Health Net
Medicare Programs

Your Medicare Health Benefits and Services as a Member of Health Net Value Orange Option 2

This mailing gives you the details about your Medicare health coverage from January 1 – December 31, 2009, and explains how to get the health care you need. This is an important legal document. Please keep it in a safe place.

Health Net Member Services:
For help or information, please call Member Services or go to our Plan website at www.healthnet.com.

1-800-806-8811 (Calls to these numbers are free)
TTY/TDD users call: 1-800-929-9955

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

During the annual enrollment period (between November 15th and December 31st) through 60 days past the beginning of the following contract year, our Plan operates a toll-free call center for both current and prospective members that is staffed seven days a week from 8:00 a.m. to 8:00 p.m. During this time period, current and prospective members are able to speak with a Customer Service representative. If you call outside these hours, when leaving a message, you should include your name, number 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 March 2, 2009, your call will be handled by our automated phone system, Saturdays, Sundays, and holidays. When leaving a message, please include your name, number and the time that you called, and a representative will return your call no later than one business day after you leave a message.

This Plan is offered by Health Net Life Insurance Company, referred throughout the EOC as "we", "us" or "our." Health Net Value Orange Option 2 is referred to as "Plan" or "our Plan." Our organization contracts with the Federal Government.

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

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

S5678_2009_48
10/2008

EOCID 222169
SAP# 6017997

This is Your 2009 Evidence of Coverage (EOC)

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1. Introduction

Thank you for being a member of our Plan!

This is your Evidence of Coverage, which explains how to get your Medicare drug coverage through our Plan, a Medicare Prescription Drug Plan

This Evidence of Coverage, together with your enrollment form, riders, formulary, and amendments that we send to you, is our contract with you. The Evidence of Coverage explains your rights, benefits, and responsibilities as a member of our Plan and is in effect from January 1, 2009 - December 31, 2009. Our plan's contract with the Centers for Medicare & Medicaid Services (CMS) is renewed annually, and availability of coverage beyond the end of the current contract year is not guaranteed.

This Evidence of Coverage will explain to you:

- What is covered by our Plan and what isn't covered.
- How to get your prescriptions filled, including some rules you must follow.
- What you will have to pay for your prescriptions.
- What to do if you are unhappy about something related to getting your prescriptions filled.
- How to leave our Plan, and other Medicare options that are available, including your options for continuing Medicare prescription drug coverage.

This Section of the EOC has important information about:

- Eligibility requirements
- The geographic service area of our Plan
- Keeping your membership record up-to-date
- Materials that you will receive from our Plan
- Paying your plan premiums
- Late enrollment penalty
- Extra help available from Medicare to help pay your plan costs

Eligibility Requirements

To be a member of our Plan, you must live in our service area, be entitled to Medicare Part A, or enrolled in Medicare Part B. 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.

The geographic service area for our Plan.

The state(s) in our service area are listed below

Virginia

We offer coverage in all states. However, there may be cost or other differences between the plans we offer in each state. If you move out of the state where you live into a state that is still within our service area, you must call Customer Service in order to update your information. If you move into a state outside of our service area, you cannot remain a member of our plan. Please call Customer Service to find out if we have a plan in your new state.

How do I keep my membership record up to date?

We have a membership record about you. Your membership record has information from your enrollment form, including your address and telephone number. Pharmacists and others use your membership record to know what drugs are covered for you. Section 3 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up to date by telling Customer Service if there are changes to your name, address, or phone number, or if you go into a nursing home. Also, tell Customer Service about any changes in other health insurance coverage you have, such as from your employer, your spouse's employer, workers' compensation, Medicaid, or liability claims such as claims from an automobile accident.

Materials that you will receive from our Plan

Plan membership card

Now that you are a member of our Plan, you must use our membership card for prescription drug coverage at network pharmacies. You may need to continue to use your red, white, and blue Medicare card to get covered services and items under Original Medicare.

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

The Pharmacy Directory gives you a list of Plan network pharmacies.

As a member of our Plan we will send you a complete Pharmacy Directory, which gives you a list of our network pharmacies, at least every three years, and an update of our Pharmacy Directory every year that we don't send you a complete Pharmacy Directory. You can use it to find the network pharmacy closest to you. If you don't have the Pharmacy Directory, you can get a copy from Customer Service. They can also give you the most up-to-date information about changes in this Plan's pharmacy network, which can change during the year. You can also find this information on our website.

Part D Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits (EOB) is a document you will get for each month you use your Part D prescription drug coverage. The EOB will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your prescription drugs. An Explanation of Benefits is also available upon request. To get a copy, please contact Customer Service.

What information is included in the Explanation of Benefits?

Your Explanation of Benefits will contain the following information:

- A list of prescriptions you filled during the month, as well as the amount paid for each prescription;
- Information about how to request an exception and appeal our coverage decisions;
- A description of changes to the formulary that will occur at least 60 days in the future and affect the prescriptions you have gotten filled;
- A summary of your coverage this year, including information about:
    - **Amount Paid For Prescriptions-**The amounts paid that count towards your initial coverage limit.
    - **Total Out-Of-Pocket Costs that count toward Catastrophic Coverage-**The total amount you and/or others have spent on prescription drugs that count towards you qualifying for catastrophic coverage. This total includes the amounts spent for your coinsurance or co-payments, and payments made on covered Part D drugs after you reach the initial coverage limit. (This amount doesn't include payments made by your current or former employer/union, another insurance plan or policy, a government-funded health program or other excluded parties.)

Your monthly plan premium

The monthly premium amount described in this section does not include any late enrollment penalty you may be responsible for paying (see "What is the Medicare Prescription Drug Plan late enrollment penalty?" later in this section for more information)."

As a member of our Plan, you pay a monthly plan premium. (If you qualify for extra help from Medicare, called the Low-Income Subsidy or LIS, you may not have to pay for all or part of the monthly premium)

Your monthly premium for our plan is listed in Section 10.

If you get benefits from your current or former employer, or from your spouse's current or former employer, call the employer's benefits administrator for information about your monthly plan premium.

Note: If you are getting extra help (LIS) with paying for your drug coverage, the premium amount that you pay as a member of this Plan is listed in your "Evidence of Coverage Rider for those who Receive Extra Help for their Prescription Drugs or, if you are a member of a State Pharmacy Assistance Program (SPAP), you may get help paying your premiums. Please contact your SPAP at the phone number listed in Section 8 to determine what benefits are available to you.

Monthly Plan Premium Payment Options

There are two ways to pay your monthly plan premium.

Option one: Pay your monthly plan premium directly to our Plan.
You may decide to pay your monthly plan premium directly to our Plan.
The monthly plan premium is due to us by the first of every month. You can make the payment by sending your check to:

Health Net Medicare Programs
P.O. Box 6000
Columbia, SC 29260-6000

Please note, a $15 fee will be assessed for all returned checks.

Instead of paying by check, you can have your monthly plan premium: automatically withdrawn from your bank account. If you are interested in this method, call Customer Service at the phone number listed on the cover for the appropriate form. Once we have your approval to automatically withdraw the monthly premium, we will deduct the payment from your account on approximately the first of every month.

Option two: **You may have your monthly plan premium directly deducted from your monthly Social Security payment.**
Contact Customer Service for more information on how to pay your monthly plan premium this way.

Note: We don't recommend this option if you are getting extra help for your monthly plan premium payment from another payer, like a State Pharmaceutical Assistance Program (SPAP). Social Security can only withhold the full amount of the monthly plan premium and will not recognize any monthly plan premium payments made by other payers as part of this process. (SPAPS have different names in different states. See Section 8 for the name and phone number for the SPAP in your area.)

Can your monthly plan premiums change during the year?

The monthly plan premium associated with this plan cannot change during the year. However, the amount you pay could change, depending on whether you become eligible for, or lose, extra help for your prescription drug costs. If our monthly plan premium changes for next year we will tell you in October and the change will take effect on January 1.

What is the Medicare Prescription Drug Plan late enrollment penalty?

If you don't join a Medicare drug plan when you are first eligible, and/or you go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a late enrollment penalty when you enroll in a plan later. The Medicare drug plan will let you know what the amount is and it will be added to your monthly premium. This penalty amount changes every year, and you have to pay it as long as you have Medicare prescription drug coverage. However, if you qualify for extra help, you may not have to pay a penalty.

If you must pay a late enrollment penalty, your penalty is calculated when you first join a Medicare drug plan. To estimate your penalty, take 1% of the national base beneficiary premium for the year you join (in 2009, the national base beneficiary premium is $30.36.). Multiply it by the number of full months you were eligible to join a Medicare drug plan but didn't, and then round that amount to the nearest ten cents. This is your estimated penalty amount, which is added each month to your Medicare drug plan's premium for as long as you are in that plan.

If you disagree with your late enrollment penalty, you may be eligible to have it reconsidered (reviewed). Call Customer Service to find out more about the late enrollment penalty reconsideration process and how to ask for such a review.

You won't have to pay a late enrollment penalty if:

- You had creditable coverage (coverage that expects to pay, on average, at least as much as Medicare's standard prescription drug coverage)
- You had prescription drug coverage but you were not adequately informed that the coverage was not creditable (as good as Medicare's drug coverage)
- Any period of time that you didn't have creditable prescription drug coverage was less than 63 continuous days
- You lived in an area affected by Hurricane Katrina at the time of the hurricane (August 2005) AND you signed up for a Medicare prescription drug plan by December 31, 2006, AND you stay in a Medicare prescription drug plan
- You received or are receiving extra help.

What happens if you don't pay or are late with your monthly plan premiums?

If your monthly plan premiums are late, we will tell you in writing that if you don't pay your monthly plan premium by a certain date, which includes a grace period, we will end your membership in our Plan." Our plans grace period is 90 days.

Should you decide later to re-enroll in our Plan, or to enroll in another plan that we offer, you will have to pay any late monthly plan premiums that you didn't pay from your previous enrollment in our Plan.

What extra help is available to help pay my plan costs?

Medicare provides "extra help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you will get help paying for any Medicare drug plan's monthly premium, and prescription co-payments. If you qualify, this extra help will count toward your out-of-pocket costs.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help one of two ways. The amount of extra help you get will depend on your income and resources.

1 **You automatically qualify for extra help and don't need to apply.** If you have full coverage from a state Medicaid program, get help from Medicaid paying your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare mails a letter to people who automatically qualify for extra help.

2 **You apply and qualify for extra help.** You may qualify if your yearly income in 2008 is less than $15,600 (single with no dependents) or $21,000 (married and living with your spouse with no dependents), and your resources are less than $11,990 (single) or $23,970 (married and living with your spouse). These resource amounts include $1,500 per person for burial expenses. Resources include your savings and stocks but not your home or car. If you think you may qualify, call Social Security at 1-800-772-1213 (TTY users should call 1-800-325-0778) or visit www.socialsecurity.gov on the Web. You may also be able to apply at your State Medical Assistance (Medicaid) office. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next.

The above income and resource amounts are for 2008 and will change in 2009. If you live in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

How do costs change when you qualify for extra help?

If you qualify for extra help, we will send you by mail an "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs" that explains your costs as a member of our Plan. If the amount of your extra help changes during the year, we will also mail you an updated "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs".

What if you believe you have qualified for extra help and you believe that you are paying an incorrect co-payment amount?

If you believe you have qualified for extra help and you believe that you are paying an incorrect co-payment amount when you get your prescription at a pharmacy, our Plan has established a

process that will allow you to either request assistance in obtaining evidence of your proper co-payment level, or, if you already have the evidence, to provide this evidence to us.

Contact the customer service number on your membership card and advise the representative that you believe you qualify for extra help and are paying an incorrect co-payment. You may be required to provide one of the following:

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

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

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

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

Important Information

We will send you Health Net Employer Status/Coordination of Benefits Survey so that we can know what other drug coverage you have besides our Plan. Medicare requires us to collect this

information from you, so when you get the survey, please fill it out and send it back. If you have additional drug coverage, you must provide that information to our Plan. The information you provide helps us calculate how much you and others have paid for your prescription drugs. In addition, if you lose or gain additional prescription drug coverage, please call Customer Service to update your membership records.

2. How You Get Prescription Drugs

What do you pay for Covered Drugs?
The amount you pay for Covered Drugs is listed in Section 10.

If you have Medicare and Medicaid
Medicare, not Medicaid, will pay for most of your prescription drugs. You will continue to get your health coverage under both Medicare and Medicaid as long as you qualify for Medicaid benefits.

If you are a member of a State Pharmacy Assistance Program (SPAP)
If you are currently enrolled in an SPAP, you may get help paying your premiums, and or cost-sharing. Please contact your SPAP to determine what benefits are available to you. SPAPs have different names in different states. See Section 8 for the name and phone number for the SPAP in your area.

What drugs are covered by this Plan?

What is a formulary?
A formulary is a list of the drugs that we cover. We will generally cover the drugs listed in our formulary as long as the drug is medically necessary, the prescription is filled at a network pharmacy and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described later in this section under "Utilization Management."

The drugs on the formulary are selected by our Plan with the help of a team of health care providers. Both brand-name drugs and generic drugs are included on the formulary. A generic drug is a prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs.

Not all drugs are covered by our plan. In some cases, the law prohibits Medicare coverage of certain types of drugs. (See Section 10 for more information about the types of drugs that are not normally covered under a Medicare Prescription Drug Plan.) In other cases, we have decided not to include a particular drug on our formulary.

In certain situations, prescriptions filled at an out-of-network pharmacy may also be covered. See information later in this section about filling a prescription at an out-of-network pharmacy.

How do you find out what drugs are on the formulary?
Each year, we send you an updated formulary so you can find out what drugs are on our formulary. You can get updated information about the drugs our Plan covers by visiting our

website. You may also call Customer Service to find out if your drug is on the formulary or to request an updated copy of our formulary.

What are drug tiers?

Drugs on our formulary are organized into different drug tiers, or groups of different drug types. Your coinsurance or co-payment depends on which drug tier your drug is in.

You may ask us to make an exception (which is a type of coverage determination) to your drug's tier placement. See Section 5 to learn more about how to request an exception.

What is reference based pricing?

