphis, TN 38115 **www.qsource.org**	1-800-528-2655 711 (National Relay Service)

State	Program Name & Address	Contact Number
Texas	TMF Health Quality Institute Bridgepoint I, Suite 300 5918 West Courtyard Drive Austin, TX 78730-5036 **www.tmf.org**	1-800-725-8315 711 (National Relay Service)
Utah	HealthInsight 348 East 4500 South, Suite 300 Salt Lake City, UT 84107 **www.healthinsight.org**	1-800-748-6773 711 (National Relay Service)
Vermont	Northeast Health Care Quality Foundation 15 Old Rollinsford Road, Suite 302 Dover, NH 03820-2830 **www.nhcqf.org**	1-800-772-0151 711 (National Relay Service)
Virginia	Virginia Health Quality Center (VHQC) 9830 Mayland Drive, Suite J Richmond, VA 23233 **www.vhqc.org**	1-800-545-3814 711 (National Relay Service)
Washington D.C.	Delmarva Foundation 6940 Columbia Gateway Drive, Suite 420 Columbia, MD 21046-2788 **www.dcqio.org**	1-800-645-0011 711 (National Relay Service)
Washington	Qualis Health P.O. Box 33400 Seattle, WA 98133-0400 **www.qualishealthmedicare.org**	1-800-445-6941 711 (National Relay Service)
West Virginia	West Virginia Medical Institute 3001 Chesterfield Place Charleston, WV 25304 **www.wvmi.org**	1-800-642-8686 x 2266 711 (National Relay Service)

State	Program Name & Address	Contact Number
Wisconsin	MetaStar, Inc. 2909 Landmark Place Madison, WI 53713 **www.metastar.com**	1-800-362-2320 711 (National Relay Service)
Wyoming	Mountain-Pacific Quality Health Foundation P.O. Box 2242 Glenrock, WY 82637 **www.mpqhf.org**	1-800-497-8232 711 (National Relay Service)

Exhibit 2 Qualified State Pharmacy Assistance Program (SPAP)

Please note, not all states have State Pharmaceutical Assistance Programs (SPAP) available. The following states do not have an SPAP:

- Alabama
- Alaska
- Arizona
- Arkansas
- California
- Connecticut
- Florida
- Georgia
- Iowa
- Kansas
- Kentucky
- Louisiana
- Michigan
- Minnesota
- Mississippi
- Nebraska
- New Hampshire
- New Mexico
- North Dakota
- Ohio
- Oklahoma
- Oregon
- South Carolina
- South Dakota
- Tennessee
- Utah
- Washington D.C.
- West Virginia
- Wyoming

For a list of states that have State Pharmaceutical Assistance Programs see below.

State	Program Name & Address	Contact Number
Colorado	Colorado Ryan White Title II ADAP Colorado Department of Public Health and Environment 4300 Cherry Creek Drive South Denver, CO 80246-1530 **http://www.cdphe.state.co.us/dc/HIVandSTD/ryanwhite/medicared.html**	In state only: 1-800-886-7689 1-303-692-2716 711 (National Relay Service)
Delaware	Delaware Prescription Assistance Program P.O. Box 950 New Castle, DE 19720 Delaware Chronic Renal Disease Program 11-13 Church Avenue Milford, DE 19963 **www.dhss.delaware.gov/dhss/dmma/dpap.html**	1-800-996-9969 711 (National Relay Service) 1-800- 464-4357 1-302-424-7180 711 (National Relay Service)

State	Program Name & Address	Contact Number
Hawaii	State Pharmacy Assistance Program P.O Box 700220 Kapolei, HI 96709 **http://www.med-quest.us/eligibility/EligPrograms_SPAP.html**	1-866-878-9769 711 (National Relay Service)
Idaho	Idaho AIDS Drug Assistance Program (IDAGAP) P.O. Box 83720 Boise, ID 83720 -0036 **http://healthandwelfare.idaho.gov/Health/FamilyPlanningSTDHIV/HIVCareandTreatment/tabid/391/Default.aspx**	1-208-334-5943 711 (National Relay Service)
Illinois	Illinois Cares Rx Plus Illinois Department on Aging P.O. Box 19003 Springfield, IL 62794-9022 **http://www.state.il.us/aging/1rx/cbrx/rx-assist.htm**	In state only: 1-800-624-2459 711 (National Relay Service)
Indiana	HoosierRx P.O. Box 6224 Indianapolis , IN 46206 **http://www.in.gov/fssa/ompp/2669.htm**	1-866-267-4679 1-317-234-1381 711 (National Relay Service)
Maine	Maine Low Cost Drugs for the Elderly or Disabled Program Office of MaineCare Services 442 Civic Center Drive Augusta, ME 04333 **www.maine.gov/dhhs/oes/resource/lc_drugs.htm**	1-866-796-2463 711 (National Relay Service)

