



HEALTH NET ORANGE

EVIDENCE OF COVERAGE

Your Medicare Prescription Drug Plan

Plan PLU
EOCID: 124167

EVIDENCE OF COVERAGE:

**Your Medicare Prescription Drug Coverage
as a Member of Health Net Orange**

January 1 – December 31, 2006

This Evidence of Coverage gives the details about your Medicare Prescription Drug Coverage. It is an important legal document. Please keep it in a safe place.

Health Net Orange Customer Service:

For help or information, please call Customer Service Monday through Friday at the number listed on the back cover. Calls to these numbers are free.

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INTRODUCTION WELCOME TO HEALTH NET ORANGE

Welcome to Health Net Orange!

Health Net Orange is a Medicare Prescription Drug Plan

Now that you are enrolled in Health Net Orange, a Medicare Prescription Drug Plan, you are getting your Medicare Prescription Drug Coverage through Health Net.

Throughout the remainder of this Evidence of Coverage, we refer to Health Net Orange as "Plan."

This Evidence of Coverage explains how to get your Medicare Prescription Drug Coverage through our Plan.

This Evidence of Coverage, together with your enrollment form, riders, and amendments that we may send to you, explain your rights, benefits, and responsibilities as a Member of our Plan. It also explains our responsibilities to you.

This Evidence of Coverage gives you the details, including:

- What is covered in our Plan and what is not 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, including your choices for continuing Medicare Prescription Drug Coverage.
- If you need this Evidence of Coverage in a different format (such as in Spanish, large print, or audio tapes), please call us so we can send you a copy.

Please tell us how we're doing

We want to hear from you about how well we are doing as your Medicare Prescription Drug Plan. You can call or write to us at any time – your comments are always welcome, whether they are positive or negative. From time to time, we conduct surveys that ask our Members to tell about their experiences with this Plan. If you are contacted, we hope you will participate in a Member satisfaction survey. Your answers to the survey questions will help us know what we are doing well and where we need to improve.

How to contact our Plan's Customer Service

If you have any questions or concerns, please call or write to Customer Service at the number (or address) on the back cover. We will be happy to help you. Our business hours are Monday through Friday, 8:00 a.m. to 5:00 p.m.

How to contact the Medicare program and the 1-800-MEDICARE (TTY/TDD 1-877-486-2048) helpline

Medicare is the Federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End Stage Renal Disease, sometimes referred to as ESRD (permanent kidney failure requiring dialysis or a kidney transplant). CMS is the Federal agency in charge of the Medicare program. "CMS" stands for Centers for Medicare & Medicaid Services. CMS contracts with and regulates Medicare Prescription Drug Plans (including our Plan).

Here are ways to get help and information about Medicare from CMS:

Call **1-800-MEDICARE** (1-800-633-4227) to ask questions or get free information booklets from Medicare. You can call this national Medicare helpline 24 hours a day, 7 days a week. TTY/TDD users should call 1-877-486-2048. Calls to these numbers are free.

Use a computer to look at www.medicare.gov, the official government Web site for Medicare information. This Web site gives you a lot of up-to-date information about Medicare and nursing homes. It includes Medicare publications you can print directly from your computer. It has tools to help you compare Medicare Health Plans and Prescription Drug Plans in your area. You can also search the "Helpful Contacts" section for the Medicare contacts in your state. If you do not have a computer, your local library or senior center may be able to help you visit this Web site using their computer.

Health Insurance Counseling and Advocacy Program (HICAP) – an organization in your state that provides free Medicare help and information

Health Insurance Counseling and Advocacy Program (HICAP) is an organization paid by the Federal government to give free health insurance information and help to people with Medicare. HICAP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. HICAP has information about Medicare Prescription Drug Plans, Medicare Health Plans and Medigap (Medicare Supplemental Insurance) policies.

You can contact HICAP at:

Council on Aging
1971 E. 4th Street, Suite 200
Santa Ana, CA 92705-3917

Toll free: 1-800-434-0222
Local call: 1-714-560-0424

You can also find the Web site for HICAP at www.medicare.gov.

Lumetra – a group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare

In California, there is a Quality Improvement Organization called Lumetra. Lumetra is a group of doctors and other health care experts paid by the Federal government to check on and help improve the care given to Medicare patients. In addition to other quality improvement and beneficiary protection activities, the doctors and other health experts in Lumetra review written quality of care complaints made by Medicare patients. See Section 6 for more information about complaints.

You can contact Lumetra at:

Lumetra Headquarters
One Sansome Street, Suite 600
San Francisco, 94104-4448
Toll-free: 1-800-841-1602
Local call: 1-415-677-2000

Other organizations

Medicaid agency – a state government agency that handles health care programs for people with low incomes

Medicaid is a joint Federal and state program that helps with medical costs for some people with low incomes and limited resources. Some people with Medicare are also eligible for Medicaid. Most health care costs are covered if you qualify for both Medicare and Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify.

To find out more about Medicaid and its programs, contact:

California Department of Health Services
P.O. Box 997413
Sacramento, CA 95899-7413

Local call: 1-916-440-7400

Social Security Administration

The Social Security Administration provides economic protection for Americans of all ages. Social Security programs include retirement benefits; disability; family benefits; survivors' benefits; and benefits for the aged, blind, and disabled. If you have questions about any of these benefits you can call the Social Security Administration at 1-800-772-1213. TTY/TDD users should call 1-800-325-0778. Calls to these numbers are free. You can also visit www.ssa.gov.

Railroad Retirement Board

If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). TTY/TDD users should call 1-312-751-4701. You can also visit www.rrb.gov.

Employer (or "Group") Coverage

Please contact your employer Group if you have any questions about your premium, benefits or the open enrollment season.

Genetically Handicapped Persons Program - a State Pharmaceutical Assistance Program (SPAP)

The Genetically Handicapped Persons Program is a state-funded program that provides financial assistance for prescription drugs to low-income and medically needy senior citizens and individuals with disabilities. The Genetically Handicapped Persons Program may help pay for copayments/coinsurance for those who qualify. Please contact the Genetically Handicapped persons Program to determine what benefits may be available to you.

You can contact the Genetically Handicapped persons Program at:

State of California Department of Health Services
Genetically Handicapped Persons Program
P.O. Box 942732
Sacramento, CA 94234-7320
Toll-free: 1-800-639-0597

SECTION 1: PLAN BASICS

What is Health Net Orange?

Health Net Orange is offered by Health Net, and is a Medicare Prescription Drug Plan. Now that you are enrolled in our Plan, you are getting your Medicare Prescription Drug Coverage through Health Net. This Evidence of Coverage explains your benefits and services, what you have to pay, and the rules you must follow to get your prescription drugs covered.

Overview of Medicare Prescription Drug Coverage

Medicare Prescription Drug Coverage is insurance that helps pay for your prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B. We will generally cover the drugs listed in our Formulary as long as the drug is Medically Necessary, the prescription is filled at a Plan Network Pharmacy, and other coverage rules are followed. This Plan does not pay for drugs that are covered by Medicare Part B. As a Member, all you have to do is continue to pay applicable copayments, and coinsurances. If you have limited income and resources, you may get extra help from Medicare to pay your copayments, and coinsurances so that you get your prescription drugs for little or no cost. Please see Section 2 or call Customer Service to learn more.

Help us keep your membership record up-to-date

We have a file of information about you as a plan Member. Pharmacists use this membership record to know what drugs are covered for you. The membership record has information from your enrollment form, including your address and telephone number. It shows your specific Plan coverage and other information. Section 8 tells you how we protect the privacy of your personal health information.

Please help us keep your membership record up-to-date by letting Customer Service know right away if there are any changes in your name, address, or phone number, or if you go into a nursing home. Also, tell Customer Service about any changes in prescription drug coverage you have from other sources, such as from Medicaid or your spouse's current or former employer. In addition, you should tell Customer Service about any changes in coverage due to claims filed under liability insurance, such as workers' compensation claims or claims against another driver in an automobile accident.

What is the geographic Service Area for our Plan?

The states in our Service Area are listed below.

Arizona
California
Connecticut
Massachusetts
New Jersey
New York
Oregon
Rhode Island
Vermont
Washington

Health Net offers Medicare Prescription Drug Coverage in several states. If you move out of the state where you live, you must contact your Group to update your information. If you move into a state not listed above, please call Customer Service to find out if we have a plan in your new state.

Use your Plan membership card instead of your red, white, and blue Medicare card

Now that you are a Member of our Plan, you have a Plan membership card. Here is a sample card to show what it looks like:

Health Net Orange

Rx BIN: 600428
 Rx PCN: 03330000
 Issuer: [(80840)]
 ID: [12345678901]
 Name: John Q. Public



Phone: 4P... PHARMACY ORANGE

MedicareRx
 Prescription Drug Coverage X

CMS - S5678 XXX

To remove card, fold back and forth along perforations

This is your replacement card. Your benefit information packet will follow.

000170
 M5000A
 MIKE A SMITH (SAMPLE)
 12320 Cirioas St
 MARENGO, CA 92476

The Health Net Orange Member: This is your current Health Net identification card. Carry it with you at all times, and present it to your Health Net Orange Participating Pharmacist when you receive services. See your Evidence of Coverage for a description of your benefits. When submitting inquiries about your coverage, always include your RX number and group number.

Health Net Use Only

1 - 0
 G8
 ENG-MEDCAR-ADV-PDP-CA
 0971
 ORANGE
 MX

During the time you are a plan Member and using plan services, you *must* use your Plan membership card at Network Pharmacies. Please carry your Plan membership card with you at all times. You will need to show this card in order to get your prescription drugs paid for. If your membership card is ever damaged, lost, or stolen, call Customer Service right away and we will send you a new card.

Using plan pharmacies to get your prescription drugs covered by us

What are Network Pharmacies?

With few exceptions, you must use Network Pharmacies to get your prescription drugs covered.

- **What is a "Network Pharmacy"?** A Network Pharmacy is a pharmacy at which you can get your 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. Once you go to one, you are not required to continue going to the same pharmacy to fill your prescription; you can go to any of our Network Pharmacies.

- **What are "Covered Drugs"?** "Covered Drugs" is the general term we use to mean all of the outpatient prescription drugs that are covered by our Plan. Covered Drugs are listed in the Formulary.

How do I 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 do not have your membership card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your copayment). If this happens, you can 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 at the end of this section.

The Pharmacy Directory gives you a list of Plan Network Pharmacies.

As a Member of our Plan we will send you a Pharmacy Directory, which gives you a list of our Network Pharmacies. You can use it to find a 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. In addition, you can find this information on our Web site.

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 I fill a prescription through Plan's network mail order pharmacy service?

You can use our network mail order pharmacy service to fill prescriptions for what we call "maintenance drugs." These are drugs that you take on a regular basis, for a chronic or long-term medical condition.

