SUMMARY OF BENEFITS AND DISCLOSURE FORM

University of California
Medicare COB • Plan 2G6

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

Health Net®
A Better Decision

Delivering choices

When it comes to your health care, the best decisions are made with the best choices. Health Net of California, Inc. (Health Net) provides you with ways to help you receive the care you deserve. This Summary of benefits/disclosure form SB/DF answers basic questions about this versatile plan. If you have further questions, just contact the Health Net Member Services Department at **1-800-539-4072**. Our friendly, knowledgeable representatives will be glad to help.

This *Summary of benefits/disclosure form* (SB/DF) is only a summary of your health plan. Your *Evidence of Coverage* (EOC), which you will receive after you enroll, contains the exact terms and conditions of your Health Net coverage. It is important for you to carefully read this SB/DF and your EOC thoroughly once received, especially those sections that apply to those with special health care needs. This SB/DF includes a matrix of benefits in the section titled "Schedule of benefits and coverage."

Table of contents

How the plan works

Please read the following information so you will know from whom health care may be obtained, or what physician group to use.

Selection of physicians and physician groups

- When you enroll with Health Net, you choose a contracting physician group. From your physician group, you select one doctor to provide basic health care; this is your Primary Care Physician (PCP). See your *Health Net HMO Directory of Participating Physician Groups and Primary Care Physicians (Health Net HMO Directory)* for detailed information about physicians and physician groups in the Health Net network. The Health Net HMO Directory is also available on the Health Net website at www.healthnet.com/uc.
- Whenever you or a covered family member needs health care, your PCP will provide the medically necessary treatment. Specialist care is also available through your Health Net plan, when authorized in advance through your PCP or physician group.
- You do not have to choose the same physician group or PCP for all members of your family. Physician groups, with names of physicians, are listed in the *Health Net HMO Directory.*

How to choose a physician

Selecting a PCP is important to the quality of care you receive. To ensure you are comfortable with your choice, we suggest the following:

- Discuss any important health issues with your selected physician group;
- Do the same with the Health Net Coordinator at the physician group, and ask for referral specialist policies and hospitals used by the physician group; and
- Ensure that you and your family members have adequate access to medical care, by selecting a doctor located within 30 miles of your residence or work.

Specialists and referral care

If you need medical care that your PCP cannot provide, your PCP may refer you to a specialist or other health care provider for that care. Your physician group must authorize all treatments recommended by such provider.

HMO specialist access

Health Net offers Rapid Access®, a service that makes it easy for you to quickly connect with a specialist in Health Net's network. Ask your group or check your *Health Net HMO Directory* to see if your physician group allows "self-referrals" or "direct referrals" to specialists within the same group. Self-referral allows you to contact a specialist directly for consultation and evaluation. Direct referral allows your doctor to refer you directly to a specialist without the need for physician group authorization. Information about your physician group's referral policies is also available to you on our Internet web site, www.healthnet.com/uc.

How to enroll

Complete the enrollment form found in the enrollment packet and return the form to your employer. If a form is not included, your employer may require you to use an electronic enrollment form or an interactive voice response enrollment system. Please contact your employer for more information.

You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association or clinic, or call Health Net Member Services Department at 1-800-539-4072 to ensure that you can obtain the health care services that you need.

This plan provides benefits required by the Newborns' and Mothers' Health Protection Act of 1996 and the Woman's Health and Cancer Right Act of 1998.

Schedule of benefits and coverage

Medical benefits

Deductibles & plan maximums

Deductible	None
Lifetime maximum	None
Calendar Year Out-of-Pocket Maximum (OOPM)	

Once your payments for covered services equals the amount shown below in any one calendar year, no additional copayments for covered services are required for the remainder of the calendar year. Once an individual member in a family satisfies the individual out-of-pocket maximum, the remaining enrolled family members must continue to pay copayments for covered services until the total amount of copayments paid by the family reaches the family out-of-pocket maximum or each enrolled family member individually satisfies the individual out-of-pocket maximum. Payments for any supplemental benefits or services not covered by this plan will not be applied to this calendar year out-of-pocket maximum, unless otherwise noted. You will need to continue making payments for any additional benefits as described in the "Additional plan benefits information" section of this SB/DF.

One member	Three (3) inpatient copayments per person per calendar year.
Family (three members or more)	Not Applicable

Type of service & what you pay for services (medical benefits)[1]

Professional services

Visit to physician	$15
Visit to physician for treatment of severe mental illness or serious emotional disturbances of a child (who is eligible under this Medicare plan)[2***]	$15
Podiatry services[6]	$15
Annual routine physical examinations	Covered in full
Specialist consultations[3]	$15
Physician visit to member's home at your physician's discretion and in accordance with criteria set by Health Net	$15
Physician visit to hospital or skilled nursing facility (excluding care for mental disorders)	Covered in full
Immunization for occupational purposes	20%
Immunization for foreign travel	20%
Allergy testing	$15
Allergy serum	Covered in full
Allergy injection services	$15
Office Based injectable medications (per dose)[13]	Covered in full
All other injections (excluding infertility injection)[13]	Covered in full
Surgeon services[4]	Covered in full
Assistant surgeon services[4]	Covered in full
Transgender surgery and services[14]	Covered in full
Administration of anesthetics	Covered in full

Laboratory procedures and diagnostic imaging (including x-ray) services	Covered in full
Rehabilitative therapy (includes physical, speech, occupational, cardiac rehabilitation and pulmonary rehabilitation therapy)	$15
Adult preventive care	
Periodic health evaluations, including well-woman exam[3, 5]	Covered in full
Vision and hearing examinations [3, 5]	$15
Immunizations	Covered in full
Hospital services	
Semi-private hospital room or intensive care unit with ancillary services, including maternity care (unlimited days)	
First three hospital admissions each calendar year	$250 per admission
Subsequent hospital admissions in the same calendar year	Covered in full
Semi-private hospital room or intensive care unit with ancillary services for treatment of severe mental illness or serious emotional disturbances of a child (who is eligible under this Medicare plan) (unlimited)[2***]	
First three hospital admissions each calendar year	$250 per admission
Subsequent hospital admissions in the same calendar year	Covered in full
Skilled nursing facility stay *(limited to 100 days each calendar year)*	Covered in full
Outpatient facility services (other than surgery)	Covered in full
Outpatient surgery (surgery performed in a hospital or outpatient surgery center only)[8]	Covered in full
Emergency health coverage	
Emergency room (professional and facility charges)[7]	$50
Urgent care center (professional and facility charges)[7]	$50
Ground ambulance	Covered in full
Air ambulance	Covered in full
Other services	
Medical social services	Covered in full
Patient education	Covered in full
Durable medical equipment (including nebulizers, face masks and tubing for the treatment of asthma)	Covered in full
Orthotics (such as bracing, supports and casts)	Covered in full
Corrective footwear	Covered in full
Diabetic equipment[9]	Covered in full
Diabetic footwear[9]	Covered in full
Hearing aids (2 standard aid(s) with a benefit maximum of $2,000 every 36 months)[16]	Covered in full
Prostheses[9]	Covered in full
Blood, blood plasma, blood derivatives and blood factors	Covered in full
Nuclear medicine	Covered in full

Organ and bone marrow transplants (nonexperimental and noninvestigational)	Covered in full
Chemotherapy	Covered in full
Renal dialysis	Covered in full
Home health services	Covered in full
Home IV therapy	Covered in full
Hospice services	Covered in full

Additional plan benefit information (supplemental)

Behavioral health services

(Benefits are administered by Managed Health Network (MHN). Please refer to the "Behavioral health services" section of this SB/DF for the definitions, benefits and limitations.)

