KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern California Region

A nonprofit corporation and a Medicare Advantage Organization

Kaiser Permanente Senior Advantage (HMO) with Part D Evidence of Coverage for
COUNTY OF SONOMA EMPLOYEES RETIREMENT ASSOCIATION

Group ID: 9072 Contract: 1 Version: 69 *EOC* Number: 4

June 1, 2012, through May 31, 2013

Member Service Call Center
Seven days a week 8 a.m.–8 p.m.
1-800-443-0815 toll free
1-800-777-1370 (toll free TTY for the hearing/speech impaired)
kp.org

This information is available for free in other languages. Please contact our Member Service Call Center number at **1-800-443-0815** for additional information. (TTY users should call **1-800-777-1370**.) Hours are 8 a.m. to 8 p.m., seven days a week. Member Services also has free language interpreter services available for non-English speakers.

Se puede obtener esta información gratis en otros idiomas. Si desea información adicional, por favor llame al número de nuestra Central de Llamadas de Servicio a los Miembros al **1-800-443-0815**. (Los usuarios de TTY deben llamar al **1-800-777-1370**.) El horario es de 8 a.m. a 8 p.m., los siete días de la semana. Servicios a los Miembros también cuenta con servicios gratuitos de interpretación para las personas que no hablan inglés.

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Benefit Highlights

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For any one Member in a Family of two or more Members	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year
Deductible or Lifetime Maximum	None

Professional Services (Plan Provider office visits)	You Pay
Most primary and specialty care consultations, exams, and treatment	$10 per visit
Annual Wellness Visit and the Welcome to Medicare Exam	No charge
Family planning counseling	$10 per visit
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	$10 per visit
Eye exams for refraction and glaucoma screening	$10 per visit
Hearing exams	$10 per visit
Urgent care consultations, exams, and treatment	$10 per visit
Physical, occupational, and speech therapy	$10 per visit

Outpatient Services	You Pay
Outpatient surgery and certain other outpatient procedures	$10 per procedure
Allergy injections (including allergy serum)	$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays, annual mammograms, and laboratory tests	No charge
Manual manipulation of the spine	$10 per visit
Health education:	
Most individual health education counseling	$10 per visit
Covered health education programs	No charge

Hospitalization Services	You Pay
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge

Emergency Health Coverage	You Pay
Emergency Department visits	$50 per visit
Note: This Cost Sharing does not apply if admitted to the hospital as an inpatient within 24 hours for the same condition for covered Services or if you are admitted directly to the hospital as an inpatient (see "Hospitalization Services" for inpatient Cost Sharing).	

Ambulance Services	You Pay
Ambulance Services	$50 per trip

Prescription Drug Coverage	You Pay
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items	$5 for up to a 100-day supply
Most brand-name items	$10 for up to a 100-day supply

Durable Medical Equipment	You Pay
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	20 percent Coinsurance

Mental Health Services	You Pay
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	$10 per visit
Group outpatient mental health treatment	$5 per visit

Chemical Dependency Services	You Pay
Inpatient detoxification	No charge
Individual outpatient chemical dependency evaluation and treatment	$10 per visit
Group outpatient chemical dependency treatment	$5 per visit
Home Health Services	**You Pay**
Home health care (part-time, intermittent)	No charge
Other	**You Pay**
Eyewear purchased at Plan Medical Offices or Plan Optical Sales Offices every 24 months	Amount in excess of $150 Allowance
Skilled Nursing Facility care (up to 100 days per benefit period)	No charge
External prosthetic devices, orthotic devices, and ostomy and urological supplies	20 percent Coinsurance
Hospice care for Members without Medicare Part A	No charge

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Sharing, out-of-pocket maximums, exclusions, or limitations, nor does it list all benefits and Cost Sharing. For a complete explanation, please refer to the "Benefits and Cost Sharing" and "Exclusions, Limitations, Coordination of Benefits, and Reductions" sections.

Introduction

Kaiser Foundation Health Plan, Inc. (Health Plan) has a contract with the Centers for Medicare & Medicaid Services as a Medicare Advantage Organization. This Medicare contract is renewed annually.

This contract provides Medicare Services (including Medicare Part D prescription drug coverage) through "Kaiser Permanente Senior Advantage with Part D" (Senior Advantage), except for hospice care for Members with Medicare Part A, which is covered under Original Medicare. Senior Advantage is for Members who have Medicare, providing the advantages of combined Medicare and Health Plan benefits. Enrollment in this Senior Advantage plan means that you are automatically enrolled in Medicare Part D.

This *Evidence of Coverage* describes our Senior Advantage health care coverage provided under the *Group Agreement (Agreement)* between Health Plan (Kaiser Foundation Health Plan, Inc.) and your Group (the entity with which Health Plan has entered into the *Agreement*). For benefits provided under any other Health Plan program, refer to that plan's evidence of coverage.