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 us 14 days to process your order and ship it to you. However, sometimes your mail order may be delayed. To get a prescription if the mail order is delayed, please contact Express Scripts at 1-800-316-3106, TTY/TDD 1-800-972-4348.

You are not required to use our mail order services to get an extended supply of maintenance medications. You can also get an extended supply through some retail Network Pharmacies. Some retail pharmacies may provide an extended supply, but charge a higher copayment than our mail order service. Please call our Customer Service to find out which retail pharmacies offer an extended supply.

Filling 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 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 your copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim form. You should submit a claim 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 (see section 4). To learn how to submit a paper claim, please refer to the paper claims process described next.

We will cover your prescription at an out-of-Network Pharmacy if at least one of the following applies:

- If you are unable to obtain a Covered Drug in a timely manner within our Service Area because there is no Network Pharmacy within a reasonable driving distance that provides 24 hour service.
- If you are trying to fill a prescription drug that is not regularly stocked at an accessible network retail or mail-order pharmacy (including high cost and unique drugs).
- If you are getting a vaccine that is Medically Necessary but not covered by Medicare Part B and some Covered Drugs that are administered in your doctor's office.

How do I submit a paper claim?

When you go to a Network Pharmacy, your claim is automatically submitted to us by the pharmacy. However, if you go to an out-of-Network Pharmacy for one of the reasons listed above, 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.

To submit a claim:

- Complete a claim form. If you need a claim form, call Customer Service. You may also print a claim form from our website at www.healthnet.com.
 - Attach your prescription receipt(s) to the claim form. You must attach the actual prescription receipt, which includes required information about the dispensing pharmacy and the prescription drug you purchased. If you do not have the actual prescription receipt, a duplicate may be obtained from the dispensing pharmacy. Cash register receipts cannot be used when submitting a claim.

- Mail the completed claim form and actual prescription receipt(s) to:

Argus Health Systems
Dept #338
P.O. Box 419019
Kansas City, Missouri 64141

- We will mail you notification of our determination on your claim within 72 hours of receipt of your claim.
- If a reimbursement is due to you, a check will be mailed within 30 days of receipt of your claim.

Specialty pharmacies

Home infusion pharmacies

Plan will cover home infusion therapy if:

- Your prescription drug is on our Plan's Formulary,
- You have followed all required coverage rules and our Plan has approved your prescription for home infusion therapy,
- Your prescription is written by a doctor, and
- You get your infused drug(s) from a Plan Network Pharmacy.

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

Long-term care pharmacies

Residents of a long-term care facility may get their prescription drugs through their long-term care pharmacy in the plan's network of long-term care pharmacies. In some cases the long-term care pharmacy will be the long-term care pharmacy that contracts directly with the long-term care facility. Please refer to your Pharmacy Directory to find out if your long-term care pharmacy is part of our network. If it is not, or for more information, please contact Customer Service.

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

Native Americans and Alaska Natives have access to Indian Health Service / Tribal / Urban Indian Health Program (I/T/U) Pharmacies through Plan's pharmacy network.

Please refer to your Pharmacy Directory to find an I/T/U pharmacy in your area. For more information, please contact Customer Service.

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

We cover vaccines that are Medically Necessary and are covered by our Plan but are not already covered by Medicare Part B. In addition we cover some drugs that may be administered in your doctor's office. (Please see Section 4, "How does your enrollment in Plan affect coverage for drugs covered under Medicare Part A or Part B?" for more information.)

SECTION 2: EXTRA HELP WITH DRUG PLAN COSTS FOR PEOPLE WITH LIMITED INCOME AND RESOURCES

What extra help is available?

Starting January 1, 2006, Medicare Prescription Drug Coverage will be available to everyone with Medicare. If you have limited income and resources, you may qualify for extra help paying your prescription drug plan costs. If you qualify, you will get help paying for your premium, prescription copayments and coinsurances.

Do you qualify for extra help?

People with limited income and resources may qualify for extra help. To qualify, your annual income must be below \$14,355 (or \$19,245 if you are married). In addition, your resources (including your savings and stocks, but not your home or car) must not exceed \$11,500 (or \$23,000 if you are married). The amount of extra help you get will depend on your income and resources.

Note: Amounts shown above are for 2006. If you live in Alaska or Hawaii, or pay more than half of the living expenses of dependent family members, income limits are higher. Please call Customer Service to find out what the income limits are.

Some people automatically qualify for extra help and do not have to apply for it. If you answer "yes" to any of the questions below, you automatically qualify for extra help:

- Do you have Medicare and full coverage from a state Medicaid?
- Do you get Supplemental Security Income?
- Do you get help from your state Medicaid program paying your Medicare premiums? That is, do you belong to a Medicare Savings Program, such as the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), or Qualified Individual (QI) program?

How do you apply for extra help?

Medicare mailed letters to people who automatically qualify for extra help in May or June. If you did not automatically qualify, the Social Security Administration (SSA) sent people with certain incomes an application for this extra help. If you got this application, fill it out and send it back to SSA as soon as possible. If you did not get an application but think you may qualify, call 1-800-772-1213, visit www.socialsecurity.gov on the Web, or apply at your State Medical Assistance office. After you apply, you will get a letter in the mail letting you know if you qualify or not and what you need to do next.

How do you get more information?

For more information on who can get extra help with prescription drug costs and how to apply, call the Social Security Administration at 1-800-772-1213, or visit www.socialsecurity.gov on the Web. TTY/TDD users should call 1-800-325-0778.

In addition, you can look at the 2006 *Medicare & You* Handbook, visit www.medicare.gov on the Web, or call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

If you have any questions about our Plan, please refer to our Customer Service numbers listed on the back cover and in the introduction section. Or, visit our website.

SECTION 3: ENROLLMENT IN THIS PLAN

Please Note: Enrollment into Medicare Part D prescription drug coverage is voluntary and you may choose to opt out of this prescription drug benefit. Please contact your Group for additional information, including what consequences opting out of Medicare Part D may have on your Group benefits.

Who Is Eligible For Coverage

The covered prescription drugs of this plan are available to the following people as long as they live in the United States, either work or live in our Service Area and meet any additional eligibility requirements of the Group:

- The principal Member who:
 - Is entitled to Medicare Part A and/or enrolled in Medicare Part B; and
 - Is not enrolled in Medicare Part D through another Health Care Service Plan.
- Spouse, who must be listed on the enrollment form completed by the principal Member and meets the same qualifications as the principal Member. (The term "spouse" also includes the Member's Domestic Partner as defined.)

Paying the plan premium for your coverage as a Member of our Plan

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.

Do you have to continue to pay your Part A or Part B premiums?

To be a Member of our Plan, you must either be entitled to Medicare Part A and/or enrolled in Medicare Part B and live in our Service Area. 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 to remain a Member of this plan.

Some Members who belong to a Medicare Savings Program (Qualified Medicare Beneficiary or QMB, Specified Low-Income Medicare Beneficiary or SLMB, Qualified Individual or QI) may be eligible to get extra help in paying for the cost of their Medicare Part A and/or Part B premiums. Please see Section 2 or call Customer Service for more information.

What is the Late Enrollment Penalty?

You will have to pay a Late Enrollment Penalty in addition to your applicable plan premium if you do not enroll in a Medicare Prescription Drug Plan during your initial enrollment period and you do not have *Creditable Coverage* for a continuous period of at least 63 days after your initial enrollment period. *Creditable* prescription drug coverage is coverage that is at least as good as the standard Medicare Prescription Drug Coverage. You pay this Late Enrollment Penalty for as long as you have Medicare Prescription Drug Coverage. The amount of the Late Enrollment Penalty may increase every year.

The Late Enrollment Penalty also applies to individuals who qualify for extra help with their drug plan costs. If you get extra help, your penalty amount may be lower than it is for those who don't qualify. In addition, you may only have to pay the penalty for a maximum of 60 months.

SECTION 4: PRESCRIPTION DRUG COVERAGE

This section describes your prescription drug coverage as a Member of our Plan. We will explain what a Formulary is and how to use it, our drug management programs, how much you will pay when you fill a prescription for a Covered Drug, and what an Explanation of Benefits is and how to get additional copies.

What drugs are covered by this Plan?

What is a Formulary?

We have a Formulary that lists all 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 or through our network mail order pharmacy service 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 in Section 4.

The drugs on the Formulary are selected by our Plan with the help of a team of health care providers. We select the prescription therapies believed to be a necessary part of a quality treatment program and both Brand Name Drugs and Generic Drugs are included on the Formulary. A Generic Drug has the same active-ingredient formula as the Brand Name Drug. Generic Drugs usually cost less than Brand Name Drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as Brand Name Drugs.

Not all drugs are included on the Formulary. In some cases, the law prohibits coverage of certain types of drugs. (See "Drug Exclusions", later in this section, for more information about the types of drugs that cannot be covered under a Medicare Prescription Drug Plan.) In other cases, we have decided not to include a particular drug.

In certain situations, prescriptions filled at an out-of-Network Pharmacy may also be covered. See Section 1 ("Plan Basics") for more information about filling prescription at out-of-Network Pharmacies.

How do you find out what drugs are on the Formulary?

You may call Customer Service to find out if your drug is on the Formulary or to request a copy of our Formulary. You can also get updated information about the drugs covered by us by visiting our Web site.

What are drug tiers?

Drugs on our Formulary are organized into different drug tiers, or groups of different drug types. Your coinsurance/copayment depends on which drug tier your drug is in. The table in "Initial Coverage Level" shows the coinsurance/copayment amount you pay for each tier when you are in your initial coverage level. (See "Initial Coverage Level" for more information about the initial coverage level.)

You can ask us to make an Exception to your drug's tier placement. See Section 6 to learn more about how to request an Exception.

Can the Formulary change?

We may add or remove drugs from the Formulary during the year. Changes in the Formulary may affect which drugs are covered and how much you will pay when filling your prescription. 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, we will notify you of the change at least 60 days before the date that the change becomes effective. If we don't notify you of the change in advance, we will give you a 60 day supply of the drug when you request a refill of the drug. However, if a drug is removed from our Formulary because the drug has been recalled from the market, we will not give 60-days notice before removing the drug from the Formulary. Instead, we will remove the drug from our Formulary immediately and notify Members about the change as soon as possible.

What if your drug is not on the Formulary?

If your prescription is not listed on the Formulary, you should first contact Customer Service to be sure it is not covered.

If Customer Service confirms that we do not cover your drug, you have three options:

- You can 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.
- You can ask us to make an Exception to cover your drug. See the section 6 to learn more about how to request an Exception.
- You can pay out-of-pocket for the drug and request that the plan reimburse you by requesting a Formulary Exception. This does not obligate the plan to reimburse you if the Exception request is not approved. See Section 6 for more information on how to request an Appeal.