Telephonic clinical consultations (limited to a maximum of 3 consultations per member per calendar year)[11]	Covered in full
Nonsevere mental disorder benefits[2***12]	
Outpatient consultation (unlimited visits)[2*]:	
Individual session	$15
Group session	$7.50
Inpatient[2**]	
First three hospital admissions each calendar year	$250 per admission
Subsequent hospital admissions in the same calendar year	Covered in full
Lifetime days maximum per member	190
Partial Hospitalization[2**]	
First three hospital admissions each calendar year	$250 per admission
Subsequent hospital admissions in the same calendar year	Covered in full
Maximum days each calendar year	Unlimited
Substance abuse benefits	
Outpatient consultation *(unlimited visits)*[2*]:	
Individual session	$15
Group session	$7.50
Inpatient [2**]	
First three hospital admissions each calendar year	$250 per admission
Subsequent hospital admissions in the same calendar year	Covered in full
Maximum days each calendar year	Unlimited

Acute care detoxification[2**]	
First three hospital admissions each calendar year	$250 per admission
Subsequent hospital admissions in the same calendar year	Covered in full
Maximum days each calendar year	Unlimited

Outpatient prescription drug plan[9]

Medicare Part D prescription drug coverage is provided through Health Net

Refer to the "Outpatient prescription drug plan" section at the end of this SB/DF for the benefits and limitations.

Chiropractic services[10]

(Benefits are administered by American Specialty Health Plans of California, Inc. (ASH Plans). Please refer to the "Chiropractic care program" section of this SB/DF for the benefits and limitations.)

Office visits *(20-visit maximum per calendar year)*	$15
Annual chiropractic appliance allowance	$50

Vision care[10]

(Benefits are administered by EyeMed Vision Care, LLC, a contracted vision services provider panel. Please refer to the "Vision care program" section of this SB/DF for the benefits and limitations.)

Frame allowance, every 24 months	$100
Lenses	Covered in full (or subject to eyewear allowance)
Contact lenses allowance, every 24 months (if contact lenses are not medically necessary and you choose to wear them instead of eyeglasses)	$100

Benefits of this plan provide coverage required by the Newborns' and Mothers' Health Protection Act of 1996 and the Women's Health and Cancer Right Act of 1998. Specifically, the Newborns' and Mothers' Health Protection Act requires group health plans to provide a minimum hospital stay for the mother and newborn child of 48 hours after a normal, vaginal delivery and 96 hours after delivery by cesarean section unless the attending physician, in consultation with the mother, determines a shorter hospital length of stay is adequate. If you are discharged earlier, your physician may decide, at his or her discretion, that you should be seen at home or in the office, within 48 hours of the discharge, by a licensed health care provider whose scope of practice includes postpartum care and newborn care. The Women's Health and Cancer Right Act of 1998 applies to medically necessary mastectomies and requires coverage for prosthetic devices and reconstructive surgery on either breast provided to restore and achieve symmetry.

Endnotes

[1] The percentages that appear in this chart are based on amounts agreed to in advance by Health Net and the member's physician group or other authorized health care provider.

[2] Please refer to the "Behavioral health services" section of this SB/DF for the definitions of severe mental illness and serious emotional disturbances of a child (who is eligible under this Medicare plan). Benefits are administered through Managed Health Network (MHN).

* Applicable only for outpatient counseling defined as individual office visits and group therapy sessions. Group sessions are equal to half of an individual session and count towards the visit maximum.

**Inpatient admission means any admission to a hospital, day treatment program, residential treatment center or structured outpatient program. The copayment is applicable for each admission.

***The mental disorder copayments and day or visit limits will not apply for severe mental illness or serious emotional disturbances of a child (who is eligible under this Medicare plan) as defined. Services for these conditions require whatever copayment would be required if the services were provided for a medical condition. Refer to the "Schedule of benefits and coverage" section of this SB/DF to determine the applicable copayment. All other mental disorders will be subject to the copayments shown under the heading "Non severe mental disorder benefits."

[3] Self-referrals are allowed for obstetrics and gynecological services including preventive care and gynecological ailments. Copayment requirements may differ depending on the services provided.

[4] Surgery includes surgical reconstruction of a breast incident to mastectomy, including surgery to restore symmetry; also includes prosthesis and treatment of physical complications at all stages of mastectomy, including lymphedema. While Health Net and your physician group will determine the most appropriate services, the length of hospital stay will be determined solely by your PCP.

[5] For preventive health purposes, a periodic health evaluation and diagnostic preventive procedures are covered, based on recommendations published by the U.S. Preventive Services Task Force. In addition, a covered annual cervical cancer screening test includes a Pap test, a human papillomavirus (HPV) screening test that is approved by the federal Food and Drug Administration (FDA), and the option of any cervical cancer screening test approved by the FDA. Vision and hearing screening, provided as part of a periodic health evaluation, are covered at no charge.

[6] Limited to one visit each calendar month. Medically necessary podiatry services covered by Medicare are covered with no limit.

[7] Copayments for emergency room or urgent care center visits will not apply if the member is admitted as an inpatient directly from the emergency room or urgent care center. A visit to one of the urgent care centers that is owned and operated by the member's physician group will be considered an office visit and the office visit copayment, if any, will apply.

[8] Diagnostic endoscopic procedures, such as diagnostic colonoscopy, performed in an outpatient facility require the copayment applicable for outpatient facility services. If, during the course of a diagnostic endoscopic procedure performed in a hospital or outpatient surgical center, a therapeutic (surgical) procedure is performed, then the copayment applicable for outpatient surgery will be required instead of the copayment for outpatient facility services.

[9] Diabetic equipment and supplies for the management and treatment of diabetes are covered as medically necessary, including:

- Insulin pumps and related supplies
- Corrective footwear
- Blood glucose monitors designed for the visually impaired and blood glucose testing strips
- Ketone urine testing strips*
- Lancets and lancet puncture devices*
- Specific brands of pen delivery systems for the administration of insulin (including pen needles)*
- Specific brands of disposable insulin needles and syringes*

* You have the outpatient prescription drug coverage, these items are covered under the prescription drug benefit including specific brands of blood glucose monitors/testing strips. Please see the "Outpatient prescription drug plan" section in this booklet for additional information.

In addition, the following supplies are covered under the medical benefit as specified: visual aids (excluding eyewear) to assist the visually impaired with the proper dosing of insulin are provided through the prosthetics benefit; Glucagon is provided through the self-injectable benefit. Self-management training, education and medical nutrition therapy will be covered only when provided by licensed health care professionals with expertise in the management or treatment of diabetes (provided through the patient education benefit).

[10] Copayments for the following services and supplies do not apply to the out-of-pocket maximum (as described under the "Medical benefits" portion of this section:

- Outpatient prescription drugs, except copayments for peak flow meter and inhaler spacers used for the treatment of asthma, and diabetic supplies
- Chiropractic care
- Vision care

[11]For Telephonic clinical consultations please call Managed Health Network (MHN) at 1-800-663-9355.

[12]Gender dysphoria is covered as any other mental illness.

[13] Injections for hormonal therapy related to Gender Identity Disorder (GID) are covered.

[14] Transgender surgery and related services, including travel, lodging and meal costs, require prior authorization. Transgender surgery and related services, including travel, lodging and meal costs, that are authorized by the Plan, are subject to a combined Inpatient and Outpatient lifetime benefit maximum of $75,000 for each Member.

[15] Limited to one visit each calendar month. Medically necessary podiatry services covered by Medicare are covered with no limit.

[16] A standard Hearing Aid (analog or digital) is one that restores adequate hearing to the Member and is determined to be Medically Necessary and authorized by the Members Physician Group. No benefits will be provided for hearing aid charges which exceeds specifications prescribed for the correction of hearing loss.