Please read the following information so that you will know from whom or what group of providers you may get health care. It is important to familiarize yourself with your coverage by reading this *Evidence of Coverage* completely, so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please carefully read the sections that apply to you.

In this *Evidence of Coverage*, Health Plan is sometimes referred to as "we" or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *Evidence of Coverage*; please see the "Definitions" section for terms you should know.

Term of this *Evidence of Coverage*

This *Evidence of Coverage* is for the period June 1, 2012, through May 31, 2013, unless amended. Benefits, formulary, pharmacy network, Copayments, and Coinsurance may change on January 1, 2013, or at other times when your Group makes changes to its plan. Your Group can tell you whether this *Evidence of Coverage* is still in effect and give you a current one if this *Evidence of Coverage* has been amended.

About Kaiser Permanente

Kaiser Permanente provides Services directly to our Members through an integrated medical care program. Health Plan, Plan Hospitals, and the Medical Group work together to provide our Members with quality care. Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital care, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in the "Benefits and Cost Sharing" section. Plus, our health education programs offer you great ways to protect and improve your health.

We provide covered Services to Members using Plan Providers located in our Service Area, which is described in the "Definitions" section. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Certain care when you visit the service area of another Region as described under "Visiting Other Regions" in the "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Cost Sharing" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Cost Sharing" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section
- Routine Services associated with Medicare-approved clinical trials as described under "Routine Services Associated with Clinical Trials" in the "Benefits and Cost Sharing" section

Definitions

Some terms have special meaning in this *Evidence of Coverage*. When we use a term with special meaning in only one section of this *Evidence of Coverage*, we define it in that section. The terms in this "Definitions" section have special meaning when capitalized and used in any section of this *Evidence of Coverage*.

Allowance: A specified credit amount that you can use toward the purchase price of an item. If the price of the item(s) you select exceeds the Allowance, you will pay the amount in excess of the Allowance (and that payment does not apply toward your annual out-of-pocket maximum).

Catastrophic Coverage Stage: The stage in the Part D Drug Benefit where you pay a low Copayment or Coinsurance for your Part D drugs after you or other qualified parties on your behalf have spent $4,700 in covered Part D drugs during the covered year. Note: This amount may change every January 1 in accord with Medicare requirements.

Centers for Medicare & Medicaid Services: The federal agency that administers the Medicare program.

Charges: "Charges" means the following:

- For Services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members
- For Services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan)
- For all other Services, the payments that Kaiser Permanente makes for the Services or, if Kaiser Permanente subtracts Cost Sharing from its payment, the amount Kaiser Permanente would have paid if it did not subtract Cost Sharing

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service as described in the "Benefits and Cost Sharing" section.

Comprehensive Outpatient Rehabilitation Facility (CORF): A facility that mainly provides rehabilitation Services after an illness or injury, and provides a variety of Services, including physician's Services, physical therapy, social or psychological Services, and outpatient rehabilitation.

Copayment: A specific dollar amount that you must pay when you receive a covered Service as described in the "Benefits and Cost Sharing" section. Note: The dollar amount of the Copayment can be $0 (no charge).

Cost Sharing: The Copayment or Coinsurance you are required to pay for a covered Service.

Coverage Determination: An initial determination we make about whether a Part D drug prescribed for you is covered under Part D and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription for a Part D drug to a Plan Pharmacy and the pharmacy tells you the prescription isn't covered by us, that isn't a coverage determination. You need to call or write us to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this *Evidence of Coverage*.

Dependent: A Member who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

Emergency Medical Condition: A medical or psychiatric condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:

- Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency Services: All of the following with respect to an Emergency Medical Condition:

- A medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services (such as imaging and laboratory Services) routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the hospital, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services

you receive are Post Stabilization Care and not Emergency Services)

***Evidence of Coverage (EOC)*:** This *Evidence of Coverage* document, which describes the health care coverage of "Kaiser Permanente Senior Advantage (HMO) with Part D" under Health Plan's *Agreement* with your Group.

Extra Help: A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Family: A Subscriber and all of his or her Dependents.

Group: The entity with which Health Plan has entered into the *Agreement* that includes this *Evidence of Coverage*.

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. This *Evidence of Coverage* sometimes refers to Health Plan as "we" or "us."

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

Kaiser Permanente: Kaiser Foundation Hospitals (a California nonprofit corporation), Health Plan, and the Medical Group.

Medical Group: The Permanente Medical Group, Inc., a for-profit professional corporation.

Medically Necessary: A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). In this *Evidence of Coverage*, Members who are "eligible for" Medicare Part A or B are those who would qualify for Medicare Part A or B coverage if they applied for it. Members who "have" Medicare Part A or B are those who have been granted Medicare Part A or B coverage. Also, a person enrolled in a Medicare Part D plan has Medicare Part D by virtue of his or her enrollment in the Part D plan (this *Evidence of Coverage* is for a Part D plan).