If you recently joined this Plan and learn that we do not cover a drug you were taking when you joined our plan, you have the following options.

- You can 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.
- You can ask us to make an Exception to cover your drug. See Section 6 to learn more about how to request an Exception.
- You can pay out-of-pocket for the drug and request that the plan reimburse you by requesting a Formulary Exception. This does not obligate the plan to reimburse you if the Exception request is not approved. See Section 6 for more information on how to request an Appeal.
- You can ask your pharmacist if the drug that is not covered can be filled by the pharmacy for up to a 60-day supply (2 fills for a 30-day supply each or 1 fill for a 60-day supply). If the pharmacist is

unsure if the drug can be covered for up to a 60-day supply or if additional information or assistance is required, you or the pharmacist may contact Customer Service.

In some cases, we will contact you if you are taking a drug that is not on our Formulary. We can give you the names of Covered Drugs that may be used to treat similar conditions so you can ask your doctor if any of these drugs are an option for your treatment. If you obtain a one time fill from the pharmacist for a drug that is not covered by us, we will send you and your doctor a letter describing the options that may be used to treat your condition. We will also describe in the letter how you and your doctor can ask us to make an Exception to cover your drug. See Section 6 to learn more about how to request an Exception.

Drug exclusions and limitations

The following exclusions and limitations apply to any category or type of drugs described throughout this Evidence of Coverage.

- Medications on the Formulary are specifically excluded by Medicare will not count towards your yearly out-of-pocket costs. In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for these drugs. These include some prescription medications in the following categories:
 - Agents used for the symptomatic relief of cough and cold;
 - Prescription vitamin and mineral products;
 - Barbiturates; and
 - Benzodiazepines
- Please refer to the Formulary to find out which drugs we are offering additional coverage for or call Customer Service if you have any questions.
- Dispensing may be limited to less than a one-month (30 days) supply due to manufacturer packaging and/or appropriate length of treatment.
- Quantity and daily dosing limits may apply to specific drugs. Please refer to the Formulary.
- Sexual dysfunction drugs are covered up to 4 tablets per month.
- Smoking cessation drugs are covered up to a 12-week course of therapy per calendar year if you are currently enrolled in a comprehensive smoking cessation program. Prior Authorization from Health Net is required.
- By law, certain types of drugs or categories of drugs are not covered by Medicare Prescription Drug Plans, including:
 - Drugs used to treat infertility;
 - Anorexiant, appetite suppressants, diet aids, weight loss medications, and drugs medications used to treat obesity or weight gain;
 - Smoking cessation medications that do not require a prescription;
 - Experimental or investigational medications;
 - Agents when used for cosmetic purposes or hair growth;
 - Non-prescription medications; and
 - Outpatient drugs for which the manufacturer seeks to require associated tests or monitoring services be purchased exclusively from the manufacturer or its designee as a condition of sale.

In addition, a Medicare Prescription Drug Plan cannot cover a drug that is covered under Medicare Part A or Part B. See "How does your enrollment in this Plan affect coverage for drugs covered under Medicare Part A or Part B?" below.

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 pharmacists developed these requirements and limits for our Plan to help us to provide quality coverage to our Members. Examples of utilization management tools are described below:

- **Prior Authorization:** We require you to get Prior Authorization for certain drugs. This means that you or your doctor will need to get approval from us before you fill your prescription. If approval is not obtained, 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 6 tablets per prescription for ZITHROMAX. This limit may replace your standard 30 or 90-day supply.
- **Electronic 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. The pharmacy computer will look for Drug A on your claims history and if found, automatically approve Drug B.
- **Generic Substitution:** When there is a generic version of a Brand Name Drug available, our Network Pharmacies will automatically give you the generic version, unless your doctor has told us that you must take the brand name drug. If you choose to fill your prescription with a Brand Name Drug when a generic equivalent is available, you may be responsible for a higher copayment and/or the difference in cost between the brand and generic medications.
- **Age Limits:** Some drugs may require Prior Authorization if your age does not meet manufacturer, Food and Drug Administration, or clinical recommendations.
- **Gender Limit:** Some drugs are only covered for males or females based on manufacturer, Food and Drug Administration, or clinical recommendations.
- **Therapy Limit:** Some drugs are only covered for a specific length of time based on manufacturer, Food and Drug Administration, or clinical recommendations.

You can find out if your drug is subject to these additional requirements or limits by looking in the Formulary. If your drug does have these additional restrictions or limits, you can ask us to make an Exception to our coverage rules. See the section, "How do I request an Exception to the Formulary?" described above for more information.

Drug utilization review

We conduct drug utilization reviews for all of our Members to make sure that they are receiving safe and appropriate care. These reviews are especially important for Members who have more than one doctor who prescribe 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 for Members who have multiple medical conditions, who are taking many prescription drugs, or 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 offer a medication therapy management program(s) for Members that meet specific criteria. 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 do not 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 does not 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 is covered by Medicare Part A or Part B, it cannot 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.

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

If you qualify for extra help with your drug costs, your costs for your drugs may be different than those described below. See Section 2 "Extra Help with Drug Plan Costs for People with Limited Income and Resources" and the "Evidence of Coverage Rider for those who get extra help paying for their prescription drugs" at the end of this booklet for more information.

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 level, 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. Your drug costs for each coverage level are described below.

Initial Coverage Level

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

Drug Tier	Retail Copayment/Coinsurance (30-day supply)	Retail Copayment/Coinsurance (90-day supply)	Mail-Order Copayment/Coinsurance (90-day supply)
Tier 1 – Preferred Generic Drug	\$10	\$30	\$20
Tier 2 – Preferred Brand Drug	\$20	\$60	\$40

Notes:

- Generic Drugs will be dispensed when a Generic Drug equivalent is available. If you request a Brand Name Drug when a generic equivalent is commercially available, you must pay the difference between the generic equivalent and the Brand Name Drug plus the applicable copayment.
- Prescription drugs for the treatment of diabetes (including insulin) are covered as stated in the Formulary, specific brands of blood glucose monitors and testing strips, Ketone test strips, lancet puncture devices and lancets when used in monitoring blood glucose levels.
- Covered Medicare Part D Drugs are available at out-of-Network Pharmacies in special circumstances including illness while traveling outside of the Plan's Service Area where there is no Network Pharmacy. In these circumstances, your copayments will be the same as retail pharmacy copayments described above.
- Some retail pharmacies may provide up to a 90-day supply of maintenance medication for a copayment per 30-day supply. Please check with your retail pharmacy to see if this service is available to you.
- Your provider must get Prior Authorization from Health Net for certain prescription drugs. Contact Health Net for details.

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 \$3,600 out-of-pocket for the year. When the total amount you have paid toward your copayments, and the cost for covered Part D Drugs after you reach the initial coverage limit reaches \$3,600, you will qualify for catastrophic coverage. During catastrophic coverage you will pay: the greater of \$2 for generics or preferred brand that is a multi-source drug* and \$5 for all other drugs, or 5% coinsurance**. We will pay the rest.

Note: As mentioned earlier we offer additional coverage on some prescription drugs not normally covered in a Medicare Prescription Drug Plan. The amount you pay when you fill a prescription for these drugs does not count towards your total out of pocket costs (that is, the amount you pay does not help you qualify for catastrophic coverage).

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

**Your coinsurance payment for each prescription drug order will not exceed \$10 for preferred Generic Drugs, \$20 for preferred brand drugs.

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 can count toward your out-of-pocket costs and help you qualify for catastrophic coverage so long as the drug is on the Formulary (or if you get a favorable decision on a Coverage Determination, Exception request or Appeal), and it was obtained at a Network Pharmacy (or you have an approved claim from an out-of-Network Pharmacy):

- Your coinsurance or copayments made on drugs that are normally covered in a Medicare Prescription Drug Plan that are:
 - Covered by the Plan during the initial coverage level;
 - Not on our Plan's Formulary, but were determined to count towards your out-of-pocket costs through the Coverage Determination, Exceptions, or Appeals process; and
 - Filled at an out-of-Network Pharmacy in accordance with our Plan's out-of-network access rules.

When you have spent a total of \$3,600 for these items, you will reach the catastrophic coverage level.

Purchases that will **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;
- Certain prescription drugs covered by us but not normally covered in a Medicare Prescription Drug Plan.

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

The prescription drug copayment and coinsurance payments you make 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 prescription drug costs, 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);
- Medicare programs that provide extra help with prescription drug coverage; and
- Most charities or charitable organizations. 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 do **not** count toward your out-of-pocket costs:

- Group Health Plans;

- Insurance Plans and government funded health programs (e.g. TRICARE the Indian Health Service); 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 that pays a part of or all of your out-of-pocket costs, you must disclose this information to us. An example of third party coverage would be an employer-sponsored health plan that offers prescription drug coverage.

We will be responsible for keeping track of your out-of-pocket cost amount and will let you know when you have qualified for catastrophic coverage. If you or another party on your behalf have purchased drugs outside of our plan benefit, you will be responsible for submitting appropriate documentation of such purchases to us. In addition, every month you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

Explanation of Benefits

What is the Explanation of Benefits?

The Explanation of Benefits is a document you will get each month you use your prescription drug coverage. It will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your drugs.

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;
- A summary of your coverage this year, including information about:
 - **Amount Paid For Prescriptions** - The amounts paid by the Plan.
 - **Total Out-Of-Pocket Costs That Count Towards 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 copayments and coinsurance. (This amount does not include payments made by your current or former employer/union, another insurance plan or policy, government funded health program or other excluded parties.)

When will you get your Explanation of Benefits?

You will get your Explanation of Benefits in the mail each month that you use the benefits provided by us.

What should you do if you did not get an Explanation of Benefits or if you wish to request one?

An Explanation of Benefits is also available upon request. To get a copy, please contact 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 will 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 they are not covered by Medicare Part A or Part B, are part of the Formulary and are purchased at one of our Network Pharmacies. We will also cover your prescription drugs if they are approved under the 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, we will cover your prescriptions as long as the skilled nursing facility's pharmacy is in our pharmacy network and the drug is not covered by Medicare Part B coverage. We will also cover your prescription drugs if they are approved under the Coverage Determination, Exceptions, or Appeals process. 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 new Medicare Prescription Drug Plan. Please see Section 7 of this document for more information about leaving this Plan and joining a new Medicare Prescription Drug Plan.

SECTION 5: IF YOU HAVE OTHER PRESCRIPTION DRUG COVERAGE

We will send you a Coordination of Benefits Survey so that we can know what other drug coverage you have in addition to the coverage you get through this plan. CMS requires us to collect this information from you, so when you get the survey, please fill it out and send it to us. The information you provide helps us calculate how much you and others have paid for your drugs. In addition, if you lose or get additional prescription drug coverage, please call Customer Service to update your membership records.