Limits of coverage

What's not covered (exclusions and limitations)

- Artificial insemination for reasons not related to infertility;
- Conception by medical procedures (IVF, GIFT and ZIFT);
- Contraceptive devices
- Corrective or support appliances or supplies except as provided for diabetic supplies;
- Cosmetic services and supplies;
- Custodial or live-in care;
- Dental services;
- Disposable supplies for home use;
- Experimental or investigational procedures, except as set out under the "Clinical trials" and "If you have a disagreement with our plan" sections of this SB/DF;
- Genetic testing is not covered except when determined by Health Net to be medically necessary. The prescribing physician must request prior authorization for coverage;
- Non-eligible institutions. This plan only covers services or supplies provided by a legally operated hospital, Medicare-approved skilled nursing facility or other properly licensed facility as specified in the EOC. Any institution that is primarily a place for the aged, a nursing home or similar institution, regardless of how it is designated, is not an eligible institution. Services or supplies provided by such institutions are not covered;
- Norplant
- Orthoptics (eye exercises);
- Orthotic items for the foot, except when incorporated into a cast, splint, brace or strapping of the foot or when medically necessary for the treatment of diabetes, or as provided under the corrective footwear benefit;
- Outpatient prescription drugs (except as noted under “Prescription drug program”);
- Personal or comfort items;
- Physician self-treatment;
- Physician treating immediate family members;
- Private rooms when hospitalized, unless medically necessary;
- Private-duty nursing;
- Refractive eye surgery unless medically necessary, recommended by the member's treating physician and authorized by Health Net;
- Reversal of surgical sterilization;
- Routine physical examinations for insurance, licensing, employment, school, camp or other nonpreventive purposes;
- Services and supplies not authorized by Health Net or the physician group according to Health Net's procedures;
- Services for a surrogate pregnancy are covered when the surrogate is a Health Net member. However, when compensation is obtained for the surrogacy, Health Net shall have a lien on such compensation to recover its medical expense;
- Services received before effective date or after termination of coverage, except as specifically stated in the "Extension of Benefits" section of the member’s EOC;
- Treatment of jaw joint disorders or surgical procedures to reduce or realign the jaw, unless medically necessary; and
- Treatment of obesity, weight reduction or weight management, except for treatment of morbid obesity.

The above is a partial list of the principal exclusions and limitations applicable to the medical portion of your Health Net plan. The EOC, which you will receive if you enroll in this plan, will contain the full list.

Benefits and coverage

What you pay for services

The comprehensive benefits of your Health Net plan are described in the "Schedule of benefits and coverage" section. Please take a moment to look it over.

Emergencies

Health Net covers emergency and urgently needed care throughout the world. If you are injured, feel severe pain, begin active labor or experience an unexpected illness that a reasonable person with an average knowledge of health and medicine would believe requires immediate treatment to prevent serious threat to your health (including severe mental illness and serious emotional disturbances of a child (who is eligible under this Medicare plan)), seek care where it is immediately available. Depending on your circumstances, you may seek this care by going to your physician group (medical) or the Behavioral Health Administrator (mental illness and detoxification), or to the nearest emergency facility or by calling **911**.

You are encouraged to use appropriately the **911** emergency response system, in areas where the system is established and operating, when you have an emergency medical condition (including severe mental illness and serious emotional disturbances of a child) that requires an emergency response. All ambulance and ambulance transport services provided as a result of a **911** call will be covered, if the request is made for an emergency medical condition (including severe mental illness and serious emotional disturbances of a child (who is eligible under this Medicare plan)).

An emergency means any otherwise covered service that a reasonable person with an average knowledge of health and medicine would believe requires immediate treatment (including severe mental illness and serious emotional disturbances of a child (who is eligible under this Medicare plan)), and without immediate treatment, any of the following would occur: (a) his or her health would be put in serious danger (and in the case of a pregnant woman, would put the health of her unborn child in serious danger); (b) his or her bodily functions, organs or parts would become seriously damaged; or (c) his or her bodily organs or parts would seriously malfunction. Emergency Care also includes treatment of severe pain or active labor. Active labor means labor at the time that either of the following would occur: (a) there is inadequate time to effect safe transfer to another hospital prior to delivery; or (b) a transfer poses a threat to the health and safety of the member or her unborn child.

All follow-up care (including severe mental illness and serious emotional disturbances of a child(who is eligible under this Medicare plan)) after the urgency has passed and your condition is stable, must be provided or authorized by your physician group (medical) or the Behavioral Health Administrator (mental illness and detoxification); otherwise, it will not be covered by Health Net.

Medically necessary care

All services that are medically necessary will be covered by your Health Net plan (unless specifically excluded under the plan). All covered services or supplies are listed in your EOC; any other services or supplies are not covered.

Second opinions

You have the right to request a second opinion when:

- Your PCP or a referral physician gives a diagnosis or recommends a treatment plan that you are not satisfied with;
- You are not satisfied with the result of treatment you have received;

- You are diagnosed with, or a treatment plan is recommended for, a condition that threatens loss of life, limb, or bodily function, or a substantial impairment, including but not limited to a serious chronic condition; or
- Your PCP or a referral physician is unable to diagnose your condition, or test results are conflicting.

To obtain a copy of Health Net's second opinion policy, contact the Health Net Member Services Department at **1-800-539-4072**.

Clinical trials

Routine patient care costs for patients diagnosed with cancer who are accepted into phase I, II, III, or IV clinical trials are covered when medically necessary, recommended by the member's treating physician and authorized by Health Net. The physician must determine that participation has a meaningful potential benefit to the member and the trial has therapeutic intent. For further information, please refer to the EOC.

Extension of benefits

If you or a covered family member is totally disabled when your employer ends its group services agreement with Health Net, we will cover the treatment for the disability until one of the following occurs:

- A maximum of 12 consecutive months elapses from the termination date;
- Available benefits are exhausted;
- The disability ends; or
- The member becomes enrolled in another plan that covers the disability.

If you are hospitalized on the date your coverage ends, you will be covered until the discharge date. If you are not hospitalized, your application for an extension of benefits for disability must be made to Health Net within 90 days after your employer ends its agreement with us. We will require medical proof of the total disability at specified intervals.

Confidentiality and release of member information

Health Net knows that personal information in your medical records is private. Therefore, we protect your personal health information in all settings (including oral, written and electronic information). The only time we would release your confidential information without your authorization is for payment, treatment, health care operations (including, but not limited to utilization management, quality improvement, disease or case management programs) or when permitted or required to do so by law, such as for court order or subpoena. We will not release your confidential claims details to your employer or their agent. Often Health Net is required to comply with aggregated measurement and data reporting requirements. In those cases, we protect your privacy by not releasing any information that identifies our members.

Privacy practices

Once you become a Health Net member, Health Net uses and discloses a member's protected health information for purposes of treatment, payment, health care operations, and where permitted or required by law. Health Net provides members with a Notice of Privacy Practices that describes how it uses and discloses protected health information; the individual's rights to access, to request amendments, restrictions, and an accounting of disclosures of protected health information; and the procedures for filing complaints. Health Net will provide you the opportunity to approve or refuse the release of your information for non-routine releases such as marketing. Health Net provides access to members to inspect or obtain a copy of the member's protected health information in designated record sets maintained by Health Net. Health Net protects oral, written and electronic information across the organization by using reasonable and appropriate security safeguards. These safeguards include limiting access to an individual's protected health information to only those who have a need to know in order to perform payment, treatment, health care operations or where permitted or required by law. Health Net releases protected health information to plan sponsors for administration of self-funded plans but does not release protected health information to plan sponsors/employers for insured products unless the plan sponsor is performing a payment or health care operation function for the plan. Health Net's entire Notice of Privacy Practices can be found in your

plan's EOC, at www.healthnet.com/uc under "Privacy" or you may contact the Member Services Department at **1-800-539-4072** to obtain a copy.