Our plan uses reference based pricing for certain drugs on our formulary. We apply reference based pricing to most generic drugs that are available from multiple manufacturers. This means we set one price for each generic drug. In the event that you receive a brand drug when a generic equivalent with a reference based price is available, you may be charged a product selection penalty. This means you may be charged the co-payment applicable to the brand drug plus the difference between the price of the brand drug and the reference based price of the generic drug. To avoid a product selection penalty, make sure to ask your pharmacy to dispense generic drugs whenever they are available. Please see our abridged or comprehensive formulary for a list of those formulary drugs impacted by reference based pricing. You can call Customer Service for more information on reference based pricing and the impact it may have on drugs you are taking.

Can the formulary change?

We may make certain changes to our formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. The kinds of formulary changes we may make include:

- Adding or removing drugs from the formulary
- Adding prior authorizations, quantity limits, and/or step-therapy restrictions on a drug
- Moving a drug to a higher or lower cost-sharing tier

If we remove drugs from the formulary, or add prior authorizations, quantity limits and/or step therapy restrictions on a drug or move a drug to a higher cost-sharing tier and you are taking the drug affected by the change, you will be permitted to continue taking that drug at the same level of cost-sharing for the remainder of the Plan year. However, if a brand name drug is replaced with a new generic drug, or our formulary is changed as a result of new information on a drug's safety or effectiveness, you may be affected by this change. We will notify you of the change at least 60 days before the date that the change becomes effective or provide you with a 60 day supply at the pharmacy. This will give you an opportunity to work with your physician to switch to a different drug that we cover or request an exception. (If a drug is removed from our formulary because the drug has been recalled from the pharmacies, we will not give 60 days notice before removing the drug from the formulary. Instead, we will remove the drug immediately and notify members taking the drug about the change as soon as possible.)

What if your drug isn't on the formulary?

If your prescription isn't listed on your copy of our formulary, you should first check the formulary on our website which we update at least monthly (if there is a change). In addition, you may contact Customer Service to be sure it isn't covered. If Customer Service confirms that we don't cover your drug, you have two options:

1. You may ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of covered drugs that are used to treat similar medical conditions, please contact Customer Service or go to our formulary on our website.
2. You or your doctor may ask us to make an exception (a type of coverage determination) to cover your drug. If you pay out-of-pocket for the drug and request an exception that we approve, the Plan will reimburse you. If the exception isn't approved, you may appeal the Plan's denial. See Section 5 for more information on how to request an exception or appeal.

In some cases, we will contact you if you are taking a drug that isn't on our formulary. We can give you the names of covered drugs that also are used to treat your condition so you can ask your doctor if any of these drugs are an option for your treatment.

If you recently joined this Plan, you may be able to get a temporary supply of a drug you were taking when you joined our Plan if it isn't on our formulary.

Transition Policy

New members in our Plan may be taking drugs that aren't on our formulary or that are subject to certain restrictions, such as prior authorization or step therapy. Current members may also be affected by changes in our formulary from one year to the next. Members should talk to their doctors to decide if they should switch to a different drug that we cover or request a formulary exception in order to get coverage for the drug. See Section 5 under "What is an exception?" to learn more about how to request an exception. Please contact Customer Service if your drug is not on our formulary, is subject to certain restrictions, such as prior authorization or step therapy, or will no longer be on our formulary next year and you need help switching to a different drug that we cover or requesting a formulary exception.

During the period of time members are talking to their doctors to determine the right course of action, we may provide a temporary supply of the non-formulary drug if those members need a refill for the drug during the first 90-days of new membership in our Plan. If you are a current member affected by a formulary change from one year to the next, we will provide a temporary supply of the non-formulary drug if you need a refill for the drug during the first 90-days of the new plan year.

When a member goes to a network pharmacy and we provide a temporary supply of a drug that isn't on our formulary, or that has coverage restrictions or limits (but is otherwise considered a "Part D drug"), we will cover a 30-day supply (unless the prescription is written for fewer days). After we cover the temporary 30-day supply, we generally will not pay for these drugs as part of our transition policy again. We will provide you with a written notice after we cover your

temporary supply. This notice will explain the steps you can take to request an exception and how to work with your doctor to decide if you should switch to an appropriate drug that we cover.

If a new member is a resident of a long-term-care facility (like a nursing home), we will cover a temporary 34-day transition supply (unless the prescription is written for fewer days). If necessary, we will cover more than one refill of these drugs during the first 90 days a new member is enrolled in our Plan. If the resident has been enrolled in our Plan for more than 90 days and needs a drug that isn't on our formulary or is subject to other restrictions, such as step therapy or dosage limits, we will cover a temporary 34-day emergency supply of that drug (unless the prescription is for fewer days) while the new member pursues a formulary exception.

Members who experience a change in level of care, e.g., hospital discharge, will be granted a transition supply of up to a 30-day supply at home or up to a 34-day supply at Long Term Care (LTC) so members can continue to receive their drug(s) while a formulary exception request is being processed. Each time a member experiences a change in level of care to home, the member is eligible to receive a 30-day transition supply of each affected drug. Each time a member experiences a change in level of care to an LTC facility, the member is eligible to receive a 34-day transition supply of each affected drug.

Please note that our transition policy applies only to those drugs that are "Part D drugs" and bought at a network pharmacy. The transition policy can't be used to buy a non-Part D drug or a drug out of network, unless you qualify for out of network access. See Section 10 for information about non-Part D drugs.

Drug Management Programs

Utilization management

For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our members use these drugs in the most effective way and also help us control drug plan costs. A team of doctors and/or pharmacists developed these requirements and limits for our Plan to help us provide quality coverage to our members. Please consult your copy of our formulary or the formulary on our website for more information about these requirements and limits.

The requirements for coverage or limits on certain drugs are listed as follows:

Prior Authorization: We require you to get prior authorization (prior approval) for certain drugs. This means that your provider will need to contact us before you fill your prescription. If we don't get the necessary information to satisfy the prior authorization, we may not cover the drug.

Quantity Limits: For certain drugs, we limit the amount of the drug that we will cover per prescription or for a defined period of time. For example, we will provide up to 9 tablets per 30-day period for Imitrex.

Step Therapy: In some cases, we require you to first try one drug to treat your medical condition before we will cover another drug for that condition. For example, if Drug A and Drug B both treat your medical condition, we may require your doctor to prescribe Drug A first. If Drug A does not work for you, then we will cover Drug B.

Generic Substitution: When there is a generic version of a brand-name drug available, our network pharmacies may recommend and/or provide you the generic version, unless your doctor has told us that you must take the brand-name drug and we have approved this request.

You can find out if the drug you take is subject to these additional requirements or limits by looking in the formulary or on our website, or by calling Customer Service. If your drug is subject to one of these additional restrictions or limits and your physician determines that you aren't able to meet the additional restriction or limit for medical necessity reasons, you or your physician may request an exception (which is a type of coverage determination). See Section 5 for more information about how to request an exception.

Drug utilization review

We conduct drug utilization reviews for all of our members to make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one doctor who prescribes their medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

- Possible medication errors
- Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition
- Drugs that are inappropriate because of your age or gender
- Possible harmful interactions between drugs you are taking
- Drug allergies
- Drug dosage errors

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

Medication therapy management programs

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

We may contact members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you don't need to pay anything extra to participate.

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

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

Your enrollment in this Plan doesn't affect Medicare 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, it can't be covered by us even if you choose not to participate in Part A or Part B. Some drugs may be covered under Medicare Part B in some cases and through this Plan (Medicare Part D) in other cases but never both at the same time. In general, your pharmacist or provider will determine whether to bill Medicare Part B or us for the drug in question.

See your *Medicare & You* handbook for more information about drugs that are covered by Medicare Part A and Part B. The Medicare & You handbook can also be found on www.medicare.gov or you can request a copy by 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

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 adjust your premium.

Each year (prior to November 15), your Medigap insurance company must send you a letter explaining your options and whether the prescription drug coverage you have is creditable (whether it expects to pay, on average, at least as much as Medicare's standard prescription drug coverage) and how the removal of drug coverage from your Medigap policy will affect your premiums. If you didn't get this letter or can't find it, you have the right to get a copy from your Medigap insurance company.

If you are a member of an employer or retiree group

If you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact your benefits administrator to determine how your current prescription drug coverage will work with this Plan. In general, if you are currently employed, the prescription drug coverage you get from us will be secondary to your employer or retiree group coverage.

Each year (prior to November 15), your employer or retiree group should provide a disclosure notice to you that indicates if your prescription drug coverage is creditable (meaning it expects to pay, on average, at least as much as Medicare's standard prescription drug coverage) and the options available to you. You should keep the disclosure notices that you get each year in your

personal records to present to a Part D plan when you enroll to show that you have maintained creditable coverage. If you didn't get this disclosure notice, you may get a copy from the employer's or retiree group's benefits administrator or employer/union.

Using network pharmacies to get your prescription drugs

With few exceptions, which are noted later in this section under "How do you fill prescriptions outside the network?", **you must use network pharmacies to get your prescription drugs covered.** A network pharmacy is a pharmacy that has a contract with us to provide your covered prescription drugs. The term "Covered Drugs" means all of the outpatient prescription drugs that are covered by our Plan. Covered Drugs are listed in our formulary.

In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies. You aren't required to always go to the same pharmacy to fill your prescription; you may go to any of our network pharmacies. However, if you switch to a different network pharmacy than the one you have previously used, you must either have a new prescription written by a doctor or have the previous pharmacy transfer the existing prescription to the new pharmacy if any refills remain. To find a network pharmacy in your area, please review your Pharmacy Directory. You can also visit our website or call Customer Service.

What is a Preferred Pharmacy?

Preferred pharmacies are pharmacies in our network in which our Plan has negotiated lower cost-sharing for its plan members for covered prescription drugs than at non-preferred pharmacies. However, you will still have access to lower drug prices at non-preferred pharmacies than at out-of-network pharmacies. You may go to either of these types of network pharmacies to receive your covered prescription drugs.

What if a pharmacy is no longer a network pharmacy?

Sometimes a pharmacy might leave the Plan's network. If this happens, you will have to get your prescriptions filled at another Plan network pharmacy. Please refer to your Pharmacy Directory or call Customer Service to find another network pharmacy in your area.

How do you fill a prescription at a network pharmacy?

To fill your prescription, you must show your Plan membership card at one of our network pharmacies. If you don't have your membership card with you when you fill your prescription, you may have the pharmacy call Customer Service to obtain the necessary information. If the pharmacy is unable to obtain the necessary information, you may have to pay the full cost of the prescription. If you pay the full cost of the prescription (rather than paying just your coinsurance or co-payment) you may ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described in the subsection below called "How do you submit a paper claim?"

How do you fill a prescription through our Plan's network mail-order-pharmacy service?

You can use our network mail-order service to fill prescriptions for some drugs. These drugs are marked as "maintenance" drugs on the formulary list. These are drugs that you take on a regular basis, for a chronic or long-term medical condition. The formulary list tells you which drugs are available through our mail-order service.

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

Generally, it takes the mail-order pharmacy 14 days to process your order and ship it to you. However, sometimes your mail-order may be delayed. If you run out of medication before your mail-order prescription arrives, call Customer Service at the phone number in Section 8 of this booklet to obtain an authorization to get a refill from a retail pharmacy.

You are not required to use mail-order prescription drug services to obtain an extended supply of medications. Instead, you have the option of using another network retail pharmacy in our network to obtain a supply of medications. Some of these retail pharmacies may agree to accept the mail-order cost-sharing amount for an extended supply of medications, which may result in no out-of-pocket payment difference to you. Other retail pharmacies may not agree to accept the mail-order cost-sharing amounts for an extended supply of medications. In this case, you will be responsible for the difference in price. Your Pharmacy Directory contains information about retail pharmacies in our network at which you can obtain an extended supply of medications. You can also call Customer Service for more information.

To get order forms and information about filling your prescriptions by mail, call Customer Service. Please note that you must use our network mail-order service. Prescription drugs that you get through any other mail-order services are not covered.

How do you fill prescriptions outside the network?

We have network pharmacies outside of the service area where you can get your drugs covered as a member of our Plan. Generally, we only cover drugs filled at an out-of-network pharmacy in limited, non-routine circumstances when a network pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at an out-of-network pharmacy. Before you fill your prescription in these situations, call Customer Service to see if there is a network pharmacy in your area where you can fill your prescription. If you do go to an out-of-network pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just coinsurance or co-payment) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a paper claim. You should submit a claim to us if you fill a prescription at an out-of-network pharmacy, as any amount you pay for a covered Part D drug will help you qualify for catastrophic coverage. To learn how to submit a paper claim, please refer to the paper claims process described in the subsection below called "How do you submit a paper claim?" If we do pay for the drugs you get at an out-of-network pharmacy, you may still pay more for your drugs than what you would have paid if you had gone to an in-network pharmacy.

We will cover your prescription at an out-of-network pharmacy, up to a 30-day supply, if at least one of the following applies:

- If you are traveling outside the Service Area and within the United States, we will cover urgent or emergency drugs.
- If you are unable to get a covered drug in a timely manner within our service area because there are no network pharmacies within a reasonable driving distance that provide 24-hour service.
- If you are trying to fill a 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 and some Covered Drugs that are administered in your doctor's office.

Please note that prescriptions filled at an out-of-network mail-order pharmacy will not be covered.

How do you submit a paper claim?

You may submit a paper claim for reimbursement of your drug expenses in the situations described below:

- **Drugs purchased out-of-network.** When you go to a network pharmacy and use our membership card, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-network pharmacy and attempt to use our membership card for one of the reasons listed in the section above ("How do you fill prescriptions outside the network?), 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 and submit a paper claim to us. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 5.

- **Drugs paid for in full when you don't have your membership card.** If you pay the full cost of the prescription (rather than paying just your coinsurance or co-payment) because you don't have your membership card with you when you fill your prescription, you may ask us to reimburse you for our share of the cost by submitting a paper claim to us. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 5.

- **Drugs paid for in full in other situations.** If you pay the full cost of the prescription (rather than paying just your coinsurance or co-payment because it is not covered for some reason (for example, the drug is not on the formulary or is subject to coverage requirements or limits) and you need the prescription immediately, you may ask us to reimburse you for our share of the cost by submitting a paper claim to us. In these situations, your doctor may need to submit additional documentation supporting your request. This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 5.

- **If you are retroactively enrolled in our Plan because you were Medicaid eligible.** As discussed in the section below ("Reimbursing plan members for coverage during retroactive periods"), you must submit a paper claim in order to be reimbursed for out-of-

pocket expenses you had during this time period (and that were not reimbursed by other insurance). This type of reimbursement request is considered a request for a coverage determination and is subject to the rules contained in Section 5.

- **Drugs purchased at a better cash price**. In rare circumstances when you are in a coverage gap or deductible period and have bought a covered Part D drug at a network pharmacy under a special price or discount card that is outside the Plan's benefit, you may submit a paper claim to have your out-of-pocket expense count towards qualifying you for catastrophic coverage.

- **Copayments for drugs provided under a drug manufacturer patient assistance program**. If you get help from, and pay co-payments under, a drug manufacturer patient assistance program outside our Plan's benefit, you may submit a paper claim to have your out-of-pocket expense count towards qualifying you for catastrophic coverage.

- Prescription claims for a calendar year can be submitted to Health Net for reimbursement through March 31st of the following calendar year.

- You should submit a written reimbursement request to us if you fill a prescription at an out-of-network pharmacy, as any amount you pay will help you qualify for catastrophic coverage.

You may ask us to reimburse you for our share of the cost of the prescription by sending a written request to us. Although not required, you may use our reimbursement claim form to submit your written request. You can get a copy of our reimbursement claim form on our website or by calling Customer Service**. Please include your receipt(s) with your written request.**

Please send your written reimbursement request to the address listed under **Part D Coverage Determinations** in Section 8.

Reimbursing Plan Members for Coverage during Retroactive Periods

If you were automatically enrolled in our Plan because you were Medicaid eligible, your enrollment in our Plan may be retroactive to when you became eligible for Medicaid. Your enrollment date may even have occurred last year. In order to be reimbursed for expenses you had during this time period (and that were not reimbursed by other insurance), you must submit a paper claim to us. (See "How do you submit a paper claim") We have a seven-month special transition period that allows us to cover most of your claims from the effective date of your enrollment to the current time; however, depending upon your situation, you or Medicare may be responsible for any out-of-network or price differences. You may also be responsible for some claims outside of the seven-month special transition period if the claims are for drugs not on our formulary. For more information, please call Customer Service.

How does your prescription drug coverage work if you go to a hospital or skilled nursing facility?

If you are admitted to a hospital for a Medicare-covered stay, Medicare Part A should generally cover the cost of your prescription drugs while you are in the hospital. Once you are released from the hospital, we will cover your prescription drugs as long as the drugs meet all of our coverage requirements (such as that the drugs are on our formulary, filled at a network pharmacy, and they aren't covered by Medicare Part A or Part B.) We will also cover your prescription drugs if they are approved under the Part D coverage determination, exceptions, or appeals process.

If you are admitted to a skilled nursing facility for a Medicare-covered stay: After Medicare Part A stops paying for your prescription drug costs as part of a Medicare-covered skilled nursing facility stay, we will cover your prescription drugs as long as the drug meets all of our coverage requirements (such as that the drugs are on our formulary, the skilled nursing facility pharmacy is in our pharmacy network and the drugs aren't otherwise covered by Medicare Part A or Part B). When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period, during which time you will be able to leave this Plan and join a Medicare Advantage Plan, new Prescription Drug Plan, or the Original Medicare Plan. See Section 6 for more information about leaving this Plan and joining a new Medicare Plan.

Long-term care (LTC) pharmacies

Generally, residents of a long-term-care facility (like a nursing home) may get their prescription drugs through the facility's LTC pharmacy or another network LTC pharmacy. Please refer to your Pharmacy Directory to find out if your LTC pharmacy is part of our network. If it isn't, or for more information, contact Customer Service.

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

Only Native Americans and Alaska Natives have access to Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) pharmacies through our Plan's pharmacy network. Others may be able to use these pharmacies under limited circumstances (e.g., emergencies). Please refer to your Pharmacy Directory to find an I/T/U pharmacy in your area. For more information, contact Customer Service.

Home infusion pharmacies:

Please refer to your Pharmacy Directory to find a home infusion pharmacy provider in your area. For more information, contact Customer Service.

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

We may cover vaccines that are preventive in nature and aren't already covered by Medicare Part B. This coverage includes the cost of vaccine administration. See Section 10 for more information about your costs for covered vaccinations.

3. Your Rights and Responsibilities as a Member of our Plan

Introduction to your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this section, we explain your Medicare rights and protections as a member of our Plan and we explain what you can do if you think you are being treated unfairly or your rights are not being respected.

Your right to be treated with dignity, respect and fairness

You have the right to be treated with dignity, respect, and fairness at all times. Our Plan must obey laws that protect you from discrimination or unfair treatment. We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. If you need help with communication, such as help from a language interpreter, please call Customer Service. Customer Service can also help if you need to file a complaint about access (such as wheel chair access). You may also call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or your local Office for Civil Rights.

Your right to the privacy of your medical records and personal health information

There are federal and state laws that protect the privacy of your medical records and personal health information. We protect your personal health information under these laws. Any personal information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people don't see or change your records. Generally, we must get written permission from you (or from someone you have given legal power to make decisions for you) before we can give your health information to anyone who isn't providing your care or paying for your care. There are exceptions allowed or required by law, such as release of health information to government agencies that are checking on quality of care. The Plan will release your information, including your prescription drug event data, to Medicare, which may release it for research and other purposes that follow all applicable Federal statutes and regulations.

The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We are required to provide you with a notice that tells about these rights and explains how we protect the privacy of your health information. You have the right to look at medical records held at the Plan, and to get a copy of your records (there may be a fee charged 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 review your request and figure out whether the changes are appropriate). You have the right to know how your health information has been given out and used for non-routine purposes. If you have questions or concerns about privacy of your personal information and medical records, please call Customer Service.

You have the right to timely access to your prescriptions at any network pharmacy

Your right to use advance directives (such as a living will or a power of attorney)

You have the right to ask someone such as a family member or friend to help you with decisions about your health care. Sometimes, people become unable to make health care decisions for themselves due to accidents or serious illness. If you want to, you can use a special form to give someone the legal authority to make decisions for you if you ever become unable to make decisions for yourself. You also have the right to give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself. The legal documents that you can use to give your directions in advance in these situations are called "advance directives." There are different types of advance directives and different names for them. Documents called "living will" and "power of attorney for health care" are examples of advance directives.

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

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

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive. If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the Office of Civil Rights. Please refer to the chart at the end of this Evidence of Coverage to locate the Office of Civil Rights for you state.

Your right to get information about our Plan

You have the right to get information from us about our Plan. This includes information about our financial condition, and how our Plan compares to other health plans. To get any of this information, call Customer Service.

Your right to get information in other formats

You have the right to get your questions answered. Our plan must have individuals and translation services available to answer questions from non-English speaking beneficiaries, and must provide information about our benefits that is accessible and appropriate for persons eligible for Medicare because of disability. If you have difficulty obtaining information from your plan based on language or a disability, call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Your right to get information about our network pharmacies

You have the right to get information from us about our network pharmacies. To get this information, call Customer Service.

Your right to get information about your prescription drugs and costs

You have the right to an explanation from us about any prescription drugs not covered by our Plan. We must tell you in writing why we will not pay for or approve a prescription drug, and how you can file an appeal to ask us to change this decision. See Section 5 for more information about filing an appeal. You also have the right to this explanation even if you obtain the prescription drug from a pharmacy not affiliated with our organization. You also have the right to receive an explanation from us about any utilization-management requirements, such as step therapy or prior authorization, which may apply to your plan. Please review our formulary website or call Customer Service for more information.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage. See Section 4 and Section 5 for more information about complaints. If you make a complaint, we must treat you fairly (i.e., not retaliate against you) because you made a complaint. You have the right to get a summary of information about the appeals and grievances that members have filed against our Plan in the past. To get this information, call Customer Service.

How to get more information about your rights

If you have questions or concerns about your rights and protections, you can

1. Call Customer Service at the number on the cover of this booklet.
2. Get free help and information from your State Health Insurance Assistance Program (SHIP). Contact information for your SHIP is in Section 8 of this booklet.
3. Visit www.medicare.gov to view or download the publication "Your Medicare Rights & Protections."
4. Call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

What can you do if you think you have been treated unfairly or your rights are not being respected?

If you think you have been treated unfairly or your rights have not been respected, you may call Customer Service or:

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, you can call the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call your local Office for Civil Rights.
- If you have any other kind of concern or problem related to your Medicare rights and protections described in this section, you can also get help from your SHIP.

Your responsibilities as a member of our Plan include:

- Getting familiar with your coverage and the rules you must follow to get care as a member. You can use this booklet to learn about your coverage, what you have to pay, and the rules you need to follow. Call Customer Service if you have questions.
- Using all of your insurance coverage. If you have additional prescription drug coverage besides our Plan, it is important that you use your other coverage in combination with your coverage as a member of our Plan to pay your prescription drug expenses. This is called "coordination of benefits" because it involves coordinating all of the drug benefits that are available to you.
- **You are required to tell our Plan if you have additional drug coverage. Call Customer Service.**
- Notifying providers when seeking care (unless it is an emergency) that you are enrolled in our Plan and you must present your plan membership card to the provider.
- Giving your doctor and other providers the information they need to care for you, and following the treatment plans and instructions that you and your doctors agree upon. Be sure to ask your doctors and other providers if you have any questions and have them explain your treatment in a way you can understand.
- Paying your plan premiums and coinsurance or co-payment for your covered services. You must pay for services that aren't covered.
- Notifying us if you move. If you move within our service area, we need to keep your membership record up-to-date. If you move outside of our plan service area, you cannot remain a member of our plan, but we can let you know if we have a plan in that area.
- Letting us know if you have any questions, concerns, problems, or suggestions. If you do, please call Customer Service.

4. How to File a Grievance

What is a Grievance?

A grievance is any complaint, other than one that involves a request for an initial determination or an appeal as described in Section 5 of this manual.

Grievances do not involve problems related to approving or paying for Part D drugs.

If we will not pay for or give you the Part D drugs you want, you must follow the rules outlined in Section 5.

What types of problems might lead to your filing a grievance?

- Problems with the service you receive from Customer Service.
- If you feel that you are being encouraged to leave (disenroll from) the Plan.
- If you disagree with our decision not to give you a "fast" decision or a "fast" appeal. We discuss these fast decisions and appeals in Section 5.
- We don't give you a decision within the required time frame.
- We don't give you required notices.
- You believe our notices and other written materials are hard to understand.
- Waiting too long for prescriptions to be filled.
- Rude behavior by network pharmacists or other staff.
- We don't forward your case to the Independent Review Entity if we do not give you a decision on time.

If you have one of these types of problems and want to make a complaint, it is called "filing a grievance."

Who may file a grievance

You or someone you name may file a grievance. The person you name would be your "representative." You may name a relative, friend, lawyer, advocate, doctor, or anyone else to act for you. Other persons may already be authorized by the Court or in accordance with State law to act for you. If you want someone to act for you who is not already authorized by the Court or under State law, then you and that person must sign and date a statement that gives the person legal permission to be your representative. To learn how to name your representative, you may call Customer Service.

Filing a grievance with our Plan

If you have a complaint, you or your representative may call the phone number for **Part D Grievances** (for complaints about Part D drugs) in Section 8. We will try to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or your complaint is related to quality of care, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We**

call this the Grievance procedure. You may submit your complaint in writing or via facsimile to Health Net at:

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

Fax: 1-800-977-1959

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

You are also entitled to a quick review of your complaint if you disagree with our decision in the following circumstances:

- We deny your request for a fast review of a request for drug benefits
- We deny your request for a fast review of an appeal of denied drug benefits

We call this the Expedited Grievance procedure. If you have questions about this procedure, please call Member Service at the phone number listed on the cover. Requests for Expedited Grievance may be submitted by telephone at 1-800-806-8811 (TTY/TTD 1-800-929-9955). You may also submit your request in writing or via facsimile to Health Net at:

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

Fax: 1-800-977-1959

We will quickly review your request and notify you of our decision within 24 hours of receiving your complaint. Once the Expedited Grievance is received by Health Net, a Clinical Practitioner will review your complaint to determine the circumstances surrounding the denial of your request for expedited review. You will be notified of the outcome of the Expedited Grievance case verbally and in writing within 24 hours of initial receipt of your complaint.

Complaints about a decision regarding payment for, or provision of, covered benefits that you believe should be provided or paid for by Health Net must be appealed through Health Net's Medicare Part D Appeals procedure.

The grievance must be submitted within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest.

If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have.

Fast Grievances

In certain cases, you have the right to ask for a "fast grievance," meaning we will answer your grievance within 24 hours. We discuss situations where you may request a fast grievance in Section 5.

For quality of care problems, you may also complain to the QIO

You may complain about the quality of care received under Medicare. You may complain to us using the grievance process, to the Quality Improvement Organization (QIO), or both. If you file with the QIO, we must help the QIO resolve the complaint. See Section 8 for more information about the QIO and for the name and phone number of the QIO in your state.

5. Complaints and Appeals about your Part D Prescription Drug(s)

Introduction

This section explains how you ask for coverage of your Part D drug(s) or payments in different situations. These types of requests and complaints are discussed below in Part 1.

Other complaints that do not involve the types of requests or complaints discussed below in Part 1 are considered **grievances**. You would file a grievance if you have any type of problem with us or one of our network providers that does not relate to coverage for Part D drugs. For more information about grievances, see Section 4.

PART 1. Requests for Part D drugs

This part explains what you can do if you have problems getting the Part D drugs you request, or payment (including the amount you paid) for a Part D drug you already received.

If you have problems getting the Part D drugs you need, or payment for a Part D drug you already received, you must request an initial determination with the plan.

Initial Determinations

The initial determination we make is the starting point for dealing with requests you may have about covering a Part D drug you need, or paying for a Part D drug you already received. Initial decisions about Part D drugs are called "**coverage determinations**." With this decision, we explain whether we will provide the Part D drug you are requesting, or pay for the Part D drug you already received.

The following are examples of requests for initial determinations:

- You ask us to pay for a prescription drug you have received.
- You ask for a Part D drug that is not on your plan sponsor's list of Covered Drugs (called a "formulary"). This is a request for a "formulary exception." **See "What is an exception?" below for more information about the exceptions process.**
- You ask for an exception to our utilization management tools - such as prior authorization, dosage limits, quantity limits, or step therapy requirements. Requesting an exception to a utilization management tool is a type of formulary exception. **See "What is an exception?" below for more information about the exceptions process.**
- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering exception." **See "What is an exception?" below for more information about the exceptions process.**
- You ask us to pay you back for the cost of a drug you bought at an out-of-network pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician's office, will be covered by the Plan. See "Filling Prescriptions Outside of Network" in Section 2 for a description of these circumstances.

What is an exception?

An exception is a type of initial determination (also called a "coverage determination") involving a Part D drug. You or your doctor may ask us to make an exception to our Part D coverage rules in a number of situations.

- You may ask us to cover your Part D drug even if it is not on our formulary. Excluded drugs cannot be covered by a Part D plan unless coverage is through an enhanced plan that covers those excluded drugs.
- You may ask us to waive coverage restrictions or limits on your Part D drug. For example, for certain Part D drugs, we limit the amount of the drug that we will cover. If your Part D drug has a quantity limit, you may ask us to waive the limit and cover more. See Section 2 ("Utilization Management") to learn more about our additional coverage restrictions or limits on certain drugs."
- You may ask us to provide a higher level of coverage for your Part D drug. If your Part D drug is contained in our non-preferred or injectable tier, you may ask us to cover it at the cost-sharing amount that applies to drugs in the preferred brand tier instead. This would lower the coinsurance/co-payment amount you must pay for your Part D drug. Please note, if we grant your request to cover a Part D drug that is not on our formulary, you may not ask us to provide a higher level of coverage for the drug. Also, you may not ask us to provide a higher level of coverage for Part D drugs that are in the specialty tier.

Generally, we will only approve your request for an exception if the alternative Part D drugs included on the Plan formulary or the Part D drug in the preferred tier would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

Your doctor must submit a statement supporting your exception request. In order to help us make a decision more quickly, the supporting medical information from your doctor should be sent to us with the exception request.

If we approve your exception request, our approval is valid for the remainder of the Plan year, so long as your doctor continues to prescribe the Part D drug for you and it continues to be safe for treating your condition. If we deny your exception request, you may appeal our decision.

Note: If we approve your exception request for a Part D non-formulary drug, you cannot request an exception to the co-payment or coinsurance amount we require you to pay for the drug.

You may call us at the phone number shown under **Part D Coverage Determinations** in Section 8 to ask for any of these requests.

Who may ask for an initial determination?

You, your prescribing physician, or someone you name may ask us for an initial determination. The person you name would be your "appointed representative." You may name a relative, friend, advocate, doctor, or anyone else to act for you. Other persons may already be authorized under State law to act for you. If you want someone to act for you who is not already authorized under State law, then you and that person must sign and date a statement that gives the person

legal permission to be your appointed representative. If you are requesting Part D drugs, this statement must be sent to us at the address or fax number listed under "**Part D Coverage Determinations**" To learn how to name your appointed representative, you may call Customer Service.

You also have the right to have a lawyer 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.

Asking for a “standard" or "fast" initial determination

A decision about whether we will give you, or pay for, the Part D drug you are requesting can be a “standard" decision that is made within the standard time frame, or it can be a “fast" decision that is made more quickly. A fast decision is also called an “expedited" decision.

Asking for a standard decision

To ask for a standard decision for a Part D drug you, your doctor, or your representative should call, fax, or write us at the numbers or address listed under **Part D Coverage Determinations** (for appeals about Part D drugs) in Section 8.

Requests received after business hours are handled the next business day.

Asking for a fast decision

You may ask for a fast decision **only** if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for benefits that you have not yet received. You cannot get a fast decision if you are asking us to pay you back for a benefit that you already received.)

If you are requesting a Part D drug that you have not yet received, you, your doctor, or your representative may ask us to give you a fast decision by calling, faxing, or writing us at the numbers or address listed under **Part D Coverage Determinations** (for appeals about Part D drugs in Section 8.

Requests received after business hours are handled the next business day.

Be sure to ask for a “fast,” or “expedited” review. If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor’s support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a “fast grievance.” You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see

Section 4). If we deny your request for a fast initial determination, we will give you a standard decision.

What happens when you request an initial determination?

- For a standard initial determination about a Part D drug (including a request to pay you back for a Part D drug that you have already received).

  Generally, we must give you our decision no later than 72 hours after we receive your request, but we will make it sooner if your request is for a Part D drug that you have not received yet and your health condition requires us to. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules – such as dosage limits, quantity limits, or step therapy requirements), we must give you our decision no later than 72 hours after we receive your physician's "supporting statement" explaining why the drug you are asking for is medically necessary.

  If you have not received an answer from us within 72 hours after we receive your request (or your physician's supporting statement if your request involves an exception), your request will automatically go to Appeal Level 2.

- For a fast initial determination about a Part D drug that you have not yet received.

  If we give you a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review. We will give you the decision sooner if your health condition requires us to. If your request involves a request for an exception, we will give you our decision no later than 24 hours after we have received your physician's "supporting statement," which explains why the drug you are asking for is medically necessary.

  If we decide you are eligible for a fast review and you have not received an answer from us within 24 hours after receiving your request (or your physician's supporting statement if your request involves an exception), your request will automatically go to Appeal Level 2.

What happens if we decide completely in your favor?

- For a standard decision about a Part D drug (including a request to pay you back for a Part D drug that you have already received):

  We must cover the Part D drug you requested as quickly as your health requires, but no later than 72 hours after we receive the request. If your request involves a request for an exception, we must cover the Part D drug you requested no later than 72 hours after we receive your physician's "supporting statement." If you are asking us to pay you back for a Part D drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request (or supporting statement if your request involves an exception).

- For a fast decision about a Part D drug that you have not yet received.

  We must cover the Part D drug you requested no later than 24 hours after we receive your request. If your request involves a request for an exception, we must cover the Part D drug you requested no later than 24 hours after we receive your physician's "supporting statement."

What happens if we decide against you?

If we decide against you, we will send you a written decision explaining why we denied your request. If an initial determination does not give you all that you requested, you have the right to appeal the decision. (See **Appeal Level 1**.)

Appeal Level 1: Appeal to the Plan

You may ask us to review our initial determination, even if only part of our decision is not what you requested. An appeal to the plan about a Part D drug is also called a plan "**redetermination**." When we receive your request to review the initial determination, we give the request to people at our organization who were not involved in making the initial determination. This helps ensure that we will give your request a fresh look.

Who may file your appeal of the initial determination?

If you are appealing an initial decision about a Part D drug, you or your representative may file a **standard appeal** request, or you, your representative, or your doctor may file a **fast appeal** request. Please see "Who may ask for an initial determination?" for information about appointing a representative.

How soon must you file your appeal?

You must file the appeal request within 60 calendar days from the date included on the notice of our initial determination. We may give you more time if you have a good reason for missing the deadline.

How to file your appeal

1. Asking for a standard appeal

To ask for a standard appeal about a Part D drug a signed, written appeal request must be sent to the address listed under **Part D Appeals** (for appeals about Part D drugs) in Section 8.

2. Asking for a fast appeal

If you are appealing a decision we made about giving you a Part D that you have not received yet, you and/or your doctor will need to decide if you need a fast appeal. The rules about asking for a fast appeal are the same as the rules about asking for a fast initial determination. You, your doctor, or your representative may ask us for a fast appeal by calling, faxing, or writing us at the numbers or address listed under **Part D Appeals** (for appeals about Part D drugs) in Section 8.

Requests received after business hours are handled on the next business day.

Be sure to ask for a "fast" or "expedited" review. Remember, if your doctor provides a written or oral supporting statement explaining that you need the fast appeal, we will automatically give you a fast appeal. If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "fast grievance." You have the right to file a fast grievance if you disagree with our decision to deny your request for a fast review (for more information about fast grievances, see Section 4). If we deny your request for a fast appeal, we will give you a standard appeal.

Getting information to support your appeal

We must gather all the information we need to make a decision about your appeal. If we need your assistance in gathering this information, we will contact you or your representative. You have the right to obtain and include additional information as part of your appeal. For example, you may already have documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information.

You may give us your additional information to support your appeal by calling, faxing, or writing us at the numbers or address listed under **Part D Appeals** (for appeals about Part D drugs) in Section 8.

You may also deliver additional information in person to the address listed under **Part D Appeals** (for appeals about Part D drugs) in Section 8.

You also have the right to ask us for a copy of information regarding your appeal. You may call or write us at the phone number or address listed under **Part D Appeals** (for appeals about Part D drugs) in Section 8.

How soon must we decide on your appeal?

- For a standard decision about a Part D drug that includes a request to pay you back for a Part D drug you have already paid for and received.

  We will give you our decision within seven calendar days of receiving the appeal request. We will give you the decision sooner if you have not received the drug yet and your health condition requires us to. If we do not give you our decision within seven calendar days, your request will automatically go to Appeal Level 2.

- For a fast decision about a Part D drug that you have not yet received.

  We will give you our decision within 72 hours after we receive the appeal request. We will give you the decision sooner if your health condition requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2.

What happens if we decide completely in your favor?

- For a standard decision about a Part D drug (including a request to pay you back for a Part D drug that you have already received).

  We must cover the Part D drug you requested as quickly as your health requires, but no later than 7 calendar days after we receive the request. If you are asking us to pay you back for a Part D drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

- For a fast decision about a Part D drug that you have not yet received.

  We must cover the Part D drug you requested no later than 72 hours after we receive your request.

Appeal Level 2: Independent Review Entity (IRE)

At the second level of appeal, your appeal is reviewed by an outside, Independent Review Entity (IRE) that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The IRE has no connection to us. You have the right to ask us for a copy of your case file that we sent to this entity.

How to file your appeal

If you asked for Part D drugs or payment for Part D drugs and we did not rule completely in your favor at Appeal Level 1, you may file an appeal with the IRE. If you choose to appeal, you must send the appeal request to the IRE. The decision you receive from the plan (Appeal Level 1) will tell you how to file this appeal, including who can file the appeal and how soon it must be filed.

How soon must the IRE decide?

The IRE has the same amount of time to make its decision as the plan had at **Appeal Level 1**.

If the IRE decides completely in your favor:

The IRE will tell you in writing about its decision and the reasons for it.

- For a decision to pay you back for a Part D drug you already paid for and received, we must send payment to you within 30 calendar days from the date we receive notice reversing our decision.

- For a standard decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 72 hours after we receive notice reversing our decision.

- For a fast decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 24 hours after we receive notice reversing our decision.

Appeal Level 3: Administrative Law Judge (ALJ)

If the IRE does not rule completely in your favor, you or your representative may ask for a review by an Administrative Law Judge (ALJ) if the dollar value of the Part D drug you asked for meets the minimum requirement provided in the IRE's decision. During the ALJ review, you may present evidence, review the record (by either receiving a copy of the file or accessing the file in person when feasible), and be represented by counsel.

How to file your appeal

The request must be filed with an ALJ within 60 calendar days of the date you were notified of the decision made by the IRE (Appeal Level 2). The ALJ may give you more time if you have a good reason for missing the deadline. The decision you receive from the IRE will tell you how to file this appeal, including who can file it.

The ALJ will not review your appeal if the dollar value of the requested Part D drug does not meet the minimum requirement specified in the IRE's decision. If the dollar value is less than the minimum requirement, you may not appeal any further.

How soon will the Judge make a decision?

The ALJ will hear your case, weigh all of the evidence, and make a decision as soon as possible.

If the Judge decides in your favor:

See the section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" below for information about what we must do if our decision denying what you asked for is reversed by an ALJ.

Appeal Level 4: Medicare Appeals Council (MAC)

If the ALJ does not rule completely in your favor, you or your representative may ask for a review by the Medicare Appeals Council (MAC).

How to file your appeal

The request must be filed with the MAC within 60 calendar days of the date you were notified of the decision made by the ALJ (Appeal Level 3). The MAC may give you more time if you have a good reason for missing the deadline. The decision you receive from the ALJ will tell you how to file this appeal, including who can file it.

How soon will the Council make a decision?

The MAC will first decide whether to review your case (it does not review every case it receives). If the MAC reviews your case, it will make a decision as soon as possible. If it decides not to review your case, you may request a review by a Federal Court Judge (see Appeal Level 5). The MAC will issue a written notice explaining any decision it makes. The notice will tell you how to request a review by a Federal Court Judge.

If the Council decides in your favor:
See the section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" below for information about what we must do if our decision denying what you asked for is reversed by the MAC.

Appeal Level 5: Federal Court
You have the right to continue your appeal by asking a Federal Court Judge to review your case if the amount involved meets the minimum requirement specified in the Medicare Appeals Council's decision, you received a decision from the Medicare Appeals Council (Appeal Level 4), and:

- The decision is not completely favorable to you, or
- The decision tells you that the MAC decided not to review your appeal request.

How to file your appeal
In order to request judicial review of your case, you must file a civil action in a United States district court within 60 calendar days after the date you were notified of the decision made by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Medicare Appeals Council will tell you how to request this review, including who can file the appeal.

Your appeal request will not be reviewed by a Federal Court if the dollar value of the requested Part D drug does not meet the minimum requirement specified in the MAC's decision.

How soon will the Judge make a decision?
The Federal Court Judge will first decide whether to review your case. If it reviews your case, a decision will be made according to the rules established by the Federal judiciary.

If the Judge decides in your favor:
See the section "**Favorable Decisions by the ALJ, MAC, or a Federal Court Judge**" below for information about what we must do if our decision denying what you asked for is reversed by a Federal Court Judge.

If the Judge decides against you:
You may have further appeal rights in the Federal Courts. Please refer to the Judge's decision for further information about your appeal rights.

Favorable Decisions by the ALJ, MAC, or a Federal Court Judge
This section explains what we must do if our initial decision denying what you asked for is reversed by the ALJ, MAC, or a Federal Court Judge.

- For a decision to pay you back for a Part D drug you already paid for and received, we must send payment to you within 30 calendar days from the date we receive notice reversing our decision.

- For a standard decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 72 hours after we receive notice reversing our decision.

- For a fast decision about a Part D drug you have not yet received, we must cover the Part D drug you asked for within 24 hours after we receive notice reversing our decision.

6. Ending your Membership

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 also limited situations where we are required to end your membership. For example, if you move permanently out of our geographic service area.

Voluntarily ending your membership

There are only certain times during the year when you may voluntarily end your membership in our Plan. The key time to make changes is the Medicare fall open enrollment period (also known as the "Annual Election Period"), which occurs every year from November 15 through December 31. This is the time to review your health care and drug coverage for the following year and make changes to your Medicare health or prescription drug coverage. Any changes you make during this time will be effective January 1. Certain individuals, such as those with Medicaid, those who get extra help, or who move, can make changes at other times. For more information on when you can make changes see the enrollment period table at the end of this section.

During the fall open enrollment period, if you want to end your membership in our plan, this is what you need to do:

- **If you are planning on joining another Medicare Prescription drug plan:** Simply join the new Medicare Prescription drug plan. You will be disenrolled automatically from our plan when your new coverage begins on January 1.

- **If you are planning on enrolling in a Medicare Advantage plan**: Request enrollment in the new plan. In most cases, you will be disenrolled automatically when your new plan's coverage begins on January 1.

  EXCEPTION -- If you are joining a Medicare Advantage "Private Fee-for-Service" plan and that plan does not offer drug coverage, or a Medicare Medical Savings Account (MSA) Plan, enrollment will not automatically disenroll you from our plan. Therefore, you will need to do the following:

  - To join a new Medicare prescription drug plan, simply join the new Medicare prescription drug plan, or
  - If you do not want Medicare prescription drug coverage, find out how to request disenrollment from our plan by contacting Customer Service. You may also call 1-800-MEDICARE (1-800-633-4227) to request disenrollment from our plan. TTY users should call 1-877-486-2048.

- **If you would like to end your membership without joining any other Medicare health or prescription drug plan:** Contact Customer Service to find out how to request disenrollment. You may also call 1-800-MEDICARE (1-800-633-4227) to

request disenrollment from our plan. TTY users should call 1-877-486-2048. Your enrollment in Original Medicare will be effective January 1.

IMPORTANT -- If you disenroll from a Medicare prescription drug plan and go without creditable prescription drug coverage (coverage that is at least as good as Medicare drug coverage), you may have to pay a penalty if you join later.

Enrollment Period	When?	Effective Date
Fall Open Enrollment (Annual Election Period) Time to review health and drug coverage and make changes.	Every year from November 15 to December 31	January 1
Medicare Advantage (MA) Open Enrollment MA-eligible beneficiaries can make one change to their health plan coverage. However, you cannot use this period to add, drop, or change your Medicare prescription drug coverage. Examples: If you are in a MA plan that does not have Medicare prescription drug coverage, you can switch to another Medicare Advantage plan that does not offer drug coverage or go to Original Medicare If you are in Original Medicare Plan and have a Medicare prescription drug plan, you can join a Medicare Advantage Plan that offers Medicare drug coverage If you are in an MA plan that offers Medicare drug coverage, you can leave and join Original Medicare Plan and a Medicare prescription drug plan	Every year from January 1 to March 31	First day of next month after plan receives your enrollment request

Special Enrollment Periods for limited special exceptions, such as: • You have a change in residence • You have Medicaid • You are eligible for extra help with Medicare prescriptions • You live in an institution (such as a nursing home)	Determined by exception.	Generally, first day of next month after plan receives your enrollment request

For more information about the options available to you during these enrollment periods, contact Medicare at 1-800-MEDICARE (1-800-633-4227.) TTY users should call 1-877-486-2048. Additional information can also be found in the *"Medicare & You"* handbook. This handbook is mailed to everyone with Medicare each fall. You may view or download a copy from www.medicare.gov - under "Search Tools," select "Find a Medicare Publication."

Until your membership ends, you must keep getting your Medicare prescription drug coverage through our Plan

If you leave our Plan, it may take some time for your membership to end and your new way of getting Medicare to take effect (we discuss when the change takes effect earlier in this section). While you are waiting for your membership to end, you are still a member and must continue to get your prescription drugs as usual through our Plan.

Until your prescription drug coverage with our Plan ends, use our network pharmacies to fill your prescriptions. While you are waiting for your membership to end, you are still a member and must continue to get your prescription drugs as usual through our Plan's network pharmacies. In most cases, your prescriptions are covered only if they are filled at a network pharmacy inlcuding our mail order pharmacy service, are listed on our formulary, and you follow other coverage rules.

We cannot ask you to leave the Plan because of your health.

We cannot ask you to leave your health plan for any health-related reasons. If you ever feel that you are being encouraged or asked to leave our Plan because of your health, you should call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Involuntarily ending your membership

If any of the following situations occur, we will end your membership in our Plan.

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

- If you move out of the service area or are away from the service area for more than 6 months you cannot remain a member of our Plan. And we must end your membership ("disenroll" you)". If you plan to move or take a long trip, please call Customer Service to find out if the place you are moving to or traveling to is in our Plan's service area.
- If you knowingly falsify or withhold information about other parties that provide reimbursement for your prescription drug coverage.
- If you intentionally give us incorrect information on your enrollment request that would affect your eligibility to enroll in our Plan.
- If you behave in a way that is disruptive, to the extent that you continued enrollment seriously impairs our ability to arrange or provide medical care for you or for others who are members of our Plan. We cannot make you leave our Plan for this reason unless we get permission first from Medicare.
- If you let someone else use your plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation.
- If you do not pay the Plan premiums, we will tell you in writing that you have a 60-days grace period during which you may pay the Plan premiums before your membership ends.

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 will tell you our reasons in writing and explain how you may file a complaint against us if you want to.

7. Definitions of Important Words Used in the EOC

Appeal – An appeal is a special kind of complaint you make if you disagree with a decision to deny a request for or prescription drugs or payment for prescription drugs you already received. For example, you may ask for an appeal if our Plan doesn't pay for a drug you think you should be able to receive. Section 5 explains appeals, including the process involved in making an appeal.

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

Catastrophic Coverage - The phase in the Part D Drug Benefit where you pay a low co-payment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,350 in Covered Drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 8 explains how to contact CMS.

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

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

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

Creditable Prescription Drug Coverage – Coverage (for example, from an employer or union) that is at least as good as Medicare's prescription drug coverage.

Customer Service – A department within our Plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Section 8 for information about how to contact Customer Service.

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). Section 6 discusses disenrollment.

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and 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).

Formulary – A list of Covered Drugs provided by the Plan.

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

Grievance - A type of complaint you make about us or one of our network pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 4 for more information about grievances.

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

Initial Coverage Period – This is the period after you have met your deductible and before your total drug expenses, have reached $2,500 including amounts you've paid and what our Plan has paid on your behalf.

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

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

Medicare Advantage (MA) Plan– Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. A MA plan offers a specific set of health benefits at the same premium and level of cost-sharing to all people with Medicare who live in the service area covered by the Plan. Medicare Advantage Organizations can offer one or more Medicare Advantage plan in the same service area. A Medicare Advantage Plan can be an HMO, PPO, a Private Fee-for-Service (PFFS) Plan, or a Medicare Medical Savings Account (MSA) plan. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage).

These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare Health Plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare 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 the Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan. (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).

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 Plan – ("Traditional Medicare" or "Fee-for-service" Medicare) The Original Medicare Plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

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

Part C – see "Medicare Advantage (MA) Plan"

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

Part D Drugs – Drugs that Congress permitted our Plan to offer as part of a standard Medicare prescription drug benefit. We may or may not offer all Part D drugs. (See your formulary for a specific list of Covered Drugs.) Certain categories of drugs, such as benzodiazepines, barbiturates, and over-the-counter drugs were specifically excluded by Congress from the standard prescription drug package (see Section 10 for a listing of these drugs). These drugs are not considered Part D drugs.

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

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the Federal Government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Section 8 for information about how to contact the QIO in your state and Section 5 for information about making complaints to the QIO.

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

Service area – "Service area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a certain plan.

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.

8. Helpful Phone Numbers and Resources

Contact Information for our Plan Customer Service

If you have any questions or concerns, please call or write to our Plan Customer Service. We will be happy to help you.

CALL 1-800-806-8811. This number is also on the cover of this booklet for easy reference. Calls to this number are free.

Hours of Operation 8:00 A.M to 8:00 P.M., 7 days a week

TTY/TDD 1-800-929-9955 This number requires special telephone equipment. Calls to this number are free.

WRITE Health Net Medicare Programs
P.O. Box 1728
Augusta, GA 30903-1728

WEBSITE www.healthnet.com

Contact Information for Grievances, Coverage Determinations and Appeals

Part D Coverage Determinations (about your Part D Prescription Drugs)

CALL 1-800-806-8811. Calls to this number are free.

TTY/TDD 1-800-929-9955 This number requires special telephone equipment. Calls to this number are free.

FAX 1-916-463-9754

WRITE Health Net Pharmaceutical Services
Attn: Pharmacy Service Center
10540 White Rock Road, Suite 280
Rancho Cordova, CA 95670

For information about Part D coverage determinations, see Section 5.

Part D Grievances (about your Part D Prescription Drugs)

CALL 1-800-806-8811. Calls to this number are free.

TTY/TDD 1-800-929-9955. This number requires special telephone equipment. Calls to this number are free.

FAX 1-800-977-1959

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

For information about Part D grievances, see Section 4.

Part D Appeals (about your Part D Prescription Drugs)

CALL 1-800-806-8811 Calls to this number are free

TTY/TDD 1-800-929-9955 This number requires special telephone equipment. Calls to this number are free.

FAX 1-800-977-1959

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

For information about Part D appeals, see Section 5.

Other important contacts

Below is a list of other important contacts. For the most up-to-date contact information, check your *Medicare & You* Handbook, visit www.medicare.gov and choose "Find Helpful Phone Numbers and Resources," or call 1-800-Medicare (1-800-633-4227). TTY users should call 1-877-486-2048.

State Health Insurance Assistance Program (SHIP)

SHIPs is a state program that gets money from the Federal Government to give free local health insurance counseling to people with Medicare. Your SHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. Your SHIP has information about Medicare Advantage Plans, Medicare Prescription Drug Plans, and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in a Medicare Advantage Plan and special Medigap rights for people who have tried a Medicare Advantage Plan for the first time.

You may contact the SHIP in your state in the "State Health Insurance Assistance Program (SHIP)" chart at the end of this Evidence of Coverage. You can find contact information for the SHIP in your state in the "State Health Insurance Assistance Program (SHIP)" chart at the end of

this Evidence of Coverage You may also find the website for your local SHIP at www.medicare.gov under "Search Tools" by selecting "Helpful Phone Numbers and Websites."

Quality Improvement Organization

"QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and health professionals in your state that reviews medical care and handles certain types of complaints from patients with Medicare, and is paid by the Federal Government to check on and help improve the care given to Medicare patients. There is a QIO in each state. QIOs have different names, depending on which state they are in. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints about quality of care and appeals filed by Medicare patients who think the coverage for their hospital, skilled nursing facility, home health agency, or comprehensive outpatient rehabilitation stay is ending too soon. See Sections 4 and 5 for more information about complaints, appeals and grievances.

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

How to contact the Medicare program

Medicare is 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). Our organization contracts with the Federal Government.

- Call 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Customer Service representatives are available 24 hours a day, including weekends.
- Visit www.medicare.gov for information. This is the official government website for Medicare**.** This website gives you up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare Prescription Drug Plans in your area. You can also search under "Search Tools" for Medicare contacts in your state. Select "Helpful Phone Numbers and Websites." 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.

Medicaid

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

Social Security

Social Security programs include retirement benefits, disability benefits, family benefits, survivors' benefits, and benefits for the aged and blind. You may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778. You may also visit **www.ssa.gov** on the Web.

State Pharmacy Assistance Program (SPAP)

SPAPs are state organizations that provide limited-income and medically needy senior citizens and individuals with disabilities financial help for prescription drugs. You may contact the SPAP in your state. Please refer to the chart at the end of this Evidence of Coverage to locate the Qualified SPAP(s) in your state

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you may call your local Railroad Retirement Board office or 1-800-808-0772. TTY users should call 312-751-4701. You may also visit www.rrb.gov on the Web.

Employer (or "Group") Coverage

If you get, or your spouse gets, benefits from your current or former employer or union, or from your spouse's current or former employer or union, call the employer/union benefits administrator or Customer Service if you have any questions about your employer/union benefits, plan premiums, or the open enrollment season. Important Note: You (or your spouse's) employer/union benefits may change, or you (or your spouse) may lose the benefits, if you enroll in Medicare Part D. Call your employer/union benefits administrator or Customer Service to find out whether the benefits will change or be terminated if you or your spouse enrolls in Part D.

9. 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, sexual orientation, 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.

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 the facilities, or personnel, of Health Net not being available to provide or arrange for services or benefits under this Evidence of Coverage, Health Net's obligation to provide such services or benefits shall be limited to the requirement that Health Net make a good faith effort to provide or arrange for the provision of such services or benefits within the resulting limitations on the availability of its facilities or personnel.

When A Third Party Causes A Member Injuries

If you are ever injured through the actions of another person (a third party), Health Net will provide benefits for all covered medications that you receive through this plan. However, if you receive money because of your injuries, you must reimburse Health Net or the pharmacy for the value of any medications provided to you through this plan. Examples of how an injury could be

caused by the actions of another person: You are in a car accident and the other driver is at fault. You slip and fall in a store because a wet spot was left on the floor.

Steps You Must Take

Health Net's legal right to reimbursement is called a lien. If you are injured because of a third party, you must cooperate with Health Net's and the pharmacy's efforts to obtain reimbursement, including: Telling Health Net and the pharmacy the name and address of the third party, if you know it, the name and address of your lawyer, if you are using a lawyer, and describing how the injuries were caused. Completing any paperwork that Health Net or the pharmacy may require to assist in enforcing the lien. Promptly responding to inquiries from the lien holders about the status of the case and any settlement discussions. Notifying the lien holders immediately upon you or your lawyer receiving any money from the third parties or their insurance companies. Holding any money that you or your lawyer receive from the third party or their insurance companies in trust, and reimbursing Health Net and the pharmacy for the amount of the lien as soon as you are paid by the third party.

How The Amount Of your Reimbursement Is Determined

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

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

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

Notice Of Privacy Practices

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

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

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

How we may use and disclose your protected health information

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

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

  If the plan sponsor provides plan administration services, we may also provide access to health information to support its performance of such services which may include but are not limited to claims audits or customer services functions. Health Net will only share health information upon a certification from the plan sponsor representing there are restrictions in place to ensure that only plan sponsor employees with a legitimate need to know will have access to health information in order to provide plan administration functions.

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

Other permitted or required disclosures

- **As Required by Law**. We must disclose protected health information about you when required to do so by law.

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

Other uses or disclosures with an authorization

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

Your rights regarding your protected health information

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

- **Right To Access Your Protected Health Information**. You have the right to review or obtain copies of your protected health information records, with some limited exceptions.

Usually the records include enrollment, billing, claims payment and case or medical management records. Your request to review and/or obtain a copy of your protected health information records must be made in writing. We may charge a fee for the costs of producing, copying and mailing your requested information, but we will tell you the cost in advance.

- **Right To Amend Your Protected Health Information**. If you feel that protected health information maintained by the Plan is incorrect or incomplete, you may request that we amend the information. Your request must be made in writing and must include the reason you are seeking a change. We may deny your request if, for example, you ask us to amend information that was not created by the Plan, as is often the case for health information in our records, or you ask to amend a record that is already accurate and complete.

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

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

  Your request for an accounting of disclosures must be made in writing and must state a time period for which you want an accounting. This time period may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you want the list (for example, on paper or electronically). The first accounting that you request within a 12-month period will be free. For additional lists within the same time period, we may charge for providing the accounting, but we will tell you the cost in advance.

- **Right To Request Restrictions on the Use and Disclosure of Your Protected Health Information**. You have the right to request that we restrict or limit how we use or disclose your protected health information for treatment, payment or health care operations. *We may not agree to your request.* If we do agree, we will comply with your request unless the information is needed for an emergency. Your request for a restriction must be made in writing. In your request, you must tell us (1) what information you want to limit; (2) whether you want to limit how we use or disclose your information, or both; and (3) to whom you want the restrictions to apply.

- **Right To Receive Confidential Communications**. You have the right to request that we use a certain method to communicate with you about the Plan or that we send Plan information to a certain location if the communication could endanger you. Your request to receive confidential communications must be made in writing. Your request must clearly state that all or part of the communication from us could endanger you. We will accommodate all reasonable requests. Your request must specify how or where you wish to be contacted.

- **Right to a Paper Copy of This Notice**. You have a right at any time to request a paper copy of this Notice, even if you had previously agreed to receive an electronic copy.

- **Contact Information for Exercising Your Rights**. You may exercise any of the rights described above by contacting our privacy office. See the end of this Notice for the contact information.

Health information security

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

Changes to this notice

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

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

You may also contact us at:

Telephone:	1-800-522-0088
Fax:	1-818-676-8981
Email:	Privacy@healthnet.com

10. How Much You Pay for Your Part D Prescription Drugs

Your Monthly Premium for Our Plan

Your monthly plan premium for our plan is $40.90

If you get your benefits from your current or former employer, or from your spouse's current or former employer, call the employer's benefits administrator for information about your Plan premium.

If you are getting extra help with paying for your drug coverage, the Part D premium amount that you pay as a member of this Plan is listed in your "Evidence of Coverage Rider for those who Receive Extra Help for their Prescription Drugs." You can also get that information by calling Customer Service. If you are a member of a State Pharmacy Assistance Program (SPAP), you may get help paying your monthly plan premiums. Please contact your SPAP to determine what benefits are available to you. Note that there is not an SPAP in every state, and in some states the SPAP has another name. See Section 8.

You can find more information about paying your plan premium in Section 1.

How Much You Pay for Part D Prescription Drugs

This section has a chart that tells you what you must pay for Covered Drugs. These are the benefits you get as a member of our Plan. (Later in this section under "General Exclusions" you can find information about drugs that are not covered.) For more detailed information about your benefits, please refer to our Summary of Benefits. If you do not have a current copy of the Summary of Benefits you can view it on our website or contact Customer Service to request one.

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

When you fill a prescription for a covered drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on what coverage level you are in (i.e., initial coverage period, the period after you reach your initial coverage limit, and catastrophic level), the type of drug it is, and whether you are filling your prescription at an in-network or out-of-network pharmacy. Each phase of the benefit is described below. Refer to your plan formulary to see what drugs we cover and what tier they are on. (More information on the formulary is included later in this section.)

If you qualify for extra help with your drug costs, your costs for your drugs may be different from those described below. For more information, see the "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs." If you do not already qualify for extra help, see "Do you qualify for extra help?" in Section 1 for more information.

Initial Coverage Period

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

You will pay the following for your covered prescription drugs:

Drug Tier	Network Retail Cost-Sharing (30 day supply)	Network Retail Cost-Sharing (60 day supply)	Network Retail Cost-Sharing (90 day supply)	Network Long-Term Care Cost-Sharing (34-day Supply)	Network Preferred Mail-Order Cost-Sharing (60-day supply)	Network Non Preferred Mail-Order Cost-Sharing (60-day supply)	Network Preferred Mail-Order Cost-Sharing (90-day supply)	Network Non Preferred Mail-Order Cost-Sharing (90-day supply)	Out-of-Network Cost-Sharing (30-day supply)
Preferred Generic Drugs (Tier 1)	$0	$0	$0	$0	$0	$0	$0	$0	$0
Preferred Brand Name Drugs (Tier 2)	$39	$78	$117	$39	$78	$78	$78	$117	$39
Non-preferred Generic and Brand Name Drugs (Tier 3)	$75	$150	$225	$75	$150	$150	$188	$225	$75
Injectable Drugs (Tier 4)	33%	Not Covered.	Not Covered.	33%	Not Covered.	Not Covered.	Not Covered.	Not Covered.	33%
Specialty Drugs (Tier 5)	33%	Not Covered.	Not Covered.	33%	Not Covered.	Not Covered.	Not Covered.	Not Covered.	33%

Once your total drug costs reach $2,500, 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.

Coverage Gap

After your total drug costs reach $2,500 you, or others on your behalf, will pay 100% for your drugs until your total out-of-pocket costs reach $4,350 and you qualify for catastrophic coverage.

Catastrophic Coverage

All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend $4,350 out-of-pocket for the year. When the total amount you have paid toward coinsurance or co-payments and the cost for covered Part D drugs after you reach the initial coverage limit reaches $4,350, you will qualify for catastrophic coverage. During catastrophic coverage you will pay: the greater of $2.40 for generics or drugs that are treated like generics and the greater of 5% coinsurance or $6.00 for all other drugs. We will pay the rest.

Additional Benefit Information

Drugs on the Injectable and Specialty tiers are limited to a 30-day supply (34-day supply for Long Term Care) per fill.

Vaccine Coverage (including administration)

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

The following chart describes some of these scenarios. Note that in some cases, you will be receiving the vaccine from someone who is not part of our pharmacy network and that you may have to pay for the entire cost of the vaccine and its administration in advance. You will need to mail us the receipts, following our out-of-network paper claims policy (see Section 2), and then you will be reimbursed up to our normal coinsurance or copayment for that vaccine. In some cases you will be responsible for the difference between what we pay and what the out-of-network provider charges you. The following chart provides examples of how much it might cost to obtain a vaccine (including its administration) under our Plan. Actual vaccine costs will vary by vaccine type and by whether your vaccine is administered by a pharmacist or by another provider.

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

If you obtain the vaccine at:	And get it administered by:	You pay (and/or are reimbursed)
The Pharmacy	The Pharmacy (not possible in all States)	You pay your normal coinsurance or co-payment for the vaccine (including administration).
Your Doctor	Your Doctor	You may be required to pay up-front for the entire cost of the vaccine and its administration. You are reimbursed this amount less your normal coinsurance or co-payment for the vaccine (including administration) less any difference between the amount the Doctor charges and what we normally pay.*
The Pharmacy	Your Doctor	You pay your normal coinsurance/co-payment for the vaccine at the pharmacy and the full amount charged by the Doctor for administering the vaccine. You are reimbursed the amount charged by the Doctor less any applicable in network charge for administering the vaccine less any difference between what the Doctor charges for administering the vaccine and what we normally pay.*

*If you receive extra help, we will reimburse you for this difference.

We can help you understand the costs associated with vaccines (including administration) available under our Plan before you go to your doctor. For more information, please contact Customer Service.

How is your out-of-pocket cost calculated?

What type of prescription drug payments count toward your out-of-pocket costs?

The following types of payments for prescription drugs may count toward your out-of-pocket costs and help you qualify for catastrophic coverage as long as the drug you are paying for is a Part D drug or transition drug, on the formulary (or if you get a favorable decision on a coverage-determination request, exception request or appeal), obtained at a network pharmacy (or you have an approved claim from an out-of-network pharmacy), and otherwise meets our coverage requirements:

- Your coinsurance or co-payments up to the initial coverage limit
- Any payments you make for drugs in the coverage gap
- Payments you made this year under another Medicare prescription drug plan prior to your enrollment in our plan

When you have spent a total of $4,350 for these items, you will reach the catastrophic coverage level.

What type of prescription drug payments will not count toward your out-of-pocket costs?

The amount you pay for your monthly premium doesn't count toward reaching the catastrophic coverage level. In addition, the following types of payments for prescription drugs **do not count** toward your out-of-pocket costs:

- Prescription drugs purchased outside the United States and its territories
- Prescription drugs not covered by the Plan
- Prescription drugs obtained at an out-of-network pharmacy when that purchase does not meet our requirements for out-of-network coverage

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

Except for your premium payments, any payments you make for Part D drugs covered by us count toward your out-of-pocket costs and will help you qualify for catastrophic coverage. In addition, when the following individuals or organizations pay your costs for such drugs, these payments will count toward your out-of-pocket costs and will help you qualify for catastrophic coverage:

- Family members or other individuals;
- Qualified State Pharmacy Assistance Programs (SPAPs)(SPAPs have different names in different states. See Section 8 for the name and phone number for the SPAP in your area.)
- Medicare programs that provide extra help with prescription drug coverage; and
- Most charities or charitable organizations that pay cost-sharing on your behalf. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

Payments made by the following don't count toward your out-of-pocket costs:

- Group Health Plans;
- Insurance plans and government funded health programs (e.g., TRICARE, the VA, the Indian Health Service, AIDS Drug Assistance Programs); and
- Third party arrangements with a legal obligation to pay for prescription costs (e.g., Workers Compensation).

If you have coverage from a third party such as those listed above that pays a part of or all of your out-of-pocket costs, you must let us know.

We will be responsible for keeping track of your out-of-pocket expenses and will let you know when you have qualified for catastrophic coverage. If you are in a coverage gap or deductible period and have purchased a covered Part D drug at a network pharmacy under a special price or discount card that is outside the Plan's benefit, you may submit documentation and have it count towards qualifying you for catastrophic coverage. In addition, for every month in which you

purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

Excluded Drugs

This part of Section 10 talks about drugs that are "excluded," meaning they aren't normally covered by a Medicare drug plan. If you get drugs that are excluded, you must pay for them yourself. We won't pay for the exclusions that are listed in this section (or elsewhere in this EOC), and neither will the Original Medicare Plan, unless they are found upon appeal to be drugs that we should have paid or covered (appeals are discussed in Section 5).

- A Medicare Prescription Drug Plan can't cover a drug that would be covered under Medicare Part A or Part B.
- A Medicare Prescription Drug Plan can't cover a drug purchased outside the United States and its territories.
- A Medicare Prescription Drug Plan can cover off-label uses (meaning for uses other than those indicated on a drug's label as approved by the Food and Drug Administration) of a prescription drug only in cases where the use is supported by certain reference-book citations. Congress specifically listed the reference books that list whether the off-label use would be permitted. (These reference books are: American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and USPDI or its successor.) If the use is not supported by one of these reference books, known as compendia, then the drug is considered a non-Part D drug and cannot be covered by our Plan.

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

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

If you receive extra help, 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.

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Quality Improvement Organization (QIO)

State	Program Name & Address	Contact Number
Alabama	AQAF Two Perimeter Park South, Suite 200 West Birmingham, AL 35243-2337	1-800-760-4550
Alaska	Qualis Health 741 Sesame Street, Suite 100 Anchorage, AK 99503	1-888-578-2547
Arizona	Health Services Advisory Group 1600 East Northern Avenue, Suite 100 Phoenix, AZ 85020-3933	1-800-359-9909
Arkansas	Arkansas Foundation for Medical Care 2201 Brooken Hill Drive Fort Smith, AR 72908-8611	1-800-272-5528
California	Lumetra One Sansome Street, Suite 600 San Francisco, CA 94104	1-800-841-1602
Colorado	Colorado Foundation for Medical Care 23 Inverness Way East, Suite 100 Englewood, CO 80112-5708	1-800-727-7086
Connecticut	Qualidigm 100 Roscommon Drive, Suite 200 Middletown, CT 06457	1-800-553-7590
Delaware	Quality Insights of Delaware Baynard Bldg, Suite 100 3411 Silverside Road Wilmington, DE 19810-4812	1-866-475-9669
Florida	FMQAI 5201 W Kennedy Boulevard, Suite 900 Tampa, FL 33609-1822	1-800-844-0795
Georgia	Georgia Medical Care Foundation 1455 Lincoln- Parkway, Suite 800 Atlanta, GA 30346	1-800-982-0411
Hawaii	Mountain-Pacific Quality Health Foundation 1360 S. Beretania, Suite 501 Honolulu, HI 96814	1-800-524-6550
Idaho	Qualis Health 720 Park Boulevard, Suite 120 Boise, ID 83712	1-800-445-6941
Illinois	Illinois Foundation for Quality Health Care 2625 Butterfield Road, Suite 102E Oak Brook, IL 60523-1234	1-800-647-8089

State	Program Name & Address	Contact Number
Indiana	Health Care Excel, Inc. 2901 Ohio Boulevard, Suite 112 Terre Haute, IN 47803	1-800-288-1499
Iowa	Iowa Foundation for Medical Care 6000 Westown Parkway West Des Moines, IA 50266-7771	1-800-752-7014
Kansas	Kansas Foundation for Medical Care, Inc 2947 SW Wanamaker Drive Topeka, KS 66614-4193	1-800-766-3777
Kentucky	Health Care Excel 1941 Bishop Lane, Suite 400 Louisville, KY 40218	1-800-288-1499
Louisiana	Louisiana Health Care Review 8591 United Plaza Boulevard, Suite 270 Baton Rouge, LA 70809	1-800-433-4958
Maine	Northeast Health Care Quality Foundation 15 Old Rollinsford Road, Suite 302 Dover, NH 03820-2830	1-800-772-0151
Maryland	Delmarva Foundation for Medical Care 9240 Centreville Road Easton, MD 21601	1-800-999-3362
Massachusetts	MassPRO 245 Winter Street Waltham, MA 02451-1231	1-800-334-6776
Michigan	MPRO 22670 Haggerty Road, Suite 100 Farmington Hills, MI 48335-2611	1-800-365-5899
Minnesota	Stratis Health 2901 Metro Drive, Suite 400 Bloomington, MN 55425-1525	1-800-444-3423
Mississippi	Information and Quality Healthcare Renaissance Place - Suite 504 385B Highland Colony Parkway Ridgeland, MS 39157-6035	1-800-844-0600
Missouri	Primaris 200 North Keene Street Columbia, MO 65201	1-800-735-6776
Montana	Mountain-Pacific Quality Health Foundation 3404 Cooney Drive Helena, MT 59602	1-800-497-8232

State	Program Name & Address	Contact Number
Nebraska	CIMRO of Nebraska 1230 O Street, Suite 120 Lincoln, NE 68508	1-800-247-3004
Nevada	HealthInsight 6830 W. Oquendo Road, Suite 102 Las Vegas, NV 89118	1-800-748-6773
New Hampshire	Northeast Health Care Quality Foundation 15 Old Rollinsford Road, Suite 302 Dover, NH 03820-2830	1-800-772-0151
New Jersey	Healthcare Quality Strategies, Inc. 557 Cranbury Road, Suite 21 East Brunswick, NJ 08816-4026	1-800-624-4557
New Mexico	New Mexico Medical Review Association 5801 Osuna Road NE, Suite 200 Albuquerque, NM 87109	1-800-663-6351
New York	IPRO 1979 Marcus Avenue Lake Success, NY 11042-1002	1-800-331-7767 1-516-326-6182 (TTY)
North Carolina	West Virgina Medical Institute 3001 Chesterfield Place Charleston, WV 25304	1-800-642-8686 1-304-346-9864
North Dakota	North Dakota Health Care Review 800 31st Avenue SW Minot, ND 58701	1-800-472-2902
Ohio	Ohio KePRO, Inc. Rock Run Center, Suite 100 5700 Lombardo Center Drive Seven Hills, OH 44131	1-800-589-7337
Oklahoma	Oklahoma Foundation for Medical Quality 14000 Quail Springs Parkway, Suite 400 Oklahoma City, OK 73134-2600	1-800-522-3414
Oregon	Acumentra Health 2020 SW Fourth Avenue, Suite 520 Portland, OR 97201-4960	1-800-344-4354
Pennsylvania	Quality Insights of Pennsylvania 2601 Market Place Street, Suite 320 Harrisburg, PA 17110	1-800-322-1914
Rhode Island	Quality Partners of Rhode Island 235 Promenade Street Suite 500, Box 18 Providence, RI 02908	1-800-662-5028
South Carolina	The Carolinas Center for Medical Excellence 246 Stoneridge Drive, Suite 200 Columbia, SC 29210	1-800-922-3089

State	Program Name & Address	Contact Number
South Dakota	South Dakota Foundation for Medical Care 2600 W. 49th Street, Suite 300 Sioux Falls, SD 57105-6575	1-800-658-2285
Tennessee	QSource 3175 Lenox Park Boulevard, Suite 309 Memphis, TN 38115	1-800-528-2655
Texas	TMF Health Quality Institute Bridgepoint I, Suite 300 5918 West Courtyard Drive Austin, TX 78730-5036	1-800-725-9216
Utah	HealthInsight 348 East 4500 South, Suite 300 Salt Lake City, Utah 84107	1-800-274-2290
Vermont	Northeast Health Care Quality Foundation 15 Old Rollinsford Road, Suite 302 Dover, NH 03820-2830	1-800-772-0151
Virginia	Virginia Health Quality Center 4510 Cox Road, Suite 400 Glen Allen, VA 23060	1-866-263-8402
Washington D.C.	Delmarva Foundation for Medical Care 2175 K Street NW, Suite 250 Washington, DC 20037	1-800-999-3362
Washington	Qualis Health 10700 Meridian Avenue North Seattle, WA 98133-9005	1-800-949-7536
West Virginia	WVMI Quality Insights 3001 Chesterfield Avenue Charleston, WV 25304-1126	1-800-642-8686
Wisconsin	MetaStar, Inc. 2909 Landmark Place Madison, WI 53713	1-800-362-2320
Wyoming	Mountain-Pacific Quality Health Foundation 2206 Dell Range Blvd., Suite G Cheyenne, WY 82009	1-877-810-6248

State Health Insurance Assistance Program (SHIP)

State	Program Name & Address	Contact Number
Alabama	Alabama Department of Senior Services 770 Washington Avenue RSA Plaza Suite 470 Montgomery, AL 36130-1851	1-800-243-5463 1-334-242-0995 (TTY)
Alaska	Alaska Medicare/Senior Information Office 3601 C Street, Suite 310 Anchorage, AK 99503-5984	1-800-478-6065 1-907-269-3691 (TTY)
Arizona	DES Aging and Adult Administration State Health Insurance and Assistance Program 1789 W. Jefferson St, Suite 950 A Phoenix, AZ 85007	1-800-432-4040 1-602-542-6366 (TTY)
Arkansas	Arkansas Insurance Department Arkansas SHIP 1200 West 3rd Street Little Rock, AR 72201-1904	1-800-224-6330
California	HICAP California Health Advocates 5380 Elvas Avenue, Suite 104 Sacramento, CA 95819	1-800-434-0222
Colorado	Department of Regulatory Agencies Senior Health Insurance Assistance Program 1560 Broadway, Suite 850 Denver, CO 80202	1-888-696-7213 1-303-894-7880 (TTY)
Connecticut	CHOICES Department of Social Services Division of Elderly Services 25 Sigourney Street, 10th Floor Hartford, CT 06106	1-800-994-9422 1-860-842-5424 (TTY)
Delaware	ELDER*info* Delaware Insurance Department 841 Silver Lake Boulevard. Dover, DE 19904	1-800-336-9500
Florida	Florida Department of Elder Affairs SHINE Program 4040 Esplanade Way, Building B Suite 270 Tallahassee, FL 32399-7000	1-800-963-5337 1-800-955-8771 (TTY)
Georgia	Division of Aging Services GeorgiaCares Two Peachtree Street, NW, Suite 9385 Atlanta, GA 30303-3142	1-866-552-4464

State	Program Name & Address	Contact Number
Hawaii	Hawaii Executive Office on Aging No. 1 Capitol District 250 S. Hotel Street, Suite 406 Honolulu, HI 96813-2831	1-888-875-9229
Idaho	Idaho Department of Insurance Senior Health Insurance Benefit Advisors 700 West State Street, 3rd Floor Boise, ID 83720-0043	1-800-247-4422
Illinois	Illinois Division of Insurance Senior Health Insurance Information Program 320 West Washington Street Springfield, IL 62767-0001	1-800-548-9034 1-217-524-4872 (TTY)
Indiana	Indiana Department of Insurance Senior Health Insurance Information Program 714 W 53rd Street Anderson, IN 46013	1-800-452-4800
Iowa	Iowa Insurance Division Senior Health Insurance Information Program 330 Maple Street Des Moines, IA 50319-0065	1-800-351-4664
Kansas	Kansas Department on Aging Senior Health Insurance Counseling For Kansas New England Building 503 S. Kansas Avenue Topeka, KS 66603-3404	1-800-432-3535
Kentucky	Kentucky Department for Aging and Independent Living State Health Insurance Assistance Program 275 East Main Street, 3W-F Frankfort, KY 40621	1-877-293-7447 1-888-642-1137 (TTY)
Louisiana	Louisiana Department of Insurance Senior Health Insurance Information Program P.O. Box 94214 Baton Rouge, LA 70804-9214	1-800-259-5301
Maine	Maine Health and Human Services Office of Elder Services 11 State House Station 442 Civic Center Drive Augusta, ME 04333-0011	1-800-262-2232 1-800-606-0215 (TTY)
Maryland	Maryland Department of Aging Senior Health Insurance Assistance Program 301 West Preston Street, Suite 1007 Baltimore, MD 21201	1-800-243-3425 1-410-767-1083 (TTY)

State	Program Name & Address	Contact Number
Massachusetts	Executive Office of Elder Affairs Serving Health Information Needs of Elders 1 Ashburton Place, 5th Floor Boston, MA 02108	1-800-243-4636 1-800-872-0166 (TTY)
Michigan	Michigan Office of Services to the Aging Medicare/Medicaid Assistance Program 6105 West Saint Joseph, Suite 204 Lansing, MI 48917-4850	1-800-803-7174
Minnesota	Minnesota Board on Aging State Health Insurance Assistance Program 444 Lafayette Road St. Paul, MN 55155	1-800-333-2433
Mississippi	Mississippi Department of Human Services Insurance Counseling and Assistance Program 750 North State Street Jackson, MS 39202	1-800-948-3090
Missouri	Missouri State Department of Insurance Community Leaders Assisting the Insured of MO 200 N Keene Street Columbia, MO 65201	1-800-390-3330
Montana	Department of Public Health & Human Services State Health Insurance Assistance Program 111 North Sanders Street, Room 210 Helena, MT 59604-4210	1-800-551-3191
Nebraska	State of Nebraska Department of Insurance Senior Health Insurance Information Program Terminal Building 941 O Street, Suite 400 Lincoln, NE 68508-3690	1-800-234-7119
Nevada	Nevada Division for Aging Services State Health Insurance Advisory Program 1860 East Sahara Ave Las Vegas, NV 89104	1-800-307-4444
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	1-866-634-9412

State	Program Name & Address	Contact Number
New Jersey	New Jersey Department of Health & Senior Services State Health Insurance Assistance Program 140 E Front St Trenton, NJ 08608-2104	1-800-792-8820
New Mexico	NM Aging & Long Term Services Department Benefits Counseling Program 2550 Cerrillos Road Santa Fe, NM 87505	1-800-432-2080
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	1-800-701-0501
North Carolina	North Carolina Department of Insurance Seniors Health Insurance Information Program 11 South Boylan Avenue Raleigh, NC 27603	1-800-443-9354
North Dakota	North Dakota Insurance Department Senior Health Insurance Counseling State Capitol 600 East Boulevard, 5th Floor Bismarck, ND 58505-0320	1-888-575-6611
Ohio	Ohio Department of Insurance. Senior Health Insurance Information Program 50 W. Town Street, Third Floor - Suite 300 Columbus, OH 43215-4142	1-800-686-1578 1-614-644-3745 (TTY)
Oklahoma	Oklahoma Insurance Department Senior Health Insurance Counseling Program 2401 N.W. 23rd, Suite 28 Oklahoma City, OK 73107	1-800-763-2828
Oregon	Oregon Division of Insurance Senior Health Insurance Benefits Assistance 250 Church Street SE, Suite 200 Salem, OR 97301-3921	1-800-722-4134 1-503-947-7280 (TTY)
Pennsylvania	Pennsylvania Department of Aging APPRISE 555 Walnut Street, 5th Floor Harrisburg, PA 17101-1919	1-800-783-7067
Rhode Island	RI Department of Elderly Affairs Senior Health Insurance Program Hazard Building 74 West Road, 2nd Floor Cranston, RI 02920	1-401-462-4444 1-401-462-0740 (TTY)

State	Program Name & Address	Contact Number
South Carolina	Insurance Counseling Assistance and Referrals for Elders (I-CARE) 1301 Gervais Street, Suite 200 Columbia, SC 292012-3301	1-800-868-9095
South Dakota	South Dakota Department of Social Services Senior Health Information & Insurance Education 2300 West 46th Street Sioux Falls, SD 57104	1-800-536-8197 1-605-367-5760 (TTY)
Tennessee	TN Commission on Aging and Disability State Health Insurance Assistance Program 500 Deaderick Street, Suite 825 Nashville, TN 37243-0860	1-877-801-0044 1-615-532-3893 (TTY)
Texas	Texas Department of Aging and Disability Services Health Information, Counseling & Advocacy Program 701 W. 51st Street, Mail Code: W350 Austin, TX 78751	1-800-252-9240
Utah	Utah Division of Aging and Adult Service Health Insurance Information Program 120 North 200 West Suite 325 Salt Lake City, UT 84103	1-800-541-7735
Vermont	Vermont Department of Aging and Disabilities State Health Insurance and Assistance Program 481 Summer Street, Suite 101 St. Johnsbury 05819	1-800-642-5119
Virginia	Commonwealth of Virginia Department for the Aging Virginia Insurance Counseling and Assistance Project Preston Building 1610 Forest Avenue, Suite 100 Richmond, VA 23229	1-800-552-3402
Washington D.C.	District of Columbia Office on Aging Health Insurance Counseling Project 2136 Pennsylvania Avenue, Washington, DC 20052	1-202-739-0668 1-202-973-1079 (TTY)
Washington	WA State Office of Insurance Commissioner Statewide Health Insurance Benefits Advisors P.O. Box 45600 Olympia, WA 98504-0255	1-800-562-6900 1-360-586-0241 (TTY)
West Virginia	West Virginia Bureau of Senior Services WV State Health Insurance Assistance Program 1900 Kanawha Boulevard, Building #10 Charleston, WV 25305-0160	1-877-987-4463
Wisconsin	Wisconsin Department of Health and Family Services Wisconsin SHIP 1 W. Wilson Street, Room. 618 Madison, WI 53703-3445	1-800-242-1060 1-888-758-6047 (TTY)

State	Program Name & Address	Contact Number
Wyoming	State of Wyoming Wyoming State Health Insurance Information Program 106 East 6th Avenue Cheyenne, WY 82002	1-800-856-4398

Medicaid Agency

State	Program Name & Address	Contact Number
Alabama	Alabama Medicaid Agency 501 Dexter Avenue Montgomery, AL 36104	1-800-362-1504
Alaska	Division of Health Care Services Alaska Office Building 350 Main Street Suite 414 Juneau, AK	1-800-780-9972
Arizona	Arizona Health Care Cost Containment System 801 E Jefferson Phoenix, AZ 85034	1-800-654-8713
Arkansas	Division of Medical Services Department of Health and Human Services P.O. Box 1437, Slot S401 Little Rock, AR 72203	1-800-482-8988
California	California Department of Health Services P.O. Box 997413 Sacramento, CA 95899-7413	1-800-541-5555
Colorado	Colorado Department of Health Care P.O. Box 30 Denver, CO 80201	1-800-221-3943
Connecticut	Department of Social Services 25 Sigourney Street Hartford, CT 06106	1-800-842-1508
Delaware	Delaware Health and Social Services (Consult your local listings)	1-800-372-2022
Florida	Agency For Health Care Administration 2727 Mahana Drive Tallahassee, FL 32308	1-888-419-3456
Georgia	Georgia Department of Community Health 2 Peachtree Street, NW Suite 18-486 Atlanta, GA 30303	1-866-322-4260
Hawaii	Department of Human Services of Hawaii P.O. Box 339 Honolulu, HI 96809	1-808-587-3521

State	Program Name & Address	Contact Number
Idaho	Family Medicaid 150 Shoup Avenue Suite 5 Idaho Falls, ID 83402	1-866-326-2485
Illinois	Department of Health Care and Family Services 201 South Grand Avenue East Springfield, IL 62763-0001	1-866-468-7543
Indiana	Family & Social Services Administration (Consult your local listings)	1-800-457-4584
Iowa	Department of Human Services (Consult your local listings)	1-800-972-2017
Kansas	Kansas Health Policy Authority Landon State Office Building, Suite 900 900 SW Jackson Street Topeka, KS 66612	1-785-296-3981
Kentucky	Cabinet For Health and Family Services Office of the Secretary 275 East Main Street Frankfort, KY 40621	1-800-372-2973
Louisiana	Department of Health and Hospitals 628 N 4th Street Baton Rouge, LA 70802	1-888-342-6207
Maine	Department of Health and Human Services 221 State Street Augusta, Maine 04333	1-800-977-6740
Maryland	Department of Health and Mental Hygiene 201 West Preston Street Baltimore, MD. 21201	1-800-392-8896
Massachusetts	Health and Human Services Office of Medicaid One Ashburton Place 11th Floor Boston, MA 02108	1-800-325-5231
Michigan	Department of Community Health Capital View Building 201 Towensend Street Lansing, MI 48913	1-517-373-3740

State	Program Name & Address	Contact Number
Minnesota	Department of Health P.O. Box 64975 St Paul, MN 55164	1-888-345-0823
Mississippi	Mississippi Division of Medicaid Walter Syllers Bldg. 550 High Street Ste 1000 Jackson, MS 39201	1-800-421-2408
Missouri	Department of Social Services 615 Howerton Court Jefferson City, MO 65102	1-800-735-2966
Montana	Department of Public Health & Human Services Cogswell Building 1400 Broadway Helena, MT 59620	1-800-362-8312
Nebraska	Department of Health and Human Services P.O. Box 95026 Lincoln, NE 68509-5026	1-402-471-3121
Nevada	Department of Health and Human Services 1100 East William Street, Suite 101 Carson City, NV 89701	1-775-684-3676
New Hampshire	Department of Health and Human Services Medicaid Program 129 Pleasant Street Concord, NH 03301	1-800-852-3345 Ext. 52544344
New Jersey	Department of Human Services P.O. Box 700 Trenton, NJ 08625	1-800-356-1561
New Mexico	Department of Human Services of New Mexico P.O. Box 2348 Santa Fe, NM 87504-2348	1-888-997-2583
New York	New York State Department of Health Office of Medicaid Management Governor Nelson A. Rockefeller Empire State Plaza Corning Tower Building Albany, NY 12237	1-800-541-2831

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 27699-2501	1-800-662-7030
North Dakota	Department of Human Services 600 E Boulevard Avenue Dept 325 Bismarck, ND 58505-0250	1-800-755-2604
Ohio	Ohio Department of Jobs & Family Services P.O. Box 182709 Columbus, OH 43218-2709	1-800-324-8680
Oklahoma	Oklahoma Medicaid Services 701 NW 63rd Street, Suite 100 Oklahoma City, OK 73116	1-800-633-4227
Oregon	Oregon Department of Human Services 500 Summer Street, NE 3rd Floor Salem, Oregon 94310	1-800-527-5772
Pennsylvania	Office of Medical Assistance Programs P.O. Box 2675 Harrisburg, PA 17105-2675	1-800-692-7462
Rhode Island	Department of Human Services (Consult your local listings)	1-401-462-5300
South Carolina	Department of Health & Human Services Department of Medicaid P.O. Box 8206 Columbia, SC 29202	1-888-549-0820
South Dakota	Department of Social Services (Consult your local listings)	1-866-854-5465
Tennessee	TennCare (Consult your local listings)	1-800-772-1213
Texas	Health & Human Services Commission of Texas 4900 N Lamar Blvd, 4th Floor Austin, TX 78751-2316	1-800-252-8263

State	Program Name & Address	Contact Number
Utah	Department of Health Division of Health Care Financing P.O. Box 143106 Salt Lake City, UT 84114-3106	1-800-662-9651
Vermont	Agency of Human Services Economic Services Division Vermont Department for Children and Families 103 South Main Street Waterbury, VT 05676-1201	1-800-250-8427
Virginia	Department of Medical Assistance Services 600 E. Broad Street, Suite 1300 Richmond, VA 23219	1-804-786-7933
Washington	Department of Social & Health Services Customer Service Center P.O. Box 45505 Olympia, WA 98504	1-800-562-3022
Washington D.C.	Medical Assistance Administration 825 North Capital Street, NE 5th Floor Washington, DC 20002	1-202-442-5988
West Virginia	Bureau for Medical Services Office of Medicaid Managed Care 350 Capitol Street, Room 251 Charleston, WV 25301-3708	1-800-642-8589
Wisconsin	Department of Health & Family Services 1 West Wilson Street Madison, WI 53702	1-800-362-3002
Wyoming	Office of Health Care Financing 6101 Yellowstone Rd Suite 210 Cheyenne, WY 82002	1-800-251-1269

Qualified State Pharmacy Assistance Program (SPAP)

State	Program & Address	Contact Number
Alaska	SeniorCare Senior Information Office 3601 C Street, Suite 310 Anchorage, AK 99503-5984	1-800-478-6065
Colorado	Colorado Ryan White Title II ADAP Colorado Department of Public Health and Environment 4300 Cherry Creek Drive South Denver, CO 80246-1530	1-303-692-2716 1-800-886-7689
Connecticut	ConnPACE P.O. Box 5011, Hartford, CT 06102	1-860-409-4555 1-800-423-5026
Delaware	Delaware Prescription Assistance Program P.O. Box 950 New Castle, DE 19720 Delaware Chronic Renal Disease Program Lewis Building, DHSS Campus Herman Holloway Sr. Campus 1901 N. DuPont Highway New Castle, DE 19720	1-800-996-9969 1-800-372-2022
Florida	Florida Comprehensive Health Association R.A. Gray Building Room 101 500 South Bronough Street Tallahassee, FL 32399-0250	1-850-245-6270
Illinois	Illinois Cares Rx Illinois Department on Aging P.O. Box 190221 Springfield, IL 62794-9022 Circuit Breakers Illinois Department on Aging P.O. Box 19003 Springfield, IL 62794-9003	1-800-226-0768 1-800-624-2459

State	Program & Address	Contact Number
Indiana	HoosierRx P.O. Box 6224 Indianapolis, IN 46206	1-866-267-4679
Maine	Maine Low Cost Drugs for the Elderly or Disabled Program Office of MaineCare Services 442 Civic Center Drive Augusta, ME 04333	1-866-796-2463
Maryland	Maryland Senior Prescription Drug Assistance Program SPDAP P.O. Box 33387 Indianapolis, IN 46203 Maryland Kidney Disease Program 201 West Preston Street Room SS-3 Baltimore, MD 21201	1-800-551-5995 1-410-767-5000
Massachusetts	Prescription Advantage P.O. Box 15153 Worcester, MA 01615-0143	1-800 -243-4636
Missouri	Missouri Rx Plan P.O. Box 6500 205 Jefferson Street, 14th Floor Jefferson City, MO 65102-6500	1-800-375-1406
Montana	Montana Big Sky Rx Program P.O. Box 202915 Helena, MT 59620 Mental Health Services Plan P.O. Box 6133, Great Falls, MT 59406	1-866-369-1233 1-877-927-6642

State	Program & Address	Contact Number
Nevada	Nevada Senior Rx Program Department of Human Resources 1761 E College Parkway, Building B, Suite 1134126 Technology Way Room 100 Carson City, NV 89706 Nevada Disability Rx Department of Human Resources 1761 E College Parkway, Building B, Suite 1134126 Technology Way Room 100 Carson City, NV 89706	1-866-303-6323 1-866-303-6323
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) P.O. Box 715 Trenton, NJ 08625	1-800-792-9745 1-800-792-9745
New York	EPIC P.O. Box 15018 Albany, NY 12212-5018	1-800-332-3742
North Carolina	NCRx P.O. 10068, Raleigh, NC 27690-2724 North Carolina ADAP 1904 Mail Service Center Raleigh, NC 27699-1904	1-888-488-6279 1-919-855-3702

State	Program & Address	Contact Number
Pennsylvania	PACE Program, 1st. Health Services 4000 Crums Mill Road, Suite 301 Harrisburg, PA 17112 PACENET Program P.O. Box 8806 Harrisburg, PA 17105 Pennsylvania Chronic Renal Disease Program and General Assistance Program, Pennsylvania Department of Health Eligibility Unit P.O. Box 8811 Harrisburg, PA 17105-8811	1-800-225-7223 1-800-225-7223 1-800-225-7223
Rhode Island	RIPAE John O. Pastore Center Benjamin Rush, Building 55 35 Howard Avenue Cranston, RI 02920	1-401-462-3000
South Carolina	South Carolina Gap Assistance Pharmacy Program for Seniors (GAPS) P.O. Box 8206 Columbia, SC 29202	1-888-549-0820
Texas	Kidney Health Care Program PO Box 149347 Austin, TX 78714-9347	1-800-222-3986
Vermont	Vermont V-Pharm 312 Hurricane Lane, Suite 201 Willston, VT 05495	1-800-250-8427
Virginia	Virginia Department of Health SPAP P.O. Box 2448 Richmond, VA 23218-2448 Department of Mental Health, Mental Retardation & Substance Abuse Services P.O. Box 1797 Richmond, VA 23218-1797	1-800-366-7741 1-800-451-5544
Washington	Washington State Health Insurance Pool P.O. Box 1090 Great Bend, KS 67530	1-800-877-5187

State	Program & Address	Contact Number
Wisconsin	Wisconsin SeniorCare P.O. Box 6710 Madison, WI 53716	1-800-657-2038
	Wisconsin Chronic Renal Disease Program P.O. Box 1508 Madison, WI 53701-1508	1-608-221-3701
	Wisconsin Cystic Fibrosis Program P.O. Box 6410 Madison, WI 53716-0410	1-608-221-3701
	Wisconsin Hemophilia Home Care Wisconsin Chronic Disease Program Attention: Eligibility Unit P.O. Box 6410 Madison, WI 53716-0410	1-608-221-3701
	Wisconsin Health Insurance Risk Sharing Plan (HIRSP) P.O. Box 8961 Madison, WI 53708-8961	1-800-828-4777 1-866-841-6572

Office of Civil Rights

State	Program Name & Address	Contact Number
Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, Vermont	Office for Civil Rights U.S. Department of Health & Human Services JFK Federal Building - Room 1875 Boston, MA 02203	1-617-565-1340 1-617-565-1343 (TDD)
New Jersey, New York	Office for Civil Rights U.S. Department of Health & Human Services 26 Federal Plaza - Suite 3313 New York, NY 10278	1-212-264-3313 1-212-264-2355 (TDD)
Delaware, DC, Maryland, Pennsylvania, Virginia, West Virginia	Office for Civil Rights U.S. Department of Health & Human Services 150 S. Independence Mall West - Suite 372 Philadelphia, PA 19106-3499	1-215-861-4441 1-215-861-4440 (TDD)
Alabama, Florida, Georgia, Kentucky, Mississippi, North Carolina, South Carolina, Tennessee	Office for Civil Rights U.S. Department of Health & Human Services 61 Forsyth Street, SW. - Suite 3B70 Atlanta, GA 30323	1-404 562-7886 1-404-331-2867 (TDD)
Illinois, Indiana, Michigan, Minnesota, Ohio, Wisconsin	Office for Civil Rights U.S. Department of Health & Human Services 233 N. Michigan Ave. - Suite 240 Chicago, IL 60601	1-312-886-2359 1-312-353-5693 (TDD)
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	1-214-767-4056 1-214-767-8940 (TDD)
Iowa, Kansas, Missouri, Nebraskas	Office for Civil Rights U.S. Department of Health & Human Services 601 East 12th Street - Room 248 Kansas City, MO 64106	1-816-426-7278 1-816-426-7065 (TDD)
Colorado, Montana, North Dakota, South Dakota, Utah, Wyoming	Office for Civil Rights U.S. Department of Health & Human Services 1961 Stout Street - Room 1426 Denver, CO 80294	1-303-844-2024 1-303-844-3439 (TDD)
Arizona,	Office for Civil Rights	1-415-437-8310

State	Program Name & Address	Contact Number
California, Hawaii, Nevada	U.S. Department of Health & Human Services 90 7th Street, Suite 4-100 San Francisco, CA 94103	1-415-437-8311 (TDD)
Alaska, Idaho, Oregon, Washington	Office for Civil Rights U.S. Department of Health & Human Services 2201 Sixth Avenue - Mail Stop RX-11 Seattle, WA 98121	1-206-615-2290 1-206-615-2296 (TDD)

Health Net Medicare Programs
Post Office Box 1728
Augusta, Georgia 30903-1728

Customer Service Department
1.800.806.8811
Our office hours are from 8:00 a.m. to 8:00 p.m., 7 days a week.
Telecommunications Device for the Deaf
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