If you have Medicare and Medicaid

Beginning January 1, 2006, your prescription drug coverage will change. Medicare, not Medicaid, will pay for most of your prescription drugs. You will continue to get your health coverage under both Medicare and Medicaid.

If you are a member of a State Pharmacy Assistance Program (SPAP)

If you are currently enrolled in a SPAP, you may get help paying your copayments/coinsurance. Please contact your SPAP to determine what benefits are available to you. Please see the Introduction for more information.

If you have a Medigap policy with prescription drug coverage

If you currently have a Medicare Supplement (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 policy and adjust your premium. In addition, under certain circumstances, you may be able to purchase a different Medigap policy from the same company. Your Medigap issuer cannot charge you more based on any past or present health problems.

In the fall of 2005, your Medigap issuer sent a letter explaining your options and how the removal of drug coverage from your Medigap policy will affect your premiums. If you did not get this letter, please contact your Medigap issuer.

If you are a Member of an employer or retiree Group

In the fall of 2005 your employer or retiree Group sent a letter that indicated whether or not your prescription drug coverage is *creditable* (meaning whether or not it covers at least as much as Medicare's prescription drug plan coverage) and the options available to you. If you did not get this letter, please contact your benefits administrator.

If you are enrolled in a Medicare-approved drug discount card program

If you have Medicare-approved drug discount card, you may continue to use your card to get discounts on your prescription drugs until the effective date of your enrollment in this Plan or until May 15, 2006 (whichever comes first).

If you are a member of a Medicare-approved drug discount card and are receiving up to \$600 credit in help paying for your prescription drugs, you will be able to use any remaining credit you have towards your prescription drug purchases until the effective date of your enrollment in this Plan or until May 15, 2006 (whichever comes first).

If you are enrolled in a non-Medicare approved drug discount card program

If you are a member of a drug discount card program that is not Medicare-approved, please contact your drug card issuer to determine what benefits are available to you. Any amount you pay while using a discount card for drugs covered by us can count towards your out-of-pocket expenses. You must submit a claim to apply your payment towards your out-of-pocket costs.

To submit a claim:

- Complete a claim form. If you need a claim form, call Customer Service. You may also print a claim form from our website at www.healthnet.com.
- Attach your prescription receipt(s) to the claim form. You must attach the actual prescription receipt, which includes required information about the dispensing pharmacy and the prescription drug you purchased. If you do not have the actual prescription receipt, a duplicate may be obtained from the dispensing pharmacy. Cash register receipts cannot be used when submitting a claim.
- Mail the completed claim form and actual prescription receipt(s) to:

Argus Health Systems
Dept #338
P.O. Box 419019
Kansas City, Missouri 64141

SECTION 6: APPEALS AND GRIEVANCES: WHAT TO DO IF YOU HAVE COMPLAINTS

What to do if you have complaints

Introduction

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage. Please call our Customer Service numbers listed on the back cover.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a plan Member. The Medicare program has helped set the rules about what you need to do to make a complaint, and what we are required to do when someone makes a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be Disenrolled from this Plan or penalized in any way if you make a complaint.

A complaint will be handled as a Grievance, Coverage Determination, or an Appeal, depending on the subject of the complaint. The following section briefly discusses Grievances, Coverage Determinations, and Appeals.

What is a Grievance?

A Grievance is any complaint other than one that involves a Coverage Determination. You would file a Grievance if you have any type of problem with us or one of our Network Pharmacies that does not relate to coverage for a prescription drug. For example, you would file a Grievance if you have a problem with things such as waiting times when you fill a prescription, the way your Network Pharmacist or others behave, being able to reach someone by phone or get the information you need, or the cleanliness or condition of a Network Pharmacy.

What is a Coverage Determination?

Whenever you ask for a Part D prescription drug benefit, the first step is called requesting a Coverage Determination. When we make a Coverage Determination, we are making a decision whether or not to provide or pay for a Part D drug and what your share of the cost is for the drug. Coverage Determinations include Exception requests. You have the right to ask us for an "Exception" if you believe you need a drug that is not on our list of Covered Drugs (Formulary) or believe you should get a drug at a lower copayment. If you request an Exception, your doctor must provide a statement to support your request.

You must contact us if you would like to request a Coverage Determination (including an Exception). You cannot request an Appeal if we have not issued a Coverage Determination.

What is an Appeal?

- An Appeal is any of the procedures that deal with the review of an unfavorable Coverage Determination. You would file an Appeal if you want us to reconsider and change a decision we have made about what Part D prescription drug benefits are covered for you or what we will pay for a prescription drug.

How to file a Grievance

This part of Section 6 explains how to file a Grievance. A Grievance is different from a request for a Coverage Determination because it usually will not involve coverage or payment for Part D prescription drug benefits (concerns about our failure to cover or pay for a certain drug should be addressed through the Coverage Determination process discussed below).

What types of problems might lead to you filing a Grievance?

- You feel that you are being encouraged to leave (Disenroll from) our Plan.
- Problems with the customer service you receive.
- Problems with how long you have to spend waiting on the phone or in the pharmacy.
- Disrespectful or rude behavior by pharmacists or other staff.
- Cleanliness or condition of pharmacy.
- If you disagree with our decision not to expedite your request for an expedited Coverage Determination or redetermination.
- You believe our notices and other written materials are difficult to understand.
- Failure to give you a decision within the required timeframe.
- Failure to forward your case to the independent review entity if we do not give you a decision within the required timeframe.
- Failure by the plan sponsor to provide required notices.
- Failure to provide required notices that comply with CMS standards.

In certain cases, you have the right to ask for a "fast Grievance," meaning your Grievance will be decided within 24 hours. We discuss these fast-track Grievances in more detail below.

If you have a Grievance, we encourage you to first call Customer Services at the number listed on the back cover. We will try to resolve any complaint that you might have over the phone. If you request a written response to your phone complaint, 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
Post Office Box 10450
Van Nuys, CA 91410-0450

Fax: 1-818-676-8179

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

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

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

We call this the Expedited Grievance procedure. If you have questions about this procedure, please call Customer Service at the phone number listed on the back cover. Requests for Expedited Grievance may be submitted telephonically 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
Post Office Box 10450
Van Nuys, CA 91410-0450

Fax: 1-818-676-8179

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 the case 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 the case.

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.

We must notify you of our decision about your Grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the timeframe by up to 14 calendar days if you request the extension, or if we justify a need for additional information and the delay is in your best interest.

For quality of care complaints, you may also complain to the Quality Improvement Organization (QIO)

Complaints concerning the quality of care received under Medicare may be acted upon by the Medicare prescription drug plan under the Grievance process, by an independent organization called the QIO, or by both. For example, if an enrollee believes his/her pharmacist provided the incorrect dose of a prescription, the enrollee may file a complaint with the QIO in addition to or in lieu of a complaint filed under the Part D plan's Grievance process. For any complaint filed with the QIO, the Part D plan must cooperate with the QIO in resolving the complaint.

How to file a quality of care complaint with the QIO

Quality of care complaints filed with the QIO must be made in writing. An enrollee who files a quality of care Grievance with a QIO is not required to file the Grievance within a specific time period. See the introduction for more information about how to file a quality of care complaint with the QIO.

How to request a Coverage Determination

This part of Section 6 explains what you can do if you have problems getting the prescription drugs you believe we should provide and you want to request a Coverage Determination. We use the word "provide" in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Part D prescription drug that you have been getting.

If your doctor or pharmacist tells you that we will not cover a prescription drug, you should contact us and ask for a Coverage Determination. The following are examples of when you may want to ask us for a Coverage Determination:

- If you are not getting a prescription drug that you believe may be covered by us.
- If you have received a Part D prescription drug you believe may be covered by us while you were a Member, but we have refused to pay for the drug.
- If we will not provide or pay for a Part D prescription drug that your doctor has prescribed for you because it is not on our list of Covered Drugs (called a "Formulary"). You can request an Exception to our Formulary.
- If you disagree with the amount that we require you to pay for a Part D prescription drug that your doctor has prescribed for you. You can request an Exception to the copayment we require you to pay for a drug.
- If you are being told that coverage for a Part D prescription drug that you have been getting will be reduced or stopped.
- If there is a limit on the quantity (or dose) of the drug and you disagree with the requirement or dosage limitation.
- If there is a requirement that you try another drug before we will pay for the drug you are requesting.
- You bought a drug at a pharmacy that is not in our network and you want to request

reimbursement for the expense.

- The process for requesting a Coverage Determination is discussed in greater detail below in the section titled "Detailed information about how to request a Coverage Determination and an Appeal."

How to request an Appeal

This part of Section 6 explains what you can do if you disagree with our Coverage Determination. If you are unhappy with the Coverage Determination, you can ask for an Appeal. The first level of Appeal is called a redetermination. There are also four other levels of Appeal that an enrollee may request.

What kinds of decisions can be Appealed?

You can generally Appeal our decision not to cover a drug, vaccine, or other Part D benefit. You may also Appeal our decision not to reimburse you for a Part D drug that you paid for. You can also Appeal if you think we should have reimbursed you more than you received or if you are asked to pay a different cost-sharing amount than you think you are required to pay for a prescription. Finally, if we deny your Exception request, you can Appeal. A Coverage Determination may be Appealed if you disagree with our decision.

Note: If we approve your Exception request for a non-Formulary drug, you cannot request an Exception to the copayment/coinsurance we require you to pay for the drug.

How does the Appeals process work?

There are five levels to the Appeals process. Here are a few things to keep in mind as you read the description of these steps in the Appeals process:

- **Moving from one level to the next.** At each level, your request for Part D benefits or payment is considered and a decision is made. The decision may be partly or completely in your favor (giving you some or all of what you have asked for), or it may be completely denied (turned down). If you are unhappy with the decision, there may be another step you can take to get further review of your request. Whether you are able to take the next step may depend on the dollar value of the requested drug or on other factors.
- **Who makes the decision at each level?** You make your request for coverage or payment of a Part D prescription drug directly to us. We review this request and make a Coverage Determination. If our Coverage Determination is to deny your request (in whole or in part), you can go on to the first level of Appeal by asking us to review our Coverage Determination. If you are still dissatisfied with the outcome, you can ask for further review. If you ask for further review, your Appeal is then sent outside of this Plan, where people who are not connected to us conduct the review and make the decision. After the first level of Appeal, all subsequent levels of Appeal will be decided by someone who is connected to the Medicare program or the Federal court system. This will help ensure a fair, impartial decision.

Each Appeal level is discussed in greater detail below in the section titled "Detailed information about how to request a Coverage Determination and an Appeal."

Detailed information about how to request a Coverage Determination and an Appeal

What is the purpose of this section?

The purpose of this section is to give you more information about how to request a Coverage Determination, or Appeal a decision by us not to cover or pay for all or part of a drug, vaccine or other Part D benefit.