Technology assessment

New technologies are those procedures, drugs or devices that have recently been developed for the treatment of specific diseases or conditions or are new applications of existing procedures, drugs or devices. New technologies are considered investigational or experimental during various stages of clinical study as safety and effectiveness are evaluated and the technology achieves acceptance into the medical standard of care. The technologies may continue to be considered investigational or experimental if clinical study has not shown safety or effectiveness or if they are not considered standard care by the appropriate medical specialty. Approved technologies are integrated into Health Net benefits.

Health Net determines whether new technologies should be considered medically appropriate, or investigational or experimental, following extensive review of medical research by appropriately specialized physicians. Health Net requests review of new technologies by an independent, expert medical reviewer in order to determine medical appropriateness or investigational or experimental status of a technology or procedure.

The expert medical reviewer also advises Health Net when patients require quick determinations of coverage, when there is no guiding principle for certain technologies or when the complexity of a patient's medical condition requires expert evaluation.

Utilization management processes

Utilization management is an important component of health care management. Through the processes of pre-authorization, concurrent and retrospective review and care management, we evaluate the services provided to our members to be sure they are medically necessary and appropriate for the setting and time. These processes help to maintain Health Net's high quality medical management standards.

Pre-Authorization

Certain proposed services may require an assessment prior to approval. Evidence-based criteria are used to evaluate whether or not the procedure is medically necessary and planned for the appropriate setting (that is, inpatient, ambulatory surgery, etc.).

Concurrent Review

This process continues to authorize inpatient and certain outpatient conditions on a concurrent basis while following a member's progress, such as during inpatient hospitalization or while receiving outpatient home care services.

Discharge Planning

This component of the concurrent review process ensures that planning is done for a member's safe discharge in conjunction with the physician's discharge orders and to authorize post-hospital services when needed.

Retrospective Review

This medical management process assesses the appropriateness of medical services on a case-by-case basis after the services have been provided. It is usually performed on cases where pre-authorization was required but not obtained.

Care or Case Management

Nurse care managers provide assistance, education and guidance to members (and their families) through major acute and/or chronic long-term health problems. The care managers work closely with members, their physicians and community resources.

If you would like additional information regarding Health Net's utilization management process, please call the Health Net Member Services Department at **1-800-539-4072**.

Payment of fees and charges

Your coinsurance, copayment and deductibles

The comprehensive benefits of your Health Net plan are described in the "Schedule of benefits and coverage" section. Please take a moment to look it over.

Prepayment fees

Your employer will pay Health Net your monthly premiums for you and all enrolled family members. Check with your employer regarding any share that you may be required to pay. If your share ever increases, your employer will inform you in advance.

Other charges

You are responsible for payment of your share of the cost of services covered by this plan. Amounts paid by you are called copayments, which are described in the "Schedule of benefits and coverage" section of this SB/DF. Beyond these charges the remainder of the cost of covered services will be paid by Health Net.

When the total amount of copayments you pay equals the out-of-pocket maximum shown in the "Schedule of benefits and coverage" section, you will not have to pay additional copayments for the rest of the year for most services provided or authorized by your physician group.

Certain copayments paid will not be applied to the out-of-pocket maximum as shown in the "Schedule of benefits and coverage" section. Payment for services not covered by this plan will not be applied to the calendar year out-of-pocket maximum. Additionally, deductibles and copayments for any covered supplemental benefits purchased by your employer, such as for prescription drugs or eyewear will also not be applied to the limit with the exception of copayments inhaler spacers, peak flow meters used for the treatment of asthma, and for diabetic supplies. For further information please refer to the EOC.

Liability of subscriber or enrollee for payment

If you receive health care services from doctors without receiving required authorization from your PCP or physician group (medical) or the Behavioral Health Administrator (mental illness and substance abuse), you are responsible for payment of expenses for these services. Remember, services are only covered when provided or authorized by a PCP or physician group or the Behavioral Health Administrator, except for emergency or out-of-area urgent care. Consult the *Health Net HMO Directory* for a full listing of Health Net-contracted physicians.

Reimbursement provisions

Payments that are owed by Health Net for services provided by or through your physician group (medical) or the Behavioral Health Administrator (mental illness and substance abuse) will never be your responsibility.

If you have out-of-pocket expenses for covered services, call the Health Net Member Services Department for a claim form and instructions. You will be reimbursed for these expenses less any required copayment or deductible. (Remember, you do not need to submit claims for medical services provided by your PCP or physician group.)

If you receive emergency services not provided or directed by your physician group (medical) or the Behavioral Health Administrator (mental illness and substance abuse), you may have to pay at the time you receive service. To be reimbursed for these charges, you should obtain a complete statement of the services received and, if possible, a copy of the emergency room report.

Please contact the Health Net Member Services Department at **1-800-539-4072** to obtain claim forms, and to find out whether you should send the completed form to your physician group (medical) or the Behavioral Health Administrator (mental illness and substance abuse) or to Health Net. Medical claims must be received by Health Net within one year of the date of service to be eligible for reimbursement.

If you need to file a claim for emergency medical services or for services authorized by your physician group or PCP with Health Net, please send a completed claim form within one year of the date of service to:

Health Net Commercial Claims
P.O. Box 14702
Lexington, KY 40512

If you need to file a claim for mental disorders and substance abuse emergency services or for services authorized by MHN, you must use the CMS (HCFA) - 1500 form. Please send the claim to MHN within one year of the date of service at the address listed on the claims form or to MHN at:

Managed Health Network
P.O. Box 14621
Lexington, KY 40512-4621

Please call MHN at **1-800-444-4281** to obtain a claim form.

If you need to file a claim for emergency chiropractic service or for the other approved services, please send your completed claim form with in one year of the date of services to:

American Specialty Health Plans of California, Inc.
Attention: Member Services Department
P.O. Box 509002
San Diego, CA 92150-9002

Claims for covered expenses filed more than one year from the date of service will not be paid unless you can show that it was not reasonably possible to file your claim within that time limit and that you have filed as soon as was reasonably possible.

Provider referral and reimbursement disclosure

If you are considering enrolling in our plan, you are entitled to ask if the plan has special financial arrangements with our physicians that can affect the use of referrals and other services you may need. Health Net uses financial incentives and various risk sharing arrangements when paying providers. To get this information, call the Health Net Member Services Department at **1-800-539-4072**, your physician group or your PCP and request information about our physician payment arrangements.

Facilities

Health care services for you and eligible members of your family will be provided at:

- The facilities of the physician group you selected at enrollment; or
- A nearby Health Net-contracted hospital, if hospitalization is required.

Many Health Net contracting physician groups have either a physician on call 24 hours a day or an urgent care center available to offer access to care at all times.

The physician group you choose will also have a contractual relationship with local hospitals (for acute, subacute and transitional care) and skilled nursing facilities. These are listed in your *Health Net HMO Directory*.

Physician group transfers

You may switch doctors within the same physician group at any time. You may also transfer to another physician group monthly. Simply contact Health Net by the 15th of the month to have your transfer effective by the 1st of the following month. If you call after the 15th, your transfer will be effective the 1st of the second following month.

Transfer requests will generally be honored unless you are confined to a hospital. (However, Health Net may approve transfers under this condition for certain unusual or serious circumstances. Please contact the Health Net Member Services Department at **1-800-539-4072**.)

Continuity of Care

Transition of Care for New Enrollees

You may request continued care from a provider who does not contract with Health Net if at the time of your enrollment with Health Net you were receiving care for the conditions listed below. Health Net may provide coverage for completion of services from a non-participating provider, subject to applicable copayments and any exclusions and limitations of your plan. You must request the coverage within 60 days of your group's effective date unless you can show that it was not reasonably possible to make the request within 60 days of the group's effective date and you make the request as soon as reasonably possible. The non-participating provider must be willing to accept the same contract terms applicable to providers currently contracted with Health Net, who are not capitated and who practice in the same or similar geographic region. If the provider does not accept such terms, Health Net is not obligated to provide coverage with that provider.