State	Program Name & Address	Contact Number
Maryland	Maryland Senior Prescription Drug Assistance Program (SPDAP) C/O Pool Administrators 628 Hebron Avenue, Suite 212 Glastonbury, CT 06033 Maryland Kidney Disease Program 201 West Preston Street Room SS-3 Baltimore, MD 21201 **www.marylandspdap.com**	1-800-551-5995 711 (National Relay Service) 1-410-767-5000 711 (National Relay Service)
Massachusetts	Prescription Advantage P.O. Box 15153 Worcester, MA 01615-0153 **http://www.q1medicare.com/PartD-SPAPMassachusettsPrescrAdvantage.php**	1-800 -243-4636, Ext. 2 711 (National Relay Service)
Missouri	Missouri Rx Plan P.O. Box 6500 Jefferson City, MO 65102-6500 **www.morx.mo.gov**	1-800-375-1406 711 (National Relay Service)
Montana	Montana Big Sky Rx Program P.O. Box 202915 Helena, MT 59620 Montana Mental Health Services Program 555 Fuller Avenue P.O. Box 202905 Helena, MT 59620 Bridging the Gap P.O Box 202951 Cogswell Building C-11 Helena, MT 59620 **www.dphhs.mt.gov/prescriptiondrug/bigsky.shtml**	1-866-369-1233 711 (National Relay Service) 1-406-444-3964 711 (National Relay Service) 1-406-444-4744 711 (National Relay Service)

State	Program Name & Address	Contact Number
Nevada	Senior Rx Program Department of Health and Human Services 3416 Goni Road, Suite B-113 Carson City, NV 89706 Nevada Disability Rx Department of Health and Human Services 3416 Goni Road, Suite B-113 Carson City, NV 89706 **http://dhhs.nv.gov/SeniorRx_qlfy.htm**	1-866-303-6323 1-775-687-4210 711 (National Relay Service) 1-866-303-6323 1-775-687-4210 711 (National Relay Service)
New Jersey	New Jersey Department of Health and Senior Services Senior Gold Prescription Discount Program P.O. Box 724 Trenton , NJ 08625 Prescription Assistance to the Aged and Disabled PAAD-HAAD P.O. Box 715 Trenton, NJ 08625 New Jersey Division of Medical Assistance and Health Services Quakerbridge Plaza P. O. Box 712 Trenton , NJ 08625 **http://www.state.nj.us/health/seniorbenefits/services.shtml**	1-800-792-9745 711 (National Relay Service) 1-800-792-9745 711 (National Relay Service) 1-800-356-1561 711 (National Relay Service)
New York	Elderly Pharmaceutical Insurance Coverage (EPIC) P.O. Box 15018 Albany, NY 12212 **http://www.health.state.ny.us/**	1-800-332-3742 711 (National Relay Service)

State	Program Name & Address	Contact Number
North Carolina	North Carolina ADAP 1902 Mail Service Center Raleigh, NC 27699 NCRx 2009 Mail Service Center Raleigh, NC 27699 **www.epi.state.nc.us/epi/hiv/adapfactsheet.html**	1-877- 466-2232 711 (National Relay Service) In state only: 1-888-488-6279 711 (National Relay Service)
Pennsylvania	Pharmaceutical Assistance Contract for the Elderly (PACE) 1st Health Services 4000 Crums Mill Road, Suite 301 Harrisburg, PA 17112 PACE Needs Enhancement Tier (PACENET) P.O. Box 8806 Harrisburg, PA 17105 Department of Public Welfare Special Pharmaceutical Benefits Program P.O. Box 8021 Harrisburg, PA 17105 **www.aging.state.pa.us**	1-800-225-7223 711 (National Relay Service) 1-800-225-7223 711 (National Relay Service) 1-800-922-9384 711 (National Relay Service)
Rhode Island	Rhode Island Prescription Assistance for the Elderly (RIPAE) Rhode Island Department of Elderly Affairs Hazard Building, Second Floor 74 West Road Cranston, RI 02920 **www.dea.state.ri.us/programs/prescription_assist.php**	1-401-462-3000 TTY: 1-401 462-0740

State	Program Name & Address	Contact Number
Texas	HIV SPAP ATTN: MSJA-MC 1873 P.O. Box 149347 Austin, TX 78714 Kidney Health Care Program Department of State Health Services, MC 1938 P.O. Box 149347 Austin, TX 78714 **www.dshs.state.tx.us/hivstd/meds/spap.shtm**	1-800-255-1090, Ext. 3004 or 3008 711 (National Relay Service) 1-800-222-3986 711 (National Relay Service)
Vermont	VPharm 312 Hurricane Lane, Suite 201 Willston, VT 05495 **http://www.q1medicare.com/PartD-SPAPVermontVPharmVHAPPharVSCRIPT.php**	1-800-250-8427 711 (National Relay Service)
Virginia	Virginia Department of Health HIV SPAP P.O. Box 5930 Midlothin, VA 23112 **www.vdh.virginia.gov/epidemiology/DiseasePrevention/spap.htm**	1-800-366-7741 711 (National Relay Service)
Washington	Washington State Health Insurance Pool P.O. Box 1090 Great Bend, KS 67530 Washington State Health Insurance Assistance Program P.O. Box 1090 Great Bend, KS 67530 **www.wship.org**	1-800-877-5187 711 (National Relay Service) 1-800-877-5187 711 (National Relay Service)

State	Program Name & Address	Contact Number
Wisconsin	Wisconsin SeniorCare P.O. Box 6710 Madison, WI 53716 Wisconsin Chronic Renal Disease Chronic Renal Disease Program Attn: Eligibility Unit P.O. Box 6410 Madison, WI 53716 Wisconsin Cystic Fibrosis Program Wisconsin Chronic Disease Program P. O. Box 6410 Madison , WI 53716 Wisconsin Hemophilia Home Care Wisconsin Chronic Disease Program P. O. Box 6410 Madison , WI 53716 **www.dhs.wisconsin.gov**	1-800-657-2038 711 (National Relay Service) 1-800-362-3002 711 (National Relay Service) 1-800-362-3002 711 (National Relay Service) 1-800-362-3002 711 (National Relay Service)