Coverage Determinations: Our Plan makes a Coverage Determination about your Part D prescription drug, or about paying for a Part D drug you have already received.

What is a Coverage Determination?

The Coverage Determination made by our Plan is the starting point for dealing with requests you may have about covering or paying for a Part D prescription drug. If your doctor or pharmacist tells you that a certain prescription drug is not covered you should contact our Plan and ask us for a Coverage Determination. With this decision, we explain whether we will provide the prescription drug you are requesting or pay for a drug you have already received. If we deny your request (this is sometimes called an "adverse Coverage Determination"), you can "Appeal" our decision by going on to Appeal Level 1. If we fail to make a timely Coverage Determination on your request, it will be automatically forwarded to the independent review entity for review (see Appeal Level 2).

The following are examples of Coverage Determinations:

- You ask us to pay for a drug you have already received. This is a request for a Coverage Determination about payment. You can call Customer Service to get help in making this request.
- You ask for a Part D drug that is not on your plan's list of Covered Drugs (called a "Formulary"). This is a request for a "Formulary Exception." You can refer to our Customer Service to ask for this type of decision.
- You ask for an Exception to our plan's utilization management tools. Requesting an Exception to a utilization management tool is a type of Formulary Exception. You can call Customer Service to ask for this type of decision.
- You ask for a non-preferred Part D drug at the preferred cost-sharing level. This is a request for a "tiering Exception." You can refer to our Customer Service to ask for this type of decision. Exceptions to your copayment/coinsurance tier are limited to non-preferred drugs at the price of a preferred drug or drugs on Specialty Group A priced at the non-preferred drug.
- You ask that we reimburse you for a purchase you made from an out-of-Network Pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a doctor's office, will be covered by the plan. See section 1 for a description of these circumstances. You can refer to our Customer Service to make a request for payment or coverage for drugs provided

by an out-of-Network Pharmacy or in a doctor's office.

When we make a Coverage Determination, we are giving our interpretation of how the Part D prescription drug benefits that are covered for Members of our Plan apply to your specific situation. This document and any amendments you may receive describe the Part D prescription drug benefits covered by our Plan, including any limitations that may apply to these benefits. This booklet also lists exclusions (benefits that are "not covered" by our Plan).

Who may ask for a Coverage Determination?

You can ask us for a Coverage Determination yourself, or your prescribing doctor or someone you name may do it for you. The person you name would be your *appointed representative*. You can name a relative, friend, advocate, doctor, or anyone else to act for you. Some other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to act as your appointed representative. This statement must be sent to us at Health Net Orange, 10540 White Rock Road, Suite 280, Rancho Cordova, CA 95670. You can call Customer Service to learn how to name your appointed representative.

You also have the right to have an attorney ask for a Coverage Determination on your behalf. You can 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" Coverage Determination

Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard timeframe?

A decision about whether we will cover a Part D prescription drug can be a "standard" Coverage Determination that is made within the standard timeframe (typically within 72 hours; see below), or it can be a "fast" Coverage Determination that is made more quickly (typically within 24 hours; see below). A fast decision is sometimes called an "expedited Coverage Determination."

You can 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 Part D Drugs that you have not received yet. You cannot get a fast decision if you are requesting payment for a Part D drug that you already received.)

Asking for a standard decision

To ask for a standard decision, you, your doctor, or your appointed representative should refer to our Customer Service numbers listed on the back cover and in the Introduction section for assistance. Or, you can deliver a written request to Health Net Orange, 10540 White Rock Road, Suite 280, Rancho Cordova, CA 95670, or fax it to 1-916-463-9754. Requests received after business hours are handled on the next business day.

Asking for a fast decision

You, your doctor, or your appointed representative can ask us to give a fast decision (rather than a standard decision) by calling our Customer Service numbers listed on the back cover and in the Introduction section. Or, you can deliver a written request to Health Net Orange, 10540 White Rock Road, Suite 280, Rancho Cordova, CA 95670, or fax it to 1-916-463-9754. Be sure to ask for a "fast," "expedited," or "24-hour" review. To request a fast decision after business hours and holidays, you would still call the Customer Service number listed on the back cover as you would during normal business hours.

- 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 Coverage Determination 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 Coverage Determination, 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 "Grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast Coverage Determination, we will give you our decision within the 72-hour standard timeframe.

What happens when you request a Coverage Determination?

What happens, including how soon we must decide, depends on the type of decision.

1. *For a standard Coverage Determination about a Part D drug, which includes a request about payment for a Part D drug that you already received.*

Generally, we must give you our decision no later than 72 hours after we have received your request, but we will make it sooner if your health condition requires. 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 or quantity limits or step therapy requirements), we must make our decision no later than 72 hours after we have received your doctor's "supporting statement," which explains why the drug you are asking for is Medically Necessary. **If you are requesting an Exception, you should submit your prescribing doctor's supporting statement with the request, if possible.**

We will give you a decision in writing about the prescription drug you have requested. You will get this notification when we make our decision under the timeframe explained above. If we do not approve your request, we must explain why, and tell you of your right to Appeal our decision. The section "Appeal Level 1" explains how to file this Appeal.

If we have not given you an answer within 72 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

2. *For a fast Coverage Determination about a Part D drug that you have not received.*

If you get a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review -- sooner if your health requires. If your request involves a request for an Exception, we must make our decision no later than 24 hours after we get your doctor's "supporting statement," which explains why the non-Formulary or non-preferred drug you are asking for is Medically Necessary.

We will give you a decision in writing about the prescription drug you have requested. You will get this notification when we make our decision, under the timeframe explained above. If we do not approve your request, we must explain why, and tell you of your right to Appeal our decision. The section "Appeal Level 1" explains how to file this Appeal.

If we decide you are eligible for a fast review, and we have not responded to you within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

If we do not grant your or your doctor's request for a fast review, we will give you our decision within the standard 72- hour timeframe discussed above. If we tell you about our decision not to provide a fast review by phone, we will send you a letter explaining our decision within three calendar days after we call you. The letter will also tell you how to file a "Grievance" if you disagree with our decision to deny your request for a fast review, and will explain that we will automatically give you a fast decision if you get a doctor's support for a fast review.

What happens if we decide completely in your favor?

If we make a Coverage Determination that is completely in your favor, what happens next depends on the situation.

1. *For a standard decision about a Part D drug, which includes a request about payment for a Part D drug that you already received.*

We must authorize or provide the benefit you have requested as quickly as your health requires, but no later than 72 hours after we received the request. If your request involves a request for an Exception, we must authorize or provide the benefit no later than 72 hours after we get your doctor's "supporting statement." If you are requesting reimbursement for a drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we get the request.

2. *For a fast decision about a Part D drug that you have not received.*

We must authorize or provide you with the benefit you have requested no later than 24 hours of receiving your request. If your request involves a request for an Exception, we must authorize or provide the benefit no later than 24 hours after we get your doctor's "supporting statement."

What happens if we deny your request?

If we deny your request, we will send you a written decision explaining the reason why your request was denied. We may decide *completely* or only *partly* against you. For example, if we deny your request for payment for a Part D drug that you have already received, we may say that we will pay nothing or only part of the amount you requested. If a Coverage Determination does not give you *all* that you requested, you have the right to Appeal the decision. (See Appeal Level 1).

Appeal Level 1: If we deny all or part of your request in our Coverage Determination, you may ask us to reconsider our decision. This is called an "Appeal" or "request for redetermination."

Please call Customer Service if you need help with filing your Appeal. You may ask us to reconsider our Coverage Determination, even if only part of our decision is not what you requested. When we get your

request to reconsider the Coverage Determination, we give the request to people at our organization who were not involved in making the Coverage Determination. This helps ensure that we will give your request a fresh look.

How you make your Appeal depends on whether you are requesting reimbursement for a Part D drug you already received and paid for, or authorization of a Part D benefit (that is, a Part D drug that you have not yet received). If your Appeal concerns a decision we made about authorizing a Part D benefit that you have not received yet, then you and/or your doctor will first need to decide whether you need a fast Appeal. The procedures for deciding on a standard or a fast *Appeal* are the same as those described for a standard or fast *Coverage Determination*. Please see the discussion under "Do you have a request for a Part D prescription drug that needs to be decided more quickly than the standard timeframe?" and "Asking for a fast decision." While the process for deciding on a standard or fast Appeal is the same as in the case of a Coverage Determination, the place where the Appeal is sent is different. See "What if you want a 'fast' Appeal" later in this section for more information.

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. You have the right to get 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 can give us your additional information in any of the following ways:

- In writing, at
Health Net Appeals & Grievances Department
Post Office Box 10450
Van Nuys, CA 91410-0450
- By fax, at 1-818-676-8179.
- By telephone -- if it is a fast Appeal -- at 1-800-806-8811.
- In person, at 21281 Burbank Blvd., Woodland Hills, CA, 91367.

You also have the right to ask us for a copy of information regarding your Appeal. You can call at 1-800-806-8811, or write us at:

Health Net Appeals & Grievances Department
Post Office Box 10450
Van Nuys, CA 91410-0450

Who may file your Appeal of the Coverage Determination?

The rules about who may file an Appeal are almost the same as the rules about who may ask for a Coverage Determination. For a standard request, you or your appointed representative may file the request. A fast Appeal may be filed by you, your appointed representative, or your prescribing doctor.

How soon must you file your Appeal?

You need to file your Appeal within 60 calendar days from the date included on the notice of our Coverage Determination. We can give you more time if you have a good reason for missing the deadline.

To file a standard Appeal, you can send the Appeal to us in writing at,

Health Net Appeals & Grievances Department
Post Office Box 10450
Van Nuys, CA 91410-0450.

What if you want a fast Appeal?

The rules about asking for a fast Appeal are the same as the rules about asking for a fast Coverage Determination. You, your doctor, or your appointed representative can ask us to give a fast Appeal (rather than a standard Appeal) by calling our Customer Service numbers listed on the back cover and in the Introduction section.

You can deliver a written request to,

Health Net Appeals & Grievances Department
Post Office Box 10450
Van Nuys, CA 91410-0450,

Or fax it to 1-818-676-8179

Be sure to ask for a "fast," "expedited," or "72-hour" review. Remember, that if your prescribing doctor provides a written or oral supporting statement explaining that you need the fast Appeal, we will automatically treat you as eligible for a fast Appeal.

How soon must we decide on your Appeal?

How quickly we decide on your Appeal depends on the type of Appeal:

1. *For a standard decision about a Part D drug, which includes a request for reimbursement for a Part D drug you already paid for and received.*

After we get your Appeal, we have up to 7 calendar days to give you a decision, but will make it sooner if your health condition requires us to. If we do not give you our decision within 7 calendar days, your request will *automatically* go to the second level of Appeal, where an independent organization will review your case.