Continuity of Care Upon Termination of Provider Contract

If Health Net's contract with a physician group or other provider is terminated, Health Net will transfer any affected members to another contracted physician group or provider to ensure that care continues. Health Net will provide a written notice to affected members at least 60-days prior to termination of a contract with a physician group or an acute care hospital to which members are assigned for services. For all other hospitals that terminate their contract with Health Net, a written notice will be provided to affected members within five days after the effective date of the contract termination.

Health Net may provide coverage for completion of services from a provider whose contract has been terminated, subject to applicable copayments and any other exclusions and limitations of your plan and if such provider is willing to accept the same contract terms applicable to the provider prior to the provider's contract termination. You must request continued care within 30 days of the provider's date of termination, unless you can show that it was not reasonably possible to make the request within 30 days of the provider's date of termination and you make the request as soon as it is reasonably possible.

You may request continued care from a provider whose contract is terminated if at the time of termination the member was receiving care from such a provider for the conditions listed below.

The following conditions are eligible for continuation of care:

- An acute condition;
- A serious chronic condition not to exceed twelve months;
- A pregnancy (including the duration of the pregnancy and immediate postpartum care);
- A newborn (up to 36 months of age, not to exceed twelve months);
- A terminal illness (through the duration of the terminal illness);
- A surgery or other procedure that has been authorized by Health Net (or by the member's prior health plan for new enrollee) as part of a documented course of treatment.

If you would like more information on how to request continued care or to request a copy of Health Net's continuity of care policy, please contact the Health Net Member Services Department at **1-800-539-4072**.

Renewing, continuing or ending coverage

Renewal provisions

The contract between Health Net and your employer is usually renewed annually. If your contract is amended or terminated, your employer will notify you in writing.

Individual continuation of benefits

Please examine your options carefully before declining coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in a higher premium or you could be denied coverage entirely.

If your employment with your current employer ends, you and your covered family members may qualify for continued group coverage under:

- COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985). For most groups with 20 or more employees, COBRA applies to employees and their eligible dependents, even if they live outside of California. Please check with your group to determine if you and your covered dependents are eligible.
- Cal-COBRA Continuation Coverage. If you began receiving federal COBRA coverage on or after January 1, 2003, have exhausted federal COBRA coverage and have had less than 36 months of COBRA coverage, you have the opportunity to continue group coverage under this plan through Cal-COBRA for up to 36 months from the date that federal COBRA coverage began.
- Additional COBRA-like Coverage ("Senior"-COBRA): California law provides that an employee and his or her spouse who elected COBRA or Cal-COBRA coverage following termination of employment may be entitled to additional COBRA-like coverage if the employee and spouse are eligible for Senior-COBRA prior to January 1, 2005.

  If the Subscriber was 60 years of age or older on the date of his or her termination of employment and had worked for the employer for the previous five years, the Subscriber and his or her spouse may be eligible for additional coverage when federal COBRA or Cal-COBRA coverage expires. Additionally, a former spouse of an employee or former employee whose coverage under COBRA or Cal-COBRA expires may be entitled to additional COBRA-like coverage.

  You may request additional information from Health Net. If you wish to purchase this additional COBRA-like coverage, you must notify Health Net in writing of your wish to do so within 30 calendar days prior to the date continuation coverage under COBRA or Cal-COBRA is scheduled to end.
- USERRA Coverage: Under a federal law known as the Uniformed Services Employment and Reemployment Rights Act (USERRA), employers are required to provide employees who are absent from

employment to serve in the uniformed services and their dependents who would lose their group health coverage the opportunity to elect continuation coverage for a period of up to 24 months. Please check with your group to determine if you are eligible.

- HIPAA Guaranteed Issue Coverage: The federal Health Insurance Portability and Accountability Act (HIPAA) makes it easier for people covered under existing group health plans to maintain coverage regardless of pre-existing conditions when they change jobs or are unemployed for brief periods of time. California law provides similar and additional protections. Applicants who meet the following requirements are eligible to enroll in a guaranteed issue individual health plan from any health plan that offers individual coverage, including Health Net's Guaranteed HMO Plans, without medical underwriting. A health plan cannot reject your application for guaranteed issue individual health coverage if you meet the following requirements, agree to pay the required premiums and live or work in the plan's service area. Specific Guaranteed Issue rates apply. Only eligible individuals qualify for guaranteed issuance. To be considered an eligible individual:

  1. The applicant must have a total of 18 months of coverage (including COBRA, if applicable) without a significant break (excluding any employer-imposed waiting periods) in coverage of more than 63 days.
  2. The most recent coverage must have been under a group health plan. COBRA and Cal-COBRA coverage are considered group coverage.
  3. The applicant must not be eligible for coverage under any group health plan, Medicare or Medicaid, and must not have other health insurance coverage.
  4. The individual's most recent coverage could not have been terminated due to fraud or nonpayment of premiums.
  5. If COBRA or Cal–COBRA coverage was available, it must have been elected and such coverage must have been exhausted.

  For more information regarding guarantee issue coverage through Health Net please call the Individual Sales Department at **1-800-909-3447**. If you believe your rights under HIPAA have been violated, please contact the Department of Managed Health Care at **1-888-HMO-2219** or visit the Department's website at **www.hmohelp.ca.gov**.

Also, if you become ineligible for group coverage, you may convert from group coverage to a type of individual coverage called conversion coverage. Application must be made within 63 days of the date group coverage ends. Please contact the Health Net Member Services Department for information about conversion plan coverage. Furthermore, you may be eligible for continued coverage for a disabling condition (for up to 12 months) if your employer terminates its agreement with Health Net. Please refer to the "Extension of benefits" section of this SB/DF for more information.

Termination of benefits

Health Net can terminate your coverage when:

- The agreement between the employer covered under this plan and Health Net ends;
- The employer covered under this plan fails to pay subscription charges;
- You cease to either live or work within Health Net's service area; or
- You no longer work for the employer covered under this plan.

Also, coverage under this Health Net plan may be terminated upon the date the notice of termination is mailed for a member who:

- Threatens the safety of the health care provider, his or her office staff, the contracting physician group or Health Net personnel if such behavior does not arise from a diagnosed illness or condition; or
- Knowingly omits or misrepresents a meaningful fact on your enrollment form or fraudulently or deceptively uses services or facilities of Health Net, its contracting physician group or other contracting providers (or knowingly allows another person to do so), including altering a prescription.

In addition, coverage under this Health Net plan 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 the physician's office or contracting physician group's ability to provide services to other patients.

Note: If the person involved in any of the above activities is the enrolled employee, coverage under this plan will terminate as well for any covered dependents.

If you have a disagreement with our plan

The California Department of Managed Health Care is responsible for regulating health care service plans.

If you have a grievance against Health Net, you should first telephone Health Net at **1-800-539-4072** and use the plan's grievance process before contacting the Department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, or a grievance that has not been satisfactorily resolved by Health Net, or a grievance that has remained unresolved for more than 30 days, you may call the Department for assistance.

You may also be eligible for an independent medical review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the Medical Necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The Department also has a toll-free telephone number **(1-888-HMO-2219)** and a **TDD line (1-877-688-9891)** for the hearing and speech impaired. The Department' s Internet Web site **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Member grievance and appeals process

If you are dissatisfied with the quality of care that you have received or feel that you have been incorrectly denied a service or claim, you may file a grievance or appeal.