Medicare Advantage Organization: A public or private entity organized and licensed by a state as a risk-bearing entity that has a contract with the Centers for Medicare & Medicaid Services to provide Services covered by Medicare, except for hospice care covered by Original Medicare. Kaiser Foundation Health Plan, Inc., is a Medicare Advantage Organization.

Medicare Advantage Plan: Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. Medicare Advantage Plans may also offer Medicare Part D (prescription drug coverage). This *Evidence of Coverage* is for a Medicare Part D plan.

Medicare Health Plan: A Medicare Health Plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage plans, Medicare Cost plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medigap (Medicare Supplement Insurance) Policy: Medicare supplement insurance sold by private insurance companies to fill "gaps" in the Original Medicare plan coverage. Medigap policies only work with the Original Medicare plan. (A Medicare Advantage Plan is not a Medigap policy.)

Member: A person who is eligible and enrolled under this *Evidence of Coverage*, and for whom we have received applicable Premiums. This *Evidence of Coverage* sometimes refers to a Member as "you."

Non–Plan Hospital: A hospital other than a Plan Hospital.

Non–Plan Pharmacy: A pharmacy other than a Plan Pharmacy. These pharmacies are also called "out-of-network pharmacies."

Non–Plan Physician: A physician other than a Plan Physician.

Non–Plan Provider: A provider other than a Plan Provider.

Non–Plan Skilled Nursing Facility: A Skilled Nursing Facility other than a Plan Skilled Nursing Facility.

Organization Determination: An initial determination we make about whether we will cover or pay for Services that you believe you should receive. Organization determinations are called "coverage decisions" in this *Evidence of Coverage.*

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

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your health resulting from an unforeseen illness or an unforeseen injury if all of the following are true:

- You are temporarily outside our Service Area
- You reasonably believed that your health would seriously deteriorate if you delayed treatment until you returned to our Service Area

Plan Facility: Any facility listed in the "Plan Facilities" section or in a Kaiser Permanente guidebook *(Your Guidebook)* for our Service Area, except that Plan Facilities are subject to change at any time without notice. For the current locations of Plan Facilities, please call our Member Service Call Center.

Plan Hospital: Any hospital listed in the "Plan Facilities" section or in a Kaiser Permanente guidebook *(Your Guidebook)* for our Service Area, except that Plan Hospitals are subject to change at any time without notice. For the current locations of Plan Hospitals, please call our Member Service Call Center.

Plan Medical Office: Any medical office listed in the "Plan Facilities" section or in a Kaiser Permanente guidebook *(Your Guidebook)* for our Service Area, except that Plan Medical Offices are subject to change at any time without notice. For the current locations of Plan Medical Offices, please call our Member Service Call Center.

Plan Optical Sales Office: An optical sales office owned and operated by Kaiser Permanente or another optical sales office that we designate. Please refer to *Your Guidebook* for a list of Plan Optical Sales Offices in your area, except that Plan Optical Sales Offices are subject to change at any time without notice. For the current locations of Plan Optical Sales Offices, please call our Member Service Call Center.

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Please refer to *Your Guidebook* for a list of Plan Pharmacies in your area, except that Plan Pharmacies are subject to change at any time without notice. For the current locations of Plan Pharmacies, please call our Member Service Call Center.

Plan Physician: Any licensed physician who is an employee of the Medical Group, or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other health care provider that we designate as a Plan Provider.

Plan Skilled Nursing Facility: A Skilled Nursing Facility approved by Health Plan.

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that this condition is Stabilized.

Premiums: The periodic amounts that your Group is responsible for paying for your membership under this *Evidence of Coverage*.

Preventive Care Services: Services that do one or more of the following:

- Protect against disease, such as in the use of immunizations
- Promote health, such as counseling on tobacco use
- Detect disease in its earliest stages before noticeable symptoms develop, such as screening for breast cancer

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Please refer to our website at **kp.org** for a directory of Primary Care Physicians, except that the directory is subject to change without notice. For the current list of physicians that are available as Primary Care Physicians, please call the personal physician selection department at the phone number listed in *Your Guidebook*.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. For information about Region locations in the District of Columbia and parts of Southern California, Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington, please call our Member Service Call Center.

Service Area: The geographic area approved by the Centers for Medicare & Medicaid Services within which an eligible person may enroll in Senior Advantage. Note: Subject to approval by the Centers for Medicare & Medicaid Services, we may reduce or expand our Service

Area effective any January 1. ZIP codes are subject to change by the U.S. Postal Service.

- All ZIP codes in Alameda County are inside our Service Area: 94501–02, 94514, 94536–46, 94550–52, 94555, 94557, 94560, 94566, 94568, 94577–80, 94586–88, 94601–15, 94617–21, 94622–24, 94649, 94659–62, 94666, 94701–10, 94712, 94720, 95377, 95391
- The following ZIP codes in Amador County are inside our Service Area: 95640, 95669
- All ZIP codes in Contra Costa County are inside our Service Area: 94505–07, 94509, 94511, 94513–14, 94516–31, 94547–49, 94551, 94553, 94556, 94561, 94563–65, 94569–70, 94572, 94575, 94582–83, 94595–98, 94706–08, 94801–08, 94820, 94850
- The following ZIP codes in El Dorado County are inside our Service Area: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762
- The following ZIP codes in Fresno County are inside our Service Area: 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618–19, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701–12, 93714–18, 93720–30, 93737, 93740–41, 93744–45, 93747, 93750, 93755, 93760–61, 93764–65, 93771–79, 93786, 93790–94, 93844, 93888
- The following ZIP codes in Kings County are inside our Service Area: 93230, 93232, 93242, 93631, 93656
- The following ZIP codes in Madera County are inside our Service Area: 93601–02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, 93720
- All ZIP codes in Marin County are inside our Service Area: 94901, 94903–04, 94912–15, 94920, 94924–25, 94929–30, 94933, 94937–42, 94945–50, 94956–57, 94960, 94963–66, 94970–71, 94973–74, 94976–79
- The following ZIP codes in Mariposa County are inside our Service Area: 93601, 93623, 93653
- The following ZIP codes in Napa County are inside our Service Area: 94503, 94508, 94515, 94558–59, 94562, 94567, 94573–74, 94576, 94581, 94589–90, 94599, 95476
- The following ZIP codes in Placer County are inside our Service Area: 95602–04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95692, 95703, 95722, 95736, 95746–47, 95765
- All ZIP codes in Sacramento County are inside our Service Area: 94203–09, 94211, 94229–30, 94232, 94234–37, 94239–40, 94244, 94246–50, 94252, 94254, 94256–59, 94261–63, 94267–69, 94271, 94273–74, 94277–80, 94282–91, 94293–98, 94571, 95608–11, 95615, 95621, 95624, 95626, 95628, 95630, 95632, 95638–41, 95652, 95655, 95660, 95662, 95670–71, 95673, 95680, 95683, 95690, 95693, 95741–42, 95757–59, 95763, 95811–38, 95840–43, 95851–53, 95860, 95864–67, 95887, 95894, 95899
- All ZIP codes in San Francisco County are inside our Service Area: 94102–05, 94107–12, 94114–27, 94129–34, 94137, 94139–47, 94151, 94156, 94158–64, 94172, 94177, 94188
- All ZIP codes in San Joaquin County are inside our Service Area: 94514, 95201–13, 95215, 95219–20, 95227, 95230–31, 95234, 95236–37, 95240–42, 95253, 95258, 95267, 95269, 95296–97, 95304, 95320, 95330, 95336–37, 95361, 95366, 95376–78, 95385, 95391, 95632, 95686, 95690
- All ZIP codes in San Mateo County are inside our Service Area: 94002, 94005, 94010–11, 94014–21, 94025–28, 94030, 94037–38, 94044, 94060–66, 94070, 94074, 94080, 94083, 94128, 94303, 94401–04, 94497
- The following ZIP codes in Santa Clara County are inside our Service Area: 94022–24, 94035, 94039–43, 94085–89, 94301–06, 94309, 94550, 95002, 95008–09, 95011, 95013–15, 95020–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95076, 95101, 95103, 95106, 95108–13, 95115–36, 95138–41, 95148, 95150–61, 95164, 95170, 95172–73, 95190–94, 95196
- All ZIP codes in Solano County are inside our Service Area: 94510, 94512, 94533–35, 94571, 94585, 94589–92, 95616, 95620, 95625, 95687–88, 95690, 95694, 95696
- The following ZIP codes in Sonoma County are inside our Service Area: 94515, 94922–23, 94926–28, 94931, 94951–55, 94972, 94975, 94999, 95401–07, 95409, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471–73, 95476, 95486–87, 95492
- All ZIP codes in Stanislaus County are inside our Service Area: 95230, 95304, 95307, 95313, 95316, 95319, 95322–23, 95326, 95328–29, 95350–58, 95360–61, 95363, 95367–68, 95380–82, 95385–87, 95397
- The following ZIP codes in Sutter County are inside our Service Area: 95626, 95645, 95648, 95659, 95668, 95674, 95676, 95692, 95836–37

- The following ZIP codes in Tulare County are inside our Service Area: 93238, 93261, 93618, 93631, 93646, 93654, 93666, 93673
- The following ZIP codes in Yolo County are inside our Service Area: 95605, 95607, 95612, 95616–18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99
- The following ZIP codes in Yuba County are inside our Service Area: 95692, 95903, 95961

For each ZIP code