2. *For a fast decision about a Part D drug that you have not received.*

After we get your Appeal, we have up to 72 hours to give you a decision, but will make it sooner if your health requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent organization will review your case.

What happens next if we decide completely in your favor?

1. *For a decision about reimbursement for a Part D drug you already paid for and received.*

We must send payment to you no later than 30 calendar days after we get your request to reconsider our Coverage Determination.

2. *For a standard decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for as quickly as your health requires, but no later than 7 calendar days after we get your Appeal.

3. *For a fast decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 72 hours of receiving your Appeal -- or sooner, if your health would be affected by waiting this long.

What happens next if we deny your Appeal?

If we deny any part of your Appeal, you or your appointed representative have the right to ask an independent organization, to review your case. This independent review organization contracts with the Federal government and is not part of our Plan.

Appeal Level 2: If we deny any part of your first Appeal, you may ask for a review by a government-contracted independent review organization

What independent review organization does this review?

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

How soon must you file your Appeal?

You or your appointed representative must make a request for review by the independent review organization in writing within 60 calendar days after the date you were notified of the decision on your first Appeal. You must send your written request to the independent review organization whose name and address is included in the redetermination notice you get from us.

What if you want a fast Appeal?

The rules about asking for a fast Appeal are the same as the rules about asking for a fast Coverage Determination, except your prescribing doctor cannot file the request for you -- only you or your appointed representative may file the request. If you want to ask for a fast Appeal, please follow the

instructions under "Asking for a fast decision." Remember, that if your prescribing doctor provides a written or oral supporting statement explaining that you need the fast Appeal, the independent review organization will automatically treat you as eligible for a fast Appeal.

How soon must the independent review organization decide?

After the independent review organization gets your Appeal, how long the organization can take to make a decision depends on the type of Appeal:

1. For a standard request about a Part D drug, which includes a request about reimbursement for a Part D drug that you already paid for and received, the independent review organization has up to 7 calendar days from the date it gets your request to give you a decision.
2. For a fast decision about a Part D drug that you have not received, the independent review organization has up to 72 hours from the time it gets the request to give you a decision.

If the independent review organization decides completely in your favor

The independent review organization will tell you in writing about its decision and the reasons for it. What happens next depends on the type of Appeal:

1. *For a decision about reimbursement for a Part D drug you already paid for and received.*

We must pay within 30 calendar days from the date we get notice reversing our Coverage Determination. We will also send the independent review organization a notice that we have abided by their decision.

2. *For a standard decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our Coverage Determination. We will also send the independent review organization a notice that we have abided by their decision.

3. *For a fast decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our Coverage Determination. We will also send the independent review organization a notice that we have abided by their decision.

What happens next if the review organization decides against you (either partly or completely)?

The independent review organization will tell you in writing about its decision and the reasons for it. You or your appointed representative may continue your Appeal by asking for a review by an Administrative Law Judge (see Appeal Level 3), provided that the dollar value of the contested Part D benefit is \$110.00 or more.

Appeal Level 3: If the organization that reviews your case in Appeal Level 2 does not rule completely in your favor, you may ask for a review by an Administrative Law Judge

As stated above, if the independent review organization does not rule completely in your favor, you or your appointed representative may ask for a review by an Administrative Law Judge. You must make a request for review by an Administrative Law Judge in writing within 60 calendar days after the date of the decision made at Appeal Level 2. You may request that the Administrative Law Judge extend this deadline for good cause. You must send your written request to the Administrative Law Judge Field Office indicated in the Notice of Reconsideration letter sent by the independent review organization. The address and contact information for the Administrative Law Judge Field Office is located in this notice. Administrative Law Judge Field Office's can also be found at <http://www.hhs.gov/omha/offices.html>.

During the Administrative Law Judge review, you may present evidence, review the record (by either receiving a copy of the file or getting the file in person when feasible), and be represented by counsel. The Administrative Law Judge will not review your Appeal if the dollar value of the requested Part D benefit is less than \$110.00. If the dollar value is less than \$110.00, you may not Appeal any further.

How is the dollar value (the "amount remaining in controversy") calculated?

If we have refused to provide Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes any costs you could incur based on the number of refills prescribed for the requested drug during the plan year. Projected value includes your copayments, all costs incurred after your costs exceed the initial coverage limit, and costs paid by other entities.

You may also combine multiple Part D claims to meet the dollar value if:

1. The claims involve the delivery of Part D prescription drugs to you;
2. All of the claims have received a determination by the independent review organization as described in Appeal Level 2;
3. Each of the combined requests for review are filed in writing within 60 calendar days after the date that each decision was made at Appeal Level 2; and
4. Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

How soon does the Judge make a decision?

The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and make a decision as soon as possible.

If the Judge decides in your favor

The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it. What happens next depends on the type of Appeal:

1. *For a decision about payment for a Part D drug you already received.*

We must send payment to you no later than 30 calendar days from the date we get notice reversing our Coverage Determination.

2. *For a standard decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our Coverage Determination.

3. *For a fast decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our Coverage Determination.

If the Judge rules against you:

You have the right to Appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4). The letter you get from the Administrative Law Judge will tell you how to request this review.

Appeal Level 4: Your case may be reviewed by the Medicare Appeals Council

The Medicare Appeals Council will first decide whether to review your case. There is no minimum dollar value for the Medicare Appeals Council to hear your case. If you got a denial at Appeal Level 3, you or your appointed representative can request review by filing a written request with the Council.

The Medicare Appeals Council does not review every case. When it gets your case, it will first decide whether to review your case. If they decide not to review your case, then you may request a review by a Federal Court Judge (see Appeal Level 5). The Medicare Appeals Council will issue a written notice advising you of any action taken with respect to your request for review. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?

If the Medicare Appeals Council reviews your case, they will make their decision as soon as possible.

If the Council decides in your favor

The Medicare Appeals Council will tell you in writing about its decision and the reasons for it. What happens next depends on the type of Appeal:

1. *For a decision about payment for a Part D drug you already received.*

We must send payment to you no later than 30 calendar days from the date we get notice reversing our Coverage Determination.

2. *For a standard decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 72 hours from the

date we get notice reversing our Coverage Determination.

3. *For a fast decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our Coverage Determination.

If the Council decides against you

If the amount involved is \$1,090.00 or more, you have the right to continue your Appeal by asking a Federal Court Judge to review the case (Appeal Level 5). The letter you get from the Medicare Appeals Council will tell you how to request this review. If the value is less than \$1,090.00, the Council's decision is final and you may not take the Appeal any further.

Appeal Level 5: Your case may go to a Federal Court

In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review. The Federal Court Judge will first decide whether to review your case.

If the contested amount is \$1,090.00 or more, you may ask a Federal Court Judge to review the case.

How soon will the Judge make a decision?

The Federal judiciary is in control of the timing of any decision.

If the Judge decides in your favor:

Once we get notice of a judicial decision in your favor, what happens next depends on the type of Appeal:

1. *For a decision about payment for a Part D drug you already received.*

We must send payment to you within 30 calendar days from the date we get notice reversing our Coverage Determination.

2. *For a standard decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 72 hours from the date we get notice reversing our Coverage Determination.

3. *For a fast decision about a Part D drug you have not received.*

We must authorize or provide you with the Part D drug you have asked for within 24 hours from the date we get notice reversing our Coverage Determination.

If the Judge decides against you:

The Judge's decision is final and you may not take the Appeal any further.

SECTION 7: LEAVING THIS PLAN AND YOUR CHOICES FOR CONTINUING PRESCRIPTION DRUG COVERAGE AFTER YOU LEAVE

What is "Disenrollment"?

"Disenrollment" from our Plan means ending your membership with us. **Disenrollment can be voluntary (your own choice) or, in limited circumstances, involuntary (not your own choice):**

- You might leave our Plan because you have decided that you *want* to leave. You can decide to leave for any reason during specified times (See "When Can You Disenroll/Switch Prescription Drug Plans?" below).
- There are also a few situations where you would be *required* to leave. For example, you would have to leave our Plan if you move out of our geographic Service Area or if we no longer offer prescription drug coverage in your geographic area. We are not allowed to ask you to leave our Plan because of your health.

Whether leaving our Plan is your choice or not, this section explains your prescription drug coverage choices after you leave and the rules that apply.

Please contact your Group for additional information, including what consequences disenrolling from this Medicare Prescription Drug Plan may have on your Group benefits.

Until your prescription drug coverage with our Plan ends, use our Network Pharmacies to fill your Rx

If you leave our Plan, it takes some time for your prescription drug coverage to end and your new prescription drug coverage to begin (we discuss when the change takes effect later in this section). You can choose to Disenroll from your current plan from November 15 through December 31 of every year. Enrollment is generally for the calendar year. In certain cases, such as if you move or enter a nursing home, you can Disenroll from your plan at other times. After you request to Disenroll, your plan will let you know, in writing, the date your coverage ends. If you don't get a letter, call the plan and ask for the date.

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, are listed on our Formulary, and you follow other coverage rules.

If you have any questions about your prescription drug coverage with our Plan, please refer to our Customer Service numbers listed on the back cover and in the Introduction section.

What are your options for getting Rx drug coverage if you leave our Plan?

If you leave our Plan, one choice for getting prescription drug coverage is to join another Medicare Prescription Drug Plan. You also have the choice of joining a Medicare Advantage Plan or a Medicare Cost Plan with prescription drug coverage *if* this type of plan is available in your area, they are accepting new members, and you meet the eligibility requirements of the plan.

Medicare Prescription Drug Plan. You may choose to join another Prescription Drug Plan that adds prescription drug benefits to your regular Medicare coverage. To enroll in another Prescription Drug Plan in your area, you must be entitled to Medicare benefits under Part A and/or currently enrolled in Part B, and reside in the Service Area of the Prescription Drug Plan. Refer to the next section, "When can you Disenroll / switch Medicare Prescription Drug plans" for information on when you can make this change.

Medicare Advantage Prescription Drug Plan (MA-PD) or Medicare Cost Plan with Prescription Drug Coverage. If you choose to join a Medicare Advantage Plan that offers prescription drug coverage, then you must get your Medicare Prescription Drug Coverage through that Medicare Advantage Plan. If you choose to join a Medicare Cost Plan that offers prescription drug coverage, you can get your drug coverage either from the Cost Plan or by joining a separate Medicare Prescription Drug Plan. For more information on joining a Medicare Advantage Plan or a Medicare Cost Plan in your area, please contact 1-800-MEDICARE (TTY/TDD users call 1-877-486-2048) or visit www.medicare.gov. Refer to the next section, "When can you Disenroll / switch Medicare Prescription Drug plans" for information on when you can make this change. You should contact the new plan that you are interested in for information on how and when you are able to join it.