To file a grievance or appeal you may call **1-800-539-4072** or submit a Member Grievance Form through the Health Net website at www.healthnet.com/uc:

You may also write to:

Health Net of California
P.O. Box 10348
Van Nuys, CA 91410-0348

Please include all the information from your Health Net identification card as well as details of your concern or problem. Health Net will acknowledge your grievance or appeal within five calendar days, review the information and tell you of our decision in writing within 30 days of receiving the grievance. For conditions where there is an immediate and serious threat to your health, including severe pain or the potential loss of life, limb or major bodily function, Health Net will notify you of the status of your grievance no later than three days from the receipt of all the required information. For urgent grievances, Health Net will immediately notify you of the right to contact the Department of Managed Health Care. There is no requirement that you participate in Health Net's grievance process prior to applying to the Department of Managed Health Care for review of an urgent grievance.

In addition, you can request an independent medical review of disputed health care services from the Department of Managed Health Care if you believe that health care services eligible for coverage and payment under the plan was improperly denied, modified or delayed by Health Net or one of its contracting providers.

Also, if Health Net denies your appeal of a denial for lack of medical necessity, or denies or delays coverage for requested treatment involving experimental or investigational drugs, devices, procedures or therapies, you can request an independent medical review of Health Net's decision from the Department of Managed Health Care if you meet the eligibility criteria set out in the EOC.

Arbitration

If you are not satisfied with the result of the grievance hearing and appeals process, you may submit the problem to binding arbitration. Health Net uses binding arbitration to settle disputes, including medical malpractice. When you enroll in Health Net, you agree to submit any disputes to arbitration, in lieu of a jury or court trial.

Additional plan benefit information

The following plan benefits show benefits available with your plan. For a more complete description of copayments, and exclusions and limitations of service, please see your plan's EOC.

Behavioral health services

Health Net contracts with Managed Health Network, a specialized health care service plan which provides behavioral health services through a personalized, confidential and affordable mental health and substance abuse care program. Just call the toll-free number shown on your Health Net ID card before receiving care.

Transition of Care for New Enrollees

If you are receiving ongoing care for an acute, serious, or chronic mental health condition from a provider not affiliated with the Behavioral Health Administrator when you enroll with Health Net, we may temporarily cover services provided by that provider, subject to applicable copayments and any other exclusions and limitations of this plan.

Your non-participating mental health professional must be willing to accept the Behavioral Health Administrator's standard mental health provider contract terms and conditions and be located in the plan's service area.

If you would like more information on how to request continued care, or to request a copy of our continuity of care policy, please call the Health Net Member Services Department at **1-800-539-4072**.

Serious emotional disturbances of a child

Serious emotional disturbances of a child (who is eligible under this Medicare plan) is when a child under the age of 18 has one or more mental disorders identified in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders, other than a primary substance use disorder or a developmental disorder, that result in behavior inappropriate to the child's age according to expected developmental norms. In addition, the child must meet one or more of the following:

- As a result of the mental disorder, the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either (i) the child is at risk of removal from home or has already been removed from the home or (ii) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year;
- The child displays one of the following: psychotic features, risk of suicide or risk of violence due to a mental disorder; or

- The child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the Government Code.

Severe mental illness

Severe mental illness includes schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorders, pervasive developmental disorder (including Autistic Disorder, Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder and Pervasive Developmental Disorder not otherwise specified to include Atypical Autism, in accordance with the most recent edition the Diagnostic and Statistical Manual for Mental Disorders), autism, anorexia nervosa, and bulimia nervosa.

Continuation of treatment

If you are in treatment for a mental health or substance abuse problem, call the telephone number shown on your Health Net ID card to receive assistance in transferring your care to a network provider.

What's covered

Please refer to the "Schedule of benefits and coverage" section of this SB/DF for the copayments.

What's not covered (exclusions and limitations)

Services or supplies excluded under behavioral health services may be covered under the medical benefits portion of your plan. Consult your plan's EOC for more information.

In addition to the exclusion and limitations listed below, mental health and substance abuse are subject to the plan's general exclusions and limitations.

- Congenital or organic disorders, including organic brain disease and mental retardation, except for some conditions when the level of severity meets the criteria of severe mental illness or serious emotional disturbances of a child (who is eligible under this Medicare plan) as described in the EOC;
- Experimental or investigational therapies;
- Marriage counseling, except when rendered in connection with services provided for a treatable mental disorder;
- Nontreatable mental disorders;
- Private-duty nursing;
- Services related to educational and professional purposes;
- Smoking cessation, weight reduction, obesity, stammering, sleeping disorders or stuttering;
- State hospital treatment, except as the result of an emergency or urgently needed care;
- Stress, except when rendered in connection with services provided for a treatable mental disorder;
- Treatment of detoxification in newborns;
- Treatment, testing or screening of learning disabilities, except for some conditions when the level of severity meets the criteria of severe mental illness or serious emotional disturbances of a child (who is eligible under this Medicare plan) as described in the EOC; and
- Care for mental health care as a condition of parole or probation, or court-ordered testing for mental disorders, except when such services are medically necessary and subject to the plan's day or visit limits;

This is only a summary. Consult your plan's EOC to determine the exact terms and conditions of your coverage.

Outpatient prescription drug plan

The information below outlines your Medicare Part D prescription drug coverage through Health Net.

Health Net makes it easy and convenient for you to get the quality medications you need at a low, affordable price! Your prescription benefit provides coverage for many medications commonly used by Medicare members including generic and brand medications. To obtain the most value for your prescription benefits coverage, you should ask your physician to prescribe medications on the Health Net Medicare Drug List that have been approved by the Centers for Medicare & Medicaid Services (CMS).

When making a prescription drug purchase, you may use your member ID card at any of our participating pharmacies. Or, use our convenient mail order service. If you have any questions or would like to request a mail order form, call Member Services at **1-800-539-4072** or the number on your Health Net ID card. For a list of participating pharmacies, please refer to your Pharmacy Directory.

For a more complete description of copayments, exclusions and limitations of service, please see the plan's EOC.

Schedule of benefits and coverage

This prescription drug plan does not cover Medicare Part B prescription drugs. Refer to your EOC to determine if these drugs are covered under your medical plan.

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

People who have low incomes or who live in long term care facilities may have different out-of-pocket drug costs. Contact the plan for details.

Drug Tier	Retail Co-payment/Co-insurance (30-day supply)	Mail-Order or obtained through the UC Walk-Up Service Co-payment/Co-Insurance (90-day supply)	Retail Co-payment/Co-insurance (90-day supply)
(There is no deductible)			
Tier 1 (preferred generic drugs on the Health Net Medicare Drug List)	$10	$20	$30
Tier 2 (preferred brand drugs on the Health Net Medicare Drug List)	$20	$40	$60
Tier 3 (non-preferred generic and brand drugs on the Health Net Medicare Drug List)	$35	$70	$105
Tier 4 Injectable Drugs	25%	N/A	25%

Tier 5 Specialty Drugs	25%	N/A	25%
Erectile Dysfunction Drugs (up to 4 doses)	50%	N/A	N/A

After you have paid $2000 in copayments for outpatient prescription medications, no further copayment will be required for the remainder of the calendar year. Copayments are combined for prescriptions that are filled through mail order and retail pharmacies. The $2000 does not include charges you may have paid for by requesting a brand drug when a generic was available.

After your yearly out-of-pocket drug costs for covered part D drugs, including any additional charges you paid for requesting a brand over a generic, reach $4,350, you pay the greater of:

- $2.25 copayment for generic or a preferred brand drug that is a multi-source drug* and $5.60 for all other drugs; or
- 5% coinsurance**

* A multiple source or multi-source drug is a drug for which there are two or more equivalent drug products marketed or sold in the United States, by two or more manufacturers, under two or more different names, or under the same generic name.