Exhibit 3 Office for Civil Rights

State	Program & Address	Contact Number
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	Office for Civil Rights U.S. Department of Health & Human Services Government Center J.F. Kennedy Federal Building, Room 1875 Boston, MA 02203	1-800-368-1019 1-617-565-1340 TDD: 1-617-565-1343
New Jersey, New York	Office for Civil Rights U.S. Department of Health & Human Services Jacob Javits Federal Building 26 Federal Plaza, Suite 3312 New York, NY 10278	1-800-368-1019 1-212-264-3313 TDD: 1-212-264-2355
Delaware, Washington D.C., Maryland, Pennsylvania, Virginia, West Virginia	Office for Civil Rights U.S. Department of Health & Human Services 150 S. Independence Mall West Suite 372, Public Ledger Building Philadelphia, PA 19106-9111	1-800-368-1019 1-215-861-4441 TDD: 1-215-861-4440
Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	Office for Civil Rights U.S. Department of Health and Human Services Atlanta Federal Center, Suite 3B70 61 Forsyth Street, S.W. Atlanta, GA 30303-8909	1-800-368-1019 1-404-562-7886 TDD: 1-404-562-7884
Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	Office for Civil Rights U.S. Department of Health & Human Services 233 N. Michigan Avenue, Suite 240 Chicago, IL 60601	1-800-368-1019 1-312-886-2359 TDD: 1-312-353-5693
Arkansas, Louisiana, New Mexico, Oklahoma, Texas	Office for Civil Rights U.S. Department of Health & Human Services 1301 Young Street, Suite 1169 Dallas, TX 75202	1-800-368-1019 1-214-767-4056 TDD: 1-214-767-8940
Iowa, Kansas, Missouri, Nebraska	Office for Civil Rights U.S. Department of Health & Human Services 601 East 12th Street, Room 248 Kansas City, MO 64106	1-800-368-1019 1-816-426-7277 TDD: 1-816-426-7065

State	Program & Address	Contact Number
Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	Office for Civil Rights U.S. Department of Health & Human Services 999 18th Street, Suite 417 Denver, CO 80202	1-800-368-1019 1-303-844-2024 TDD: 1-303-844-3439
Arizona, California, Hawaii, Nevada	Office for Civil Rights U.S. Department of Health & Human Services 90 7th Street, Suite 4-100 San Francisco, CA 94103	1-800-368-1019 1-415-437-8310 TDD: 1-415-437-8311
Alaska, Idaho, Oregon, Washington	Office for Civil Rights U.S. Department of Health & Human Services 2201 Sixth Avenue, M.S. RX-11 Seattle, WA 98121-1831	1-800-368-1019 1-206-615-2290 TDD: 1-206-615-2296

Exhibit 4 State Health Insurance Assistance Program (SHIP)

State	Program Name & Address	Contact Number
Alabama	Alabama Department of Senior Services 770 Washington Avenue RSA Plaza, Suite 570 Montgomery, AL 36130-1851 **www.alabamaageline.gov**	1-800-243-5463 711 (National Relay Service)
Alaska	Medicare Information Office 3601 C Street, Suite 310 Anchorage, AK 99503-5209 **http://hss.state.ak.us/dsds/medicare/**	1-800-478-6065 711 (National Relay Service)
Arizona	DES Division of Aging and Adult Services Arizona State Health Insurance Assistance Program 1789 W. Jefferson Street, Suite 950 A Phoenix, AZ 85007 **www.azdes.gov**	1-800-432-4040 711 (National Relay Service)
Arkansas	Arkansas Insurance Department Arkansas State Health Insurance Information Program 1200 W. 3rd Street Little Rock, AR 72201 **http://www.insurance.arkansas.gov/seniors/homepage.htm**	1-800-282-9134 1-501-371-2600 711 (National Relay Service)
California	HICAP 1300 National Drive, Suite 200 Sacramento, CA 95834-1992 **www.cahealthadvocates.org**	1-800-434-0222 TDD: 1-800-735-2929
Colorado	Department of Regulatory Agencies Senior Health Insurance Assistance Program 1560 Broadway, Suite 850 Denver, CO 80202 **www.dora.state.co.us/insurance/senior/senior.htm**	1-888-696-7213 TTY: 1-303-894-7880

State	Program Name & Address	Contact Number
Connecticut	CHOICES Department of Social Services Aging Services Division 25 Sigourney Street, 10th Floor Hartford, CT 06106 **www.ct.gov/agingservices/cwp/view.asp?a=2513&q=313032**	1-800-994-9422 TTY: 1-860-842-5424
Delaware	ELDER*info* Delaware Insurance Department 841 Silver Lake Blvd. Dover, DE 19904 **http://delawareinsurance.gov/elder/**	1-800-336-9500 1-302-674-7364 711 (National Relay Service)
Florida	SHINE Program Department of Elder Affairs 4040 Esplanade Way Tallahassee, FL 32399-7000 **www.floridashine.org**	1-800-963-5337 711 (National Relay Service)
Georgia	GeorgiaCares 2 Peachtree Street NW, 9th Floor Atlanta, GA 30303 **http://www.mygeorgiacares.org/Home/SHIP/tabid/62/Default.aspx**	1-800-669-8387 TTY: 1-404-657-1929
Hawaii	Sage PLUS Program Hawaii Executive Office on Aging No. 1 Capitol District 250 S. Hotel Street, Suite 406 Honolulu, HI 96813-2831 **http://www.hawaiiship.org/**	1-888-875-9229 711 (National Relay Service)