You may also be able to get back the prescription drug coverage you had before you enrolled in our Plan. Please contact your previous Prescription Drug Plan for more information.

Note: If you Disenroll from our Plan and do not enroll in another Medicare Prescription Drug Plan, or have other prescription drug coverage that is at least as good as Medicare Prescription Drug Coverage, you may have to pay a penalty if you enroll in a Medicare prescription drug plan at a later date. Refer to Section 3 for more information on the penalty.

When can you Disenroll / switch Medicare Prescription Drug Plans?

In general, you may only Disenroll or switch prescription drug plans every year during the Annual Coordinated Enrollment Period (see below) or under certain special circumstances, such as during the Group's Open Enrollment Period.

If you have a Medigap (Medicare Supplement) Policy with prescription drug coverage, you should have received a letter in the fall of 2005 from your Medigap issuer explaining your options and explaining how the removal of drug coverage from your Medigap plan will affect your premiums. If you enroll in a Prescription Drug Plan during the initial enrollment period (November 15, 2005 through May 15, 2006),

you will also be guaranteed the right to switch to a different Medigap plan without drug coverage from the same issuer that sold you your Medigap policy with the drug coverage. If you did not get this letter, contact the issuer of your Medigap policy.

Annual Coordinated Election Period

During the Annual Coordinated Election Period, anyone with prescription drug coverage may Disenroll from any Prescription Drug Plan and join another Prescription Drug Plan, or join a Medicare Advantage Plan with Prescription Drug Coverage, or choose not to have any Medicare Prescription Drug Coverage. Please contact your Group for additional information on when you can Disenroll, and what consequences Disenrolling from this Medicare Prescription Drug Plan may have on your Group benefits.

For coverage beginning in 2006, the annual coordination election period begins on November 15, 2005 and ends on May 15, 2006.

For coverage beginning in 2007 and afterwards, the annual coordinated election period goes from November 15 through December 31 of each year.

Please remember, if during this election period you Disenroll from our Plan and do not enroll in another Prescription Drug Plan or Medicare Advantage Plan with Prescription Drug Coverage during this election period, you may have to pay a higher premium for Medicare Prescription Drug Coverage in the future.

If you join another Prescription Drug Plan during the annual coordinated election period, your enrollment in our Plan will end on December 31 and your enrollment in the new Plan will be effective on January 1st of the following year.

Exception for January 1, 2006 through May 15, 2006. If you Disenroll from our Plan to join another Prescription Drug Plan between January 1, 2006 and May 15, 2006, your coverage will be effective on the first day of the month after the month in which you join the Plan.

Special Enrollment Period

Generally, you may not Disenroll from our Plan and enroll in a new Prescription Drug Plan during other times of the year *unless* you qualify for a Special Enrollment Period. In order to qualify for a Special Enrollment Period, one of the following must apply to you:

- Our Plan no longer offers prescription drug coverage in the area where you live.
- You move outside our Plan's Service Area.
- You have an involuntary loss of creditable prescription drug coverage.
- You were not adequately informed about your loss of creditable prescription drug coverage, or you were not adequately informed that you never had creditable prescription drug coverage.
- Your enrollment in our Plan was unintentional, inadvertent, or a mistake, because of the error, misrepresentation or inaction of a Federal employee, or a person acting upon the Federal

government's behalf.

- You get benefits from both Medicare and Medicaid programs or you were eligible for benefits from both Medicare and Medicaid and you lose your Medicaid benefits.
- Our Plan's contract with the Centers for Medicare & Medicaid Services is terminated.
- You were a member of a Medicare Advantage Plan with Prescription Drug Coverage and decided to join a Prescription Drug Plan during the Medicare Advantage Plan's Open Election Period.
- You are able to demonstrate that our Plan has substantially violated a material provision in its contract. This includes, but is not limited to:
 - If our Plan failed to provide you with prescription drug coverage in a timely manner.
 - If our Plan failed to provide your prescription drug coverage with applicable quality standards.
 - You are able to demonstrate that our Plan misrepresented itself in its marketing.
- You are enrolling in or Disenrolling from a Medicare Prescription Drug Plan sponsored by your current or former employer or by your spouse's current or former employer.
- In certain cases in which Plan is sanctioned by the Centers for Medicare & Medicaid Services.
- You enroll in or Disenroll from your state's Program of All-Inclusive Care for the Elderly.
- You move into, live in, or move out of certain medical facilities, including a skilled nursing facility, nursing facility, intermediate care facility for the mentally retarded, psychiatric hospital or unit, rehabilitation hospital or unit, long-term care hospital, or certain other hospitals.
- You get extra help and the Centers for Medicare & Medicaid Services enrolled you in your current plan.

In the event that you are eligible for a Special Enrollment Period, the Centers for Medicare & Medicaid Services will determine the time frame for you to enroll in another Plan. If you feel you qualify for a Special Enrollment Period, please contact your Group to assist you in the enrollment process.

How do you Disenroll?

If you wish to leave our Plan, and you are not enrolling in another Prescription Drug Plan, you will need to submit a Disenrollment request to your Group. Your request should include your name, Medicare number, Social Security number, date of birth, and requested Disenrollment date. (Please note that we may not be able to Disenroll you on the date you request.) Please remember to sign and date the request and to include a phone number where we can reach you in case we need additional information. You can contact your Group to get a copy of the Disenrollment form and the address or fax number where you can send the Disenrollment request. You may also Disenroll by calling 1-800-MEDICARE (1-800-633-4227), TTY/TDD users should call 1-877-486-2048. You may only Disenroll during the Annual Coordinated Election Period unless you qualify for a Special Enrollment Period.

If you are joining another Prescription Drug Plan, you must contact that Plan to request enrollment information. Once you are enrolled in your new Plan, your membership in our Plan will *automatically* end with no action required on your part. Your new Plan will tell you, in writing, the date when your prescription drug coverage in that Plan begins. Your prescription drug coverage with our Plan will end on that same day (this will be your "Disenrollment date"). Remember, you are still a Member of our Plan until your Disenrollment date, and must continue to get your prescription drug coverage, as usual, through our Plan until the date your membership ends.

When can Plan Disenroll you?

Our Plan can Disenroll you for the following reasons:

- You are no longer eligible for Medicare Prescription Drug Coverage.
- If our Plan is no longer contracting with Medicare or leaves your Service Area.
- When you move out of our Plan's Service Area.
- You materially misrepresent third-party reimbursement.
- You engage in disruptive behavior, provided fraudulent information when you enrolled or abuse your enrollment card.
- The Policy (between the Group and us) is terminated, including termination due to nonpayment of premiums by the Group. In this case, your coverage will be converted to the Medicare Prescription Drug Plan Individual Policy

If You Are No Longer Eligible For Medicare Prescription Drug Coverage

If you lose your eligibility for Medicare Prescription Drug Coverage, our Plan can no longer offer you prescription drug coverage. In order to be eligible for prescription drug coverage under Medicare, you must have Part A and/or Part B, and reside in our Plan's Service Area.

When Plan Is No Longer Contracting With Medicare Or Leaves Your Service Area

If we leave the Medicare program or no longer offer prescription drug coverage in the Service Area where you live, we will notify you in writing. If this happens, your membership in our Plan will end, and you will have to enroll in another Medicare Prescription Drug Plan to continue your prescription drug coverage. All of the benefits and rules described in this Evidence of Coverage will continue until your membership ends. This means that you must continue to get your prescription drugs in the usual way through our Plan's Network Pharmacies until your membership ends.

Your choices include joining another Medicare Prescription Drug Plan or a Medicare Advantage Plan with Prescription Drug Coverage if these plans are available in your area and are accepting new

members. Once we have notified you in writing that we are leaving the Medicare program or the area where you live, you may enroll in another plan (See "When Can You Disenroll/Switch Prescription Drug Plans?" above for specific information on special enrollment periods).

Our Plan has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs Medicare. This contract may be renewed each year. However, our Plan or CMS can decide to end the contract at any time. You will generally be notified 90 days in advance if this situation occurs. However, your advance notice may be as little as 30 days or even fewer days if CMS must end our contract in the middle of the year.

When You Move Out Of Our Plan's Service Area

If you plan to move, please call our Customer Service numbers listed on the back cover and in the Introduction section to find out if the place you are moving to is in our Plan's Service Area. If you move permanently out of our Service Area, you will need to leave ("Disenroll" from) our Plan. An earlier part of this section tells about the choices you have if you leave our Plan and explains how to leave.

You Materially Misrepresent Third-Party Reimbursement

If you intentionally withhold or falsify information about third-party reimbursement coverage, CMS requires our Plan to Disenroll you. In addition, if you are Disenrolled from our Plan for misrepresentation of third party reimbursement, our Plan has the right to decline your future enrollment in our Prescription Drug Plan.

You Engage in Disruptive Behavior, Provide Fraudulent Information When You Enrolled, or Abuse Your Enrollment Card

You may be asked to leave our Plan in the following circumstances:

- If you behave in a way that seriously affects our ability to arrange or provide services for you or for others who are Members of our Plan. We cannot make you leave (i.e., Disenroll from) our Plan for this reason unless we get permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
- If you give us information on your enrollment form that you know is false or deliberately misleading, and it affects whether or not you can enroll in our Plan.
- If you let someone else use your Plan membership card to get prescription drugs for themselves or for others. Before we ask you to leave (i.e., Disenroll from) our Plan for this reason, we must refer your case to the Inspector General, and this may result in criminal prosecution.

We cannot ask you to leave our Plan because of your health

No member of any Medicare Prescription Drug Plan can be asked to leave the Plan for any health-related reasons or the number of prescriptions a member takes. 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; TTY/TDD 1-877-486-2048), the national Medicare help line.

You have the right to make a complaint if we ask you to leave our Plan

If we ask you to leave our Plan, we will tell you our reasons in writing and explain how you can file a complaint against us if you want. Refer to Section 6 for more information.

SECTION 8: YOUR RIGHTS AND RESPONSIBILITIES AS A MEMBER OF THIS PLAN

Introduction about your rights and protections

Since you have Medicare, you have certain rights to help protect you. In this first part of Section 8, we explain your Medicare rights and protections as a Member of this Plan. We will tell you what you can do if you think you are being treated unfairly or your rights are not being respected. If you want Medicare publications on your rights, you may call and request them at 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Your right to be treated with fairness and respect

You have the right to be treated with dignity, respect, and fairness at all times. We must obey laws against discrimination that protect you from unfair treatment. These laws say that we cannot discriminate against you (treat you unfairly) because of your race or color, age, religion, national origin, or any mental or physical disability you may have.

If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion, please let us know. You can also reach the Office for Civil Rights at 1-800-368-1019 or TTY/TDD 1-800-537-7697, or call the Office for Civil Rights in your area.

If you need help with communication, such as help from a language interpreter, please call our Customer Service numbers listed on the back cover.