**Your payment for each prescription drug order will not exceed $10 for preferred generic drugs, $20 for preferred brand drugs, and $35 for nonpreferred generic and brand drugs.

Notes:

- Generic drugs will be dispensed when a generic drug equivalent is available. If you request a brand name drug when a generic equivalent is commercially available, you must pay the difference between the generic equivalent and the brand name drug plus the applicable copayment. However, if the prescription drug order states "dispense as written," "do not substitute" or words of similar meaning in the physician's handwriting, you will only be responsible for the applicable copayment.
- Covered Medicare Part D drugs are available at out-of-network pharmacies in special circumstances including illness while traveling outside of the Plan's service area where there is no network pharmacy. In these circumstances, your copayments will be the same as retail pharmacy copayments described above.
- Some retail pharmacies may provide up to a 90-day supply of maintenance medication for a copayment per 30-day supply. Please check with your retail pharmacy to see if this service is available to you.
- Your provider must get prior authorization from Health Net for certain prescription drugs. Contact Health Net for details.

What are the limitations?

The plan includes the following limitations:

- Dispensing may be limited to less than a one-month (30 days) supply due to manufacturer packaging and/or appropriate length of treatment.
- Medications on the Health Net Medicare Drug List that are specifically excluded by Medicare will not count towards your yearly out-of-pocket costs. These include some prescription medications in the following categories:
  1. Agents used for the symptomatic relief of cough and cold;
  2. Prescription vitamin and mineral products;
  3. Barbiturates; and
  4. Benzodiazepines

- Quantity and daily dosing limits may apply to specific drugs. Please refer to the Health Net Medicare Drug List.
- Sexual dysfunction drugs are limited to 2 doses per week or 8 tablets per month.
- Smoking cessation drugs are covered up to a 12-week course of therapy per calendar year if you are currently enrolled in a comprehensive smoking cessation program. Prior authorization from Health Net is required.
- Health Net does not cover certain drugs such as:
  1. Drugs used to treat infertility
  2. Anorexiants, appetite suppressants, diet aids, weight loss medications, and drugs medications used to treat obesity or weight gain
  3. Smoking cessation medications that do not require a prescription
  4. Experimental or investigational medications
  5. Agents when used for cosmetic purposes or hair growth
  6. Non-prescription medications
  7. Outpatient drugs for which the manufacturer seeks to require associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale

Where can I get my prescriptions?

Health Net has formed a network of pharmacies. You must use a network pharmacy to receive plan benefits. Health Net may not pay for your prescriptions if you use an out-of-network pharmacy, except in certain cases.

The pharmacies in our network can change at any time. For a complete and up-to-date list of network pharmacies, please visit our website at www.healthnet.com/uc or call the Health Net Member Services Department at **1-800-539-4072** or the number on your Health Net ID card.

What is the Medicare Drug List ?

Health Net's Medicare Drug List– also called a formulary – is a list of safe, effective and affordable medications for most medical conditions. All the medications on the Health Net Medicare Drug List are covered under your prescription benefit. Physicians and specialists refer to this list when choosing drugs for their patients who are members of Health Net. This ensures that you receive a prescription medication of high quality and value. The Health Net Medicare Drug List is updated quarterly, based on input from the Health Net Pharmacy and Therapeutics (P&T) Committee, a group of multi-specialty practicing physicians and clinical pharmacists. The Health Net Medicare Drug List may also be updated more frequently as new clinical information becomes available and as new drugs are approved or re-evaluated by the Food and Drug Administration (FDA).

How do I find out if my prescription medication is on the Health Net Medicare Drug List?

When your doctor prescribes a medication, ask if it is on the Health Net Medicare Drug List. If you already have the prescription, you can find out if it is on the Health Net Medicare Drug List by calling Member Services at **1-800-539-4072** or the number on your Health Net ID card. You can also log on to www.healthnet.com/uc.

What if my drug is not on the Health Net Medicare Drug List?

If you learn that the plan does not cover your drug, you have two options:

- You can talk to your physician about switching your prescription to a covered preferred drug.
- You can ask Health Net to make an exception and cover your drug.

How do I request an exception to the Health Net Medicare Drug List?

You can ask Health Net to make an exception to the coverage rules. There are several types of exceptions that you can request.

- You can ask Health Net to cover your drug even though it is not on the Health Net Medicare Drug List.
- You can ask Health Net to waive coverage restrictions or limits on your drug. For example, for certain drugs, Health Net limits the amount of the drug that is covered. If your drug has a quantity limit, you can ask to waive the limit and to have a higher quantity covered.
- You can ask Health Net to provide a higher level of coverage for your drug. This would lower the amount you must pay for your drug. This type of exception is only available for Tier 3 drugs (non-preferred generic and brand drugs on the Health Net Medicare Drug List).

These exceptions are subject to the restrictions listed below and Health Net's medical necessity guidelines. Please note, if Health Net grants your request to cover a drug that is not on the Health Net Medicare Drug List, you may not also ask for the drug to be covered at a lower tier.

Generally, Health Net will only approve your request for an exception if the alternative drugs included on the Health Net Medicare Drug List or a lower-tiered drug would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

To ask for an initial coverage decision for a Health Net Medicare Drug List or tiering exception, please contact Member Services at **1-800-539-4072** or the number on your Health Net ID card . When you are requesting a Health Net Medicare Drug List or tiering exception, you should submit a statement from your physician supporting your request. Generally, Health Net will make a decision within 72 hours of your request.

How much will I pay?

How much you will pay for your medications, also called your copayment or coinsurance level, is based on three key factors:

- Is the medication on the Health Net Medicare Drug List?
- Is the medication a generic or a brand name drug product?
- What tier is your medication on?

Refer to the "Schedule of benefits and coverage" portion of this section for your copayment and coinsurance information. In some cases, your physician may be asked to request prior authorization for a medication. Coverage of the medication is dependent on medical necessity as determined by Health Net.

Why should I use generic medications?

Get the most out of your prescription drug benefit coverage. To make sure your out-of-pocket costs are as low as possible, this plan covers many generic medications. Preferred generic medications on the Health Net Medicare Drug List are available at the your lowest copayment. Generic medications are less expensive than brand name medications, but contain the same active ingredients and have the same medical benefit. Generic drugs medications must meet the same U.S. Food and Drug Administration standards for safety, purity, strength and effectiveness as their brand name counterparts. If you choose to fill your prescription with a brand name medication when a generic is available, you may have to pay more.

How do I use the mail order drug program?

Medications ordered through mail order must be ordered from Health Net's contracted mail order pharmacy and should be for treatment of long-term, on-going medical problems in which the drug dosage has already been determined (referred to as "maintenance drugs").

Your medication is a maintenance drug if it is taken continuously to manage a chronic or long-term condition.

If you receive your medications from the mail order pharmacy in Health Net's network, you can receive up to a three-month supply at a reduced copayment. Mail order is convenient, easy to use, offers less expensive copayments, and has free delivery to anywhere in the United States.

Ordering your mail order prescriptions

To ensure you receive your medications in a timely manner, follow these tips:

- Have your doctor write two prescriptions: one for a 30-day supply you can use to get your initial prescription at a retail pharmacy, and one for a 90-day supply you can send to the mail order pharmacy.
- You should use mail order only for maintenance medications that you have been taking for a while. Do not use mail order for medications you have not yet tried.
- Complete a mail order form. To get the form, call Member Services at **1-800-539-4072** or the number on your Health Net ID card. You can also log on to www.healthnet.com/uc, click on "Pharmacy Info", click on "Get Forms", and then click on "Mail Order Form."
- Fill your 30-day supply at a retail pharmacy.