State	Program Name & Address	Contact Number
Idaho	Idaho Department of Insurance Senior Health Insurance Benefit Advisorsits 700 West State Street, 3rd Floor Boise, ID 83720-0043 d **http://www.doi.idaho.gov/shiba/shibahealth.aspx**	1-800-247-4422 1-208-334-4250 711 (National Relay Service)
Illinois	Illinois Division of Insurance Senior Health Insurance Information Program 320 West Washington Street Springfield, IL 62767-0001 **http://insurance.illinois.gov/ship/**	1-800-548-9034 1-217-782-4515 TDD: 1-217-524-4872
Indiana	Indiana Department of Insurance Senior Health Insurance Information Program 714 West 53rd Street Anderson, IN 46013 **http://www.in.gov/idoi/2508.htm**	1-800-452-4800 TDD: 1-866-846-0139
Iowa	Senior Health Insurance Information Program 330 Maple Street Des Moines, IA 50319-0065 **http://www.shiip.state.ia.us/**	1-800-351-4664 TTY: 1-800-735-2942
Kansas	Kansas Department on Aging Senior Health Insurance Counseling for Kansas New England Building 503 S. Kansas Avenue Topeka, KS 66603-3404 **http://agingkansas.org/**	1-800-860-5260 1-785-296-4986 TTY: 1-785-291-3167
Kentucky	Kentucky Department for Aging and Independent Living State Health Insurance Assistance Program 275 E. Main Street, 3E-E Frankfort, KY 40621 **http://chfs.ky.gov/dail/ship.htm**	1-877-293-7447 1-502-564-6930 TTY: 1-888-642-1137

State	Program Name & Address	Contact Number
Louisiana	Louisiana Department of Insurance Senior Health Insurance Information Program P.O. Box 94214 Baton Rouge, LA 70804-9214 **http://www.ldi.louisiana.gov/Health/SHIIP/index.html**	In state only: 1-800-259-5301 1-800-259-5300 711 (National Relay Service)
Maine	Maine Health and Human Services Office of Elder Services 11 State House Station 32 Blossom Lane Augusta, ME 04333 **http://www.maine.gov/dhhs/oes/**	1-207-287-9200 1-800-262-2232 TTY: 1-800-606-0215
Maryland	Maryland Department of Aging Senior Health Insurance Assistance Program 301 W. Preston Street, Suite 1007 Baltimore, MD 21201 **http://www.aging.maryland.gov/senior.html** **www.dhmh.state.md.us/index.html**	1-800-243-3425 TTY: 1-800-201-7165
Massachusetts	Executive Office of Elder Affairs Serving Health Information Needs of Elders 1 Ashburton Place, 5th Floor Boston, MA 02108 **http://www.mass.gov/?pageID=eldershomepage&L=1&L0=Home&sid=Eelders**	1-800-243-4636 TTY: 1-800-872-0166
Michigan	Michigan Office of Services to the Aging Medicare/Medicaid Assistance Program 6105 W. Saint Joseph, Suite 204 Lansing, MI 48917-4850 **http://mmapinc.org/index.html**	1-800-803-7174 711 (National Relay Service)

State	Program Name & Address	Contact Number
Minnesota	Minnesota Board on Aging P.O. Box 64976 St. Paul, MN 55164-0976 **www.mnaging.org**	1-800-882-6262 1-651-431-2500 TTY: 1-800-627-3529
Mississippi	Mississippi Department of Human Services Insurance Counseling and Assistance Program 750 N. State Street Jackson, MS 39202 **http://www.mdhs.state.ms.us/aas_ship.html**	1-800-345-6347 1-601-359-4500 711 (National Relay Service)
Missouri	Missouri State Department of Insurance Community Leaders Assisting the Insured of MO 200 N. Keene Street Columbia, MO 65201 **http://www.missouriclaim.org/**	1-800-390-3330 711 (National Relay Service)
Montana	Department of Public Health & Human Services State Health Insurance Assistance Program 2030 11th Avenue Helena, MT 59604-4210 **http://www.dphhs.mt.gov/sltc/services/aging/SHIP/ship.shtml**	1-800-551-3191 711 (National Relay Service)
Nebraska	Nebraska Department of Insurance Senior Health Insurance Information Program Terminal Building 941 O Street, Suite 400 Lincoln, NE 68508-3690 **http://www.doi.ne.gov/shiip/index.htm**	1-800-234-7119 1-402- 471-2201 TDD: 1-800-833-7352
Nevada	Nevada Division for Aging Services State Health Insurance Advisory Program 1840 E. Sahara Avenue, Suite 110 Las Vegas, NV 89104 **www.nvaging.net**	1-800-307-4444 1-702-486-3478 711 (National Relay Service)

State	Program Name & Address	Contact Number
New Hampshire	NH DHHS, Bureau of Elderly & Adult Services Health Insurance Counseling Education & Assistance Services 129 Pleasant Street State Office Park Street South Concord, NH 03301 **http://www.dhhs.nh.gov/dcbcs/beas/**	1-800-351-1888 711 (National Relay Service)
New Jersey	New Jersey Department of Health and Senior Services State Health Insurance Assistance Program P. O. Box 360, Trenton, NJ 08625-0360 **http://www.state.nj.us/health/senior/ship.shtml**	1-800-792-8820 711 (National Relay Service)
New Mexico	NM Aging & Long Term Services Department Benefits Counseling Program 2550 Cerrillos Road Santa Fe, NM 87505 **www.nmaging.state.nm.us**	1-800-432-2080 1-505-476-4846 711 (National Relay Service)
New York	New York State Office for the Aging Health Insurance Information Counseling and Assistance Program 2 Empire State Plaza, Agency Building #2 Albany, NY 12223-1251 **www.aging.ny.gov**	1-800-342-9871 711 (National Relay Service)
North Carolina	North Carolina Department of Insurance Seniors Health Insurance Information Program 11 S. Boylan Avenue Raleigh, NC 27603 **http://www.ncdoi.com/shiip/default.asp**	1-800-443-9354 711 (National Relay Service)

State	Program Name & Address	Contact Number
North Dakota	North Dakota Insurance Department Senior Health Insurance Counseling State Capitol 600 E. Boulevard Avenue, 5th Floor Bismarck, ND 58505-0320 **http://www.nd.gov/ndins/consumer/shic/**	1-800-247-0560 1-888-575-6611 1-701-328-2440 TTY: 1-800-366-6888
Ohio	Ohio Department of Insurance Senior Health Insurance Information Program 50 W. Town Street, Third Floor, Suite 300 Columbus, OH 43215-4142 **www.insurance.ohio.gov**	1-800-626-1578 TTY: 1-614-644-3745
Oklahoma	Oklahoma Insurance Department Senior Health Insurance Counseling Program 2401 N.W. 23rd, Suite 28 Oklahoma City, OK 73107 **http://www.ok.gov/oid/Consumers/Information_for_Seniors/Senior_Health_Insurance_Counseling_Program_(SHIP)/index.html**	1-800-763-2828 711 (National Relay Service)
Oregon	Oregon Division of Insurance Senior Health Insurance Benefits Assistance 350 Winter Street NE, Suite 330 P.O. Box 14480 Salem, OR 97309-0405 **http://oregonshiba.org/**	1-800-722-4134 1-503-947-7979 TTY: 1-800-735-2900
Pennsylvania	Pennsylvania Department of Aging APPRISE 555 Walnut Street, 5th Floor Harrisburg, PA 17101-1919 **http://www.portal.state.pa.us/portal/server.pt/community/department_of_aging_home/18206**	1-800-783-7067 711 (National Relay Service)

State	Program Name & Address	Contact Number
Rhode Island	RI Department of Elderly Affairs Senior Health Insurance Program Hazard Building 74 West Road, 2nd Floor Cranston, RI 02920 **http://adrc.ohhs.ri.gov/**	1-401-462-4444 TTY: 1-401-462 4445
South Carolina	Insurance Counseling Assistance and Referrals for Elders (I-CARE) 1301 Gervais Street, Suite 350 Columbia, SC 29201-3301 **www.aging.sc.gov**	1-800-868-9095 1-803-734-9900 711 (National Relay Service)
South Dakota	South Dakota Department of Social Services Senior Health Information & Insurance Education 2300 West 46th Street Sioux Falls, SD 57104 **www.shiine.net**	1-800-536-8197 TTY: 1-605-367-5760
Tennessee	TN Commission on Aging and Disability State Health Insurance Assistance Program 500 Deaderick Street, Suite 825 Nashville, TN 37243-0860 **http://www.state.tn.us/comaging/ship.html**	1-877-801-0044 TTY: 1-615-532-3893
Texas	Texas Department of Aging and Disability Services Health Information, Counseling & Advocacy Program 701 W. 51st Street, Mail Code: W350 Austin, TX 78751 **http://www.dads.state.tx.us/**	1-800-252-9240 711 (National Relay Service)

State	Program Name & Address	Contact Number
Utah	Utah Division of Aging and Adult Service Health Insurance Information Program 195 North 1950 West Salt Lake City, UT 84116-3097 **www.hsdaas.utah.gov**	1-800-541-7735 711 (National Relay Service)
Vermont	Central Vermont Council on Aging 30 Washington Street Barre, Vermont 05641 Champlain Valley Agency on Aging 76 Pearl Street, Suite 201 Essex Junction, Vermont 05452 Council on Aging for Southeastern Vermont 56 Main Street Springfield, Vermont 05156 Northeastern Vermont Area Agency on Aging 481 Summer Street, Suite 101 St. Johnsbury, Vermont 05819 Southwestern Vermont Council on Aging 1085 U.S. Route 4 East, Unit 2B Rutland, Vermont 05701 **http://www.medicarehelpvt.net/**	1-802-479-0531 711 (National Relay Service) 1-802-865-0360 711 (National Relay Service) 1-802-885-6636 1-802-885-2656 711 (National Relay Service) 1-802-748-5182 711 (National Relay Service) 1-802-786-5990 711 (National Relay Service)
Virginia	Commonwealth of Virginia Department for the Aging Virginia Insurance Counseling and Assistance Project Preston Building 1610 Forest Avenue, Suite 100 Richmond, VA 23229 **www.vda.virginia.gov**	1-800-552-3402 1-804- 662-9333 711 (National Relay Service)

State	Program Name & Address	Contact Number
Washington D.C.	District of Columbia Office on Aging Health Insurance Counseling Project 2136 Pennsylvania Avenue, Washington, DC 20052 **http://dcoa.dc.gov/DC/DCOA/Our+Programs/Health+Insurance+Counseling**	1-202-739-0668 TTY: 1-202-973-1079
Washington	WA State Office of Insurance Commissioner Statewide Health Insurance Benefits Advisors P.O. Box 40256 Olympia, WA 98504-0256 **http://www.insurance.wa.gov/shiba/index.shtml**	1-800-562-6900 TTY: 1-360-586-0241
West Virginia	West Virginia Bureau of Senior Services WV State Health Insurance Assistance Program 1900 Kanawha Boulevard, East Charleston, WV 25305-0160 **www.wvship.org**	1-877-987-4463 1-304-558-3317 711 (National Relay Service)
Wisconsin	Wisconsin Department of Health and Family Services Wisconsin SHIP 1 W. Wilson Street, Room 618 Madison, WI 53703-3445 **www.dhs.wisconsin.gov**	1-800-242-1060 TTY: 1-888-701-1251
Wyoming	State of Wyoming Wyoming State Health Insurance Information Program 106 East 6th Avenue Cheyenne, WY 82002 P.O. Box BD Riverton, WY 82501 **www.wyomingseniors.com**	1-800-856-4398 711 (National Relay Service)

Exhibit 5 Medicaid Agency

State	Program Name & Address	Contact Number
Alabama	Alabama Medicaid Agency 501 Dexter Avenue Montgomery, AL 36104 PO Box 5624 Montgomery, AL 36103-5624 **http://www.medicaid.alabama.gov/**	1-800-362-1504 711 (National Relay Service)
Alaska	Division of Health Care Services 350 Main Street, Room 404 P.O. Box 110601 Juneau, AK 99811-0601 **http://www.hss.state.ak.us/dpa/**	1-800-780-9972 711 (National Relay Service)
Arizona	Arizona Health Care Cost Containment System 801 E. Jefferson, MD 4100 Phoenix, AZ 85034 **http://www.azahcccs.gov/**	1-800-654-8713 Toll Free: 1-800-523-0231 Local: 1-602-417-7000 Spanish: 1-602-417-7700 711 (National Relay Service)
Arkansas	Department of Human Services Donaghey Plaza South P.O. Box 1437, Slot S401 Little Rock, AR 72203-1437 **http://www.medicaid.state.ar.us/**	1-800-482-8988 Local: 1-501-682-8233 Spanish: 1-800-482-8988 711 (National Relay Service)
California	Department of Health Care Services PO Box 997417 MS 607 Sacramento, CA 95899-7417 **www.medi-cal.ca.gov**	1-916-552-9200 1-916-636-1980 711 (National Relay Service)
Colorado	Colorado Department of Health Care Policy and Financing 1570 Grant Street Denver, CO 80203-1818 **www.colorado.gov**	1-800-221-3943 Local: 1-303-866-3513 711 (National Relay Service)

State	Program Name & Address	Contact Number
Connecticut	Department of Social Services 25 Sigourney Street Hartford, CT 06106-5033 **www.dss.state.ct.us**	1-800-842-1508 Local: 1-860-424-4908 TTY: 1-800-842-4524
Delaware	Delaware Health and Social Services Division of Medicaid and Medical Assistance 1901 N. Du Pont Highway, Lewis Bldg. New Castle, DE 19720 **www.dhss.delaware.gov**	1-800-372-2022 1-302- 255-9500 711 (National Relay Service)
Florida	Agency For Health Care Administration 2727 Mahan Drive Tallahassee, FL 32308 **www.fdhc.state.fl.us**	1-888-419-3456 Toll Free: 1-866-762-2237 Local: 1-850-487-1111 711 (National Relay Service)
Georgia	Georgia Department of Community Health 2 Peachtree Street, NW Atlanta, GA 30303 **www. dch.georgia.gov**	Toll Free: 1-800-869-1150 Local: 1-404-651-9982 711 (National Relay Service)
Hawaii	Department of Human Services of Hawaii P.O. Box 339 Honolulu, HI 96809 **www.med-quest.us**	1-800-316-8005 Local: 1-808-524-3370 TTY: 1-800-603-1201
Idaho	Idaho Department of Health and Welfare PO Box 83720 Boise, ID 83720-0036 **www. healthandwelfare.idaho.gov**	1-800-926-2588 Local: 1-208-334-6700
Illinois	Department of Health Care and Family Services 201 South Grand Avenue East Springfield, IL 62763-0001 **www.hfs.illinois.gov**	1-866-468-7543 Toll Free: 1-800-226-0768 Spanish: 1-217-785-8036 TTY: 1-800-526-5812

State	Program Name & Address	Contact Number
Indiana	Family & Social Services Administration P.O. Box 7083 402 W. Washington Street Indianapolis, IN 46207-7083 **www.in.gov/fssa**	1-800-457-4584 Toll Free: 1-800-403-0864 Local: 1-317-233-4454 711 (National Relay Service)
Iowa	Department of Human Services Hoover State Office Building 1305 E. Walnut Street Des Moines, Iowa 50319 **www.dhs.state.ia.us**	1-800-972-2017 Toll Free: 1-800-338-8366 Local: 1-515-256-4606 711 (National Relay Service)
Kansas	Kansas Health Policy Authority Room 900-N, Landon State Office Building 900 SW Jackson Street Topeka, Kansas 66612 **https://www.kmap-state-ks.us/**	1-785-296-3981 Toll Free: 1-800-766-9012 Local: 1-785-296-3981 TTY: 1-785-296-1491
Kentucky	Cabinet for Health and Family Services Department of Medicaid Services 275 East Main Street Frankfort, KY 40621 **www.chfs.ky.gov**	Toll Free: 1-800-635-2570 Local: 1-502-564-4321 TTY 1-800-627-4702
Louisiana	Department of Health and Hospitals P. O. Box 629 Baton Rouge, LA 70821-0629 **http://new.dhh.louisiana.gov/**	1-888-342-6207 Local: 1-877-252-2447 711 (National Relay Service)
Maine	Department of Health and Human Services 11 State House Station, Augusta, Maine 04333-0011 **http://www.maine.gov/dhhs/oms/**	1-800-321-5557 Toll Free: 1-800-977-6740 Local: 1-207-287-9202 TTY: 1-800-606-0215
Maryland	Department of Health and Mental Hygiene 201 West Preston Street Baltimore, MD 21201 **www.dhmh.state.md.us**	In state: 1-877-463-3464 Toll Free: 1-800-492-5231 Local: 1-410-767-5800 711 (National Relay Service)

State	Program Name & Address	Contact Number
Massachusetts	Office of Health and Human Services Office of Medicaid One Ashburton Place 11th Floor Boston, MA 02108 **www.mass.gov**	1-800-841-2900 711 (National Relay Service)
Michigan	Department of Community Health Capital View Building 201 Townsend Street Lansing, MI 48913 **www.michigan.gov/mdch**	Toll Free: 1-800-642-3195 Local: 1-517-373-3740 TTY: 1-800-649-3777
Minnesota	Department of Health P.O. Box 64975 St Paul, MN 55164 **www.dhs.state.mn.us**	1-888-345-0823 Toll Free: 1-800-657-3739 Local: 1-651-201-5000 TTY: 1-800-627-3529
Mississippi	Mississippi Division of Medicaid Walter Sillers Bldg. 550 High Street Ste 1000 Jackson, MS 39201 **www.medicaid.ms.gov**	1-800-421-2408 Local: 1-601-359-6050 711 (National Relay Service)
Missouri	Department of Social Services 221 West High Street P.O. Box 1527 Jefferson City, MO 65102 **www.dss.mo.gov**	Toll Free: 1-800-392-2161 Local: 1-573-751-3425 TTY: 1-800-735-2966
Montana	Department of Public Health & Human Services Cogswell Building 1400 Broadway Helena, MT 59620 111 North Sanders PO Box 4210 Helena, MT 59604-4210 **www.dphhs.mt.gov**	1-800-362-8312 711 (National Relay Service)

State	Program Name & Address	Contact Number
Nebraska	Department of Health and Human Services P.O. Box 95026 Lincoln, NE 68509-5026 **www.hhs.state.ne.us**	1-402-471-3121 Toll Free: 1-800-430-3244 711 (National Relay Service)
Nevada	Department of Health and Human Services 1100 East William Street, Suite 101 Carson City, NV 89701 **www.dhcfp.nv.gov**	1-775-684-3600 Toll Free: 1-800-992-0900 Local: 1-775-684-7200
New Hampshire	Department of Health and Human Services NH DHHS Office of Medicaid Business & Policy Brown Building 129 Pleasant Street Concord, NH 03301 **www.dhhs.state.nh.us**	In state: 1-800-852-3345, Ext. 4344 711 (National Relay Service)
New Jersey	Department of Human Services Division of Medical Assistance and Health Services PO Box 712 Trenton, NJ 08625-0712 **http://www.state.nj.us/humanservices/dmahs/home/index.html**	1-800-356-1561 Spanish: 1-800-356-1561 711 (National Relay Service)
New Mexico	New Mexico Human Services Department Medical Assistance Division P.O. Box 2348 Santa Fe, NM 87504-2348 2009 S. Pacheco, Pollon Plaza Santa Fe, NM 87504 **www.hsd.state.nm.us/mad/index.htm**	1-888-997-2583 Local: 1-505-827-3100 Spanish: 1-800-432-6217 711 (National Relay Service)
New York	New York State Department of Health Corning Tower, Empire State Plaza Albany, NY 12237 **www.health.state.ny.us**	1-800-541-2831 711 (National Relay Service)

State	Program Name & Address	Contact Number
North Carolina	North Carolina Department of Health & Human Services Office of Medical Assistance 2501 Mail Service Center Raleigh, NC 27699-2001 **www.ncdhhs.gov**	1-800-662-7030 Local: 1-919-855-4400 TTY: 1-919-733-4851
North Dakota	Department of Human Services 600 E Boulevard Avenue Dept 325 Bismarck, ND 58505-0250 **www.nd.gov/dhs**	1-800-755-2604 Local: 1-701-328-2321 TTY: 1-701-328-3480
Ohio	Ohio Department of Jobs & Family Services P.O. Box 182709 Columbus, OH 43218-2709 30 E. Broad Street, 32nd Floor Columbus, Ohio 43215 **http://jfs.ohio.gov/ohp/**	1-800-324-8680 Local: 1-614-644-0140 711 (National Relay Service)
Oklahoma	Oklahoma Health Care Authority 2401 N.W. 23rd St., Suite 1A Oklahoma City, OK 73107 **http://www.okhca.org/**	1-405-522-7300 Toll Free: 1-800-522-0310 711 (National Relay Service)
Oregon	Oregon Department of Human Services Division of Medical Assistance Administrative Office 500 Summer Street NE Salem, OR 97301-1079 **www.oregon.gov**	In state only: 1-800-527-5772 Local: 1-503-945-5772 TTY: 1-503-945-6214
Pennsylvania	Department of Public Welfare Office of Medical Assistance Programs P.O. Box 2675 Harrisburg, PA 17105-2675 **www.dpw.state.pa.us**	1-800-692-7462 711 (National Relay Service)

State	Program Name & Address	Contact Number
Rhode Island	Department of Human Services Louis Pasteur Building #57 600 New London Avenue Cranston, RI 02920 **www.dhs.ri.gov**	1-401-462-5300 TTY: 1-800-745-5555
South Carolina	South Carolina Department of Health & Human Services P.O. Box 8206 Columbia, SC 29202 **www.dhhs.state.sc.us**	1-888-549-0820 Local: 1-803-898-2500 711 (National Relay Service)
South Dakota	South Dakota Department of Social Services 700 Governors Drive Pierre, SD 57501 **http://dss.sd.gov/**	1-605-773-3495 Toll Free: 1-800-597-1603 711 (National Relay Service)
Tennessee	TennCare 310 Great Circle Road Nashville, TN 37243 **http://www.state.tn.us/tenncare/**	1-866-311-4287 1-800-342-3145 711 (National Relay Service)
Texas	Texas Health and Human Services Commission 4900 N. Lamar Blvd., 4th Floor Austin, TX 78751-2316 **http://www.hhsc.state.tx.us/**	1-800-252-8263 1-800-964-2777 TTY:1-512-424-6597
Utah	Department of Health Division of Medicaid and Health Financing P.O. Box 143106 Salt Lake City, UT 84114-3106 **http://health.utah.gov/medicaid/**	1-800-662-9651 1-801-538-6155 711 (National Relay Service)

State	Program Name & Address	Contact Number
Vermont	Agency of Human Services Economic Services Division Vermont Department for Children and Families 103 South Main Street Waterbury, VT 05676 **www.greenmountaincare.org**	1-800-250-8427 Local: 1-802-879-5900 711 (National Relay Service)
Virginia	Department of Medical Assistance Services 600 E. Broad Street Richmond, VA 23219 **www.dmas.virginia.gov**	1-804-786-7933 711 (National Relay Service)
Washington	Department of Social and Health Services Customer Service Center P.O. Box 45502 Olympia, WA 98504 P.O. Box 11699 Tacoma, WA 98411-9905 **www.dshs.wa.gov**	1-800-562-3022 711 (National Relay Service)
Washington D.C.	Department of Health Government of the District of Columbia 899 N. Capitol Street, NE Washington, DC 20002 **www.doh.dc.gov**	1-202-698-4350 711 (National Relay Service)
West Virginia	West Virginia Dept of Health & Human Resources 350 Capitol Street, Room 251 Charleston, WV 25301-3708 **http://www.dhhr.wv.gov/bms/Pages/default.aspx**	1-800-642-8589 Local: 1-304-558-1700 711 (National Relay Service)
Wisconsin	Department of Health Services 1 W. Wilson Street Madison, WI 53703 **www.dhs.wisconsin.gov**	1-800-362-3002 Local: 1-608-221-5720 TTY: 888-701-1251

State	Program Name & Address	Contact Number
Wyoming	Department of Health 401 Hathaway Building Cheyenne, WY 82002 **http://health.wyo.gov/**	1-800-251-1269 1-307-777-7531 711 (National Relay Service)

Health Net Prescription Drug Plan (Employer PDP) Member Services

CALL	**1-800-539-4072** Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week. During the Medicare annual enrollment period (between October 15 and December 7) through February 14, our plan operates a toll-free call center for both current and prospective members that is staffed seven days a week from 8:00 a.m. to 8:00 p.m. Pacific time. During this time period, current and prospective members are able to speak with a Member Service representative. If you call outside these hours, when leaving a message, you should include your name, phone number and the time you called, and a representative will return your call no later than one business day after you leave a message. However, after February 14, 2012, your call will be handled by our automated phone system, Saturdays, Sundays, and holidays. When leaving a message, please include your name, phone number and the time that you called, and a representative will return your call no later than one business day after you leave a message Member Services also has free language interpreter services available for non-English speakers.
TTY/TDD	**1-800-929-9955** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. 8:00 a.m. to 8:00 p.m., Pacific time, seven days a week.
FAX	**1-888-268-2393**
WRITE	Health Net Medicare P.O. Box 6501 Rensselaer, NY 12144-6501
WEBSITE	www.healthnet.com/uc

State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a state program that gets money from the Federal government to give free local health insurance counseling to people with Medicare.

You can find contact information for the SHIP in your state in Exhibit 4 “State Health Insurance Assistance Program (SHIP),” located at the end of this *Evidence of Coverage*.