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 keep your personal health information private as protected under these laws. Any personal health information that you give us when you enroll in this plan is protected. We will make sure that unauthorized people do not 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 is not 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 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. For example, you have the right to look at your medical records, and to get a copy of the 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 determine 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 the privacy of your personal information and medical records, please call our Customer Service numbers listed on the back cover.

Your right to get your prescriptions filled within a reasonable period of time

As explained in this Evidence of Coverage, you should get all of your prescriptions filled from a Network Pharmacy, that is, from pharmacies that contract with our Plan. You have the right to go to any Network Pharmacies in order to get your prescriptions filled at the benefit level. You have the right to timely access to your prescriptions. "Timely access" means that you can get your prescriptions filled within a reasonable amount of time. Section 1 explains how to use a Network Pharmacy to get your prescriptions filled.

Your right to know your treatment choices and participate in decisions about your health care

You have the right to know about the different Medication Management Treatment Programs we offer and in which you may participate. You have the right to be told about any risks involved in your care. You have the right to refuse treatment. This includes the right to stop taking your medication. If you refuse treatment, you accept responsibility for what happens as a result of refusing treatment.

You have the right to get a detailed explanation from us if you believe that a Network Pharmacy has denied coverage for a drug that you believe you are entitled to get or care you believe you should continue to get. In these cases, you must request an initial decision. "Initial decisions" are discussed in Section 6.

Your right to make complaints

You have the right to make a complaint if you have concerns or problems related to your coverage or care. "Appeals" and "Grievances" are the two different types of complaints you can make. Which one you make depends on your situation. Appeals and Grievances are discussed in Section 6.

If you make a complaint, we must treat you fairly (i.e., not discriminate against you). You have the right to get a summary of information about the Appeals and Grievances that Members have filed *against* us in the past. To get this information, call our Customer Service numbers listed on the back cover.

Your right to get information about your drug coverage and costs

This Evidence of Coverage tells you what you have to pay for prescription drugs as a Member of Plan. If you need more information, please call our Customer Service numbers listed on the back cover. You have the right to an explanation from us about any bills you may get for drugs not covered by our Plan. We must tell you in writing why we will not pay for a drug, and how you can file an Appeal to ask us to change this decision. See Section 6 for more information about filing an Appeal.

Your right to get information about our Plan and our Network Pharmacies

You have the right to get information from us about Health Net and your Plan. This includes information about our financial condition and about our Network Pharmacies. To get any of this information, call Customer Service at the phone number listed on the back cover.

How to get more information about your rights

If you have questions or concerns about your rights and protections, please call our Customer Service number listed on the back cover and in the Introduction section. You can also get free help and information from your State Health Insurance Assistance Program, or SHIP (the Introduction tells how to contact the SHIP in your state). In addition, the Medicare program has written a booklet called *Your Medicare Rights and Protections*. To get a free copy, call 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, you can visit www.medicare.gov to order this booklet or print it directly from your computer.

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

For concerns or problems related to your Medicare rights and protections described in this section, you can call our Customer Service number listed on the back cover. You can also get help from your State Health Insurance Assistance Program, or SHIP (the Introduction tells how to contact the SHIP in your state).

What are your responsibilities as a Member of our Plan?

Along with the rights you have as a Member of our Plan, you also have some responsibilities. Your responsibilities include the following:

- Become familiar with your coverage and the rules you must follow to get care as a Member. You can use this Evidence of Coverage and other information we give you to learn about your coverage,

what you have to pay, and the rules you need to follow. Please call Customer Service at the phone number listed on the back cover if you have any questions.

- Give your health care provider(s) the information they need to care for you, and follow the treatment plans and instructions given to you. Be sure to ask your health care provider(s) if you have any questions.
- Pay any copayments you may owe for the Covered Drugs you get. You must also meet your other financial responsibilities that are described in Section 3.
- Let us know if you have any questions, concerns, problems, or suggestions. If you do, please call our Customer Service number listed on the back cover.

SECTION 9: LEGAL NOTICES

Notice about governing law

Many different laws apply to this Evidence of Coverage. Some parts may apply to your situation because they are required by law. This can affect your rights and responsibilities even if the laws are not included or explained in this document. The 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 (CMS). In addition, other Federal laws may apply and, under certain situations, the laws of your state may also apply.

Notice about nondiscrimination

When we make decisions about the provision of health care services, we do not 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 us, 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.

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 lienholders about the status of the case and any settlement discussions.
- Notifying the lienholders 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.

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.
- **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. In some cases, we may use or disclose the information for underwriting or determining premiums.
- **Treatment.** We may use and disclose your protected health information to assist your health care providers (doctors, dentists, pharmacies, Hospitals and others) in your diagnosis and treatment. For example, we may disclose your protected health information to providers to provide information about alternative treatments.
- **Plan Sponsor.** If you are enrolled through a group health plan, we may provide non-identifiable summaries of claims and expenses for enrollees in 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 health plan operations 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 firewalls in place to ensure that only employees with a legitimate need to know will have access to health information in order to provide plan administration functions.
- **Enrolled Dependents and Family Members.** We will mail explanation of benefits forms and other mailings containing protected health information to the address we have on record for the subscriber of the health plan.

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., state insurance departments) 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
Post Office 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

SECTION 10: DEFINITIONS OF SOME WORDS USED IN THIS EVIDENCE OF COVERAGE

For the terms listed below, this section either gives a definition or directs you to a place in this Evidence of Coverage that explains the term

Appeal – A type of complaint you make when you want a reconsideration and a change to a decision we have made about what drugs are covered for you or what we will pay for a drug. Section 6 explains what Appeals are, 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 sometimes not available until after the patent on the Brand Name Drug has expired.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 1 tells how you can contact CMS.

Coverage Determination – The decision the Plan makes about the prescription drug benefits you are entitled to get under the plan, and the amount that you are required to pay for a drug.

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

Creditable Coverage – Coverage that is at least as good as the standard Medicare Prescription Drug Coverage.

Customer Service – A department responsible for answering your questions about your membership, benefits, Grievances, and Appeals. See the introduction for information about how to contact Customer Service.

Domestic Partner – A person eligible for coverage provided that the partnership with the principal Member meets all domestic partnership requirements under California law or other recognized state or local agency. The Domestic Partner and the principal Member must:

- Have a common residence. It is not necessary that the legal right to possess the common residence be in both names.
- Not be married or a member of another domestic partnership with someone else that has not been terminated, dissolved or judged a nullity.
- Not be related by blood in a way that would prevent them from being married to each other in this state.
- Be at least 18 years of age.

- Be capable of consenting to the domestic partnership.
- Be either of the following:
 - Members of the same sex; or
 - Members of the opposite sex and one or both be eligible for Social Security benefits and one or both be over the age of 62.
- Both file a Declaration of Domestic Partnership with the Secretary of State or an equivalent document with another recognized state or local agency, or both are persons of the same sex who have validly formed a legal union other than marriage in a jurisdiction outside of California which is substantially equivalent to a Domestic Partnership as defined under California law.

(The requirements listed above are statutory eligibility requirements. Your Group's Domestic Partner eligibility requirements may be less restrictive.)

Disenroll or Disenrollment – The process of ending your membership in our Plan. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 7 discusses Disenrollment.

Evidence of Coverage and Disclosure Information – This document, along with your enrollment form and any other attachments, which explains your coverage, defines our obligations, and explains your rights and responsibilities 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 drugs that are covered by this Plan. Our Formulary includes drugs that are listed on the Health Net Medicare Drug List and the Health Net Group Formulary Supplement.

Generic Drug – A prescription drug that has the same active-ingredient formula as a Brand Name Drug. Generic Drugs usually cost less than Brand Name Drugs and are rated by the Food and Drug Administration (FDA) to be as safe and effective as Brand Name Drugs.

Grievance - A type of complaint you make about us or one of our plan providers, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes. See Section 6 for more information about Grievances.

Group - The business organization (usually an employer or trust) to which Health Net has issued the Policy to provide the benefits of this Plan.

Late Enrollment Penalty – If you do not have creditable prescription drug coverage, you will have to pay a Late Enrollment Penalty in addition to your monthly plan premium.

Medically Necessary – Services that are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for the convenience of you or your doctor.

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

Medicare Advantage Plan with Prescription Drug Coverage – A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at a uniform premium and level of cost-sharing to all people with Medicare who live in the Service Area covered by the Plan. A Medicare Advantage Organization may offer more than one plan in the same Service Area.

Medicare Health Plan – A benefit packaged offered by an insurance company that contracts with Medicare. The plan is available to anyone who lives in the plan Service Area and who has Medicare Parts A and B, except those who have End-Stage Renal Disease (unless certain exceptions apply).

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

"Medigap" (Medicare Supplement Insurance) policy – Many people who have Original Medicare also buy "Medigap" or Medicare Supplement Insurance policies to fill "gaps" in Original Medicare coverage.

Member (Member of our Plan) – 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.

Non-Preferred Network Pharmacy – A Network Pharmacy that offers Covered Drugs to Members of our Plan at higher cost-sharing levels than apply at a preferred Network Pharmacy.

Group's Open Enrollment Period – A period of time each calendar year, during which individuals who are eligible for coverage in this Group Plan may enroll for the first time or principal Members, who were enrolled previously, may add their eligible dependents.

Out-of-Network Pharmacy – A pharmacy that we have not arranged with to coordinate or provide Covered Drugs to Members of our Plan. As explained in this Evidence of Coverage, most

services you get from non-Network Pharmacies are not covered by our Plan unless certain conditions apply. See section 1.

Part D Drugs – Any drug that can be covered under a Medicare Prescription Drug Plan. Generally, any drug not specifically excluded under Medicare drug coverage is considered a Part D Drug unless it is covered under Part A or Part B.

Preferred Network Pharmacy – A Network Pharmacy that offers Covered Drugs to Members of our Plan at lower cost-sharing levels than apply at another Network Pharmacy.

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

Service Area – A geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a particular plan offered by a Medicare Prescription Drug Plan.

Specialty Group A and Specialty Group B Drugs – Category of non-traditional therapeutic agents that (1) target and treat chronic severe complex medical conditions, (2) are designed and developed by advanced technology, (3) may have a high risk-to-benefit potential, and (4) are significantly more costly than traditional agents. Some oral agents and most injectable drugs, excluding insulin, are specialty drugs. The Health Net Medicare Drug List and the Health Net Group Formulary Supplement identify these drugs as either Specialty Group A or Specialty Group B.

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.

For more information, please contact us at:

Health Net Orange
Post Office Box 10420
Van Nuys, California 91410-0420

Customer Service Department

Members who are enrolled in Health Net Orange only:
1-800-806-8811

Members who are enrolled in Health Net Orange and:
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1-877-891-9050 (Cantonese)
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