After filling your 30-day supply, mail your 90-day prescription to Health Net's contracted mail order pharmacy using the pre-paid envelope provided with the mail order form. When it is time for your prescription to be filled, the mail order pharmacy will send it to you before your 30-day supply runs out. For quick and easy payment, include your credit card number. Allow up to 14 days to receive your order. After five days, you can call the mail-order pharmacy at **1-800-316-3106 (TTY/TDD 1-800-972-4348)**, to check on the status. If you would like to order refills, you can do so via telephone, interactive voice response (IVR), or by going to the website listed on the mail order form.

For more information about the Mail Order Drug Program, please call Member Services at **1-800-539-4072** or the number on your Health Net ID card.

UC Walk-Up Service through UC Medical Center Pharmacies

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

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "grievances" are the two different types of complaints you can make. Which one you make depends on your situation. If Health Net ever denies coverage for your prescription drugs, we will explain our decision to you. You always have the right to appeal and ask us to review the drug that was denied. In addition, if your doctor prescribes a drug that is not on our drug list or is not a preferred drug, you may ask us to make a coverage exception. Please refer to the "What if my drug is not on the Health Net Medicare Drug List?" portion of this section for more information about requesting exceptions to the Health Net Medicare Drug List.

To file a complaint, you may call **1-800-539-4072**, the phone number on your Health Net ID card or submit a Member Grievance Form through the Health Net website at www.healthnet.com/uc. You may also write to:

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

Please include all the information from your Health Net identification card as well as details of your concern or problem. When you file a grievance, we will notify you of our decision as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. When you file an appeal, there are five levels to the appeal process. After we get your appeal, we have up to 7 calendar days to give you a decision, but will make it sooner if your health condition requires us to. This is the first level of the appeal process. After the first level of appeal, all subsequent levels will be decided by someone who is connected to the Medicare program or the Federal court system. This will help ensure a fair, impartial decision.

For more information about the appeal, grievance or exception process, please refer to your Evidence of Coverage for the outpatient prescription drug plan or contact Member Services at **1-800-539-4072**, the phone number on your Health Net ID card.

This is only a summary. Consult your plan's EOC to determine the exact terms and conditions of your coverage.

Chiropractic care program

Health Net has partnered with American Specialty Health Plans of California, Inc. (ASH Plans) to offer quality and affordable chiropractic coverage. With this program, you are free to obtain this care by selecting a contracted chiropractor from our *ASH Plans Contracted Chiropractor Directory*. Although you are always welcome to consult your PCP, you will not need a referral to see a contracted chiropractor.

What's covered

Please refer to the "Schedule of benefits and coverage" section of this SB/DF for the copayments.

- Office visits;
- Chiropractic items such as supports, collars, pillows, heel lifts, ice packs, cushions, orthotics, rib belts and home traction units prescribed by a ASH Plans contracted chiropractor and approved by ASH Plans; and
- All covered chiropractic services require pre-approval from ASH Plans except for a new patient examination by a contracted chiropractor and emergency chiropractic services.

What's not covered (exclusions and limitations)

Services or supplies excluded under the chiropractic care program may be covered under the medical benefits portion of your plan. Consult your plan's EOC for more information.

- Air conditioners, air purifiers, therapeutic mattresses, vitamins, minerals, nutritional supplements, durable medical equipment, appliances or comfort items;
- Charges for hospital confinement and related services;
- Charges for anesthesia;
- Conjunctive physical therapy not associated with spinal, muscle or joint adjustment;
- Diagnostic scanning, MRI, CAT scans or thermography;
- Exams or treatment of strictly non-neuromusculoskeletal disorders;

- Experimental or investigational chiropractic services. Only chiropractic services that are non-investigational, proven and meet professionally recognized standards of practice in the chiropractic provider community are covered. ASH Plans will determine what will be considered experimental or investigational;
- Hypnotherapy, behavioral training, sleep therapy, weight programs, educational programs, nonmedical self-help or self-care, or any self-help physical exercise training;
- Lab tests, x-rays, adjustments, physical therapy or other services not chiropractically necessary or classified as experimental;
- Pre-employment physicals or vocational rehabilitation arising from employment or covered under any public liability insurance;
- Treatment for temporomandibular joint syndrome (TMJ); and
- Treatment or services not authorized by ASH Plans or delivered by an ASH Plans contracted provider (except emergency chiropractic services or upon a referral to a non-contracted provider approved by ASH Plans).

This is only a summary. Consult your plan's EOC to determine the exact terms and conditions of your coverage.

Vision care program

Not only can you obtain an annual eye exam through your PCP, we also offer coverage for your eyewear. Eyewear benefits are provided by Health Net. Health Net contracts with EyeMed Vision Care, LLC, a vision services provider panel, to provide and administer eyewear benefits. EyeMed Vision Care provides benefits for eyewear through a network of dispensing opticians and optometric laboratories. Vision examinations are provided through your Physician Group. To find a participating eyewear dispenser, contact the Health Net Vision Program at **1-866-392-6058** or visit our website at www.healthnet.com/uc.

What's covered

Please refer to the "Schedule of benefits and coverage" section of this SB/DF for the copayments.

- Frames are covered once every 24 months (up to calendar year maximum in value listed in the "Schedule of benefits and coverage" section);
- Lenses are covered once every 24 months if your prescription changes. Lenses must be single, bifocal, trifocal, glass or plastic, and no larger than 56mm; tints can only be pink or rose, #1 or #2;
- One pair of contact lenses are covered once every 24 months up to amount specified in the "Schedule of benefits and coverage" section, instead of eyeglasses when determined to be medically necessary by your eyecare provider. Contact lenses are considered medically necessary when:
  1. A natural lens is removed through cataract surgery and not replaced with an implant (aphakia);
  2. They are necessary because of astigmatism of 3 diopters or more;
  3. They are necessary because of hyperopia of greater than 7 diopters;
  4. They are necessary because of myopia of greater than 12 diopters;
  5. They are necessary because of anisometropia 3 diopters or more, provided visual activity improves to 20/40 or better in the weaker eye, or
  6. They are necessary because of keratoconus, when visual acuity cannot be corrected to 20/40 with the use of spectacles.

If contact lenses are not medically necessary and you choose to wear them instead of eyeglasses, the cost of contact lenses is covered once every 24 months, up to a calendar year dollar maximum listed in the "Schedule of benefits and coverage" section.

What's not covered (exclusions and limitations)

Services or supplies excluded under the vision care program may be covered under the medical benefits portion of your plan. Consult your plan's EOC for more information.

In addition to the limitations described above, the plan does not cover the following:

- Eye examinations required for work or school;
- Medical or surgical treatment of the eyes;
- Nonprescription eyewear, vision devices or nonprescription sunglasses; and
- Replacement of lost, stolen or broken frames or lenses, unless benefits are otherwise available.

Liability for payment

If you go to a care provider not affiliated with Health Net, you will be responsible for payment of your eye exam, glasses or contact lenses.

You may also have to pay additional fees when you use an affiliated provider if you choose lenses, frames or contact lenses that cost more than the covered expense. Health Net will seek reimbursement for vision and eyewear services that are covered under Workers' Compensation or required by occupational disease law.

This is only a summary. Consult your plan's EOC to determine the exact terms and conditions of your coverage.

For more information,
please contact us at:

Health Net
Health Net Medicare COB
Post Office Box 10348
Van Nuys, California 91409-10348

Customer Contact Center

1-800-539-4072 or www.healthnet.com/uc

1-800-331-1777 (Spanish)
1-877-891-9053 (Mandarin)
1-877-891-9050 (Cantonese)
1-877-339-8596 (Korean)
1-877-891-9051 (Tagalog)
1-877-339-8621 (Vietnamese)

Telecommunications Device
for the Hearing and Speech Impaired:
1-800-995-0852

Health Net of California, Inc., is a subsidiary of Health Net, Inc.
Health Net® is a registered service mark of Health Net, Inc. All rights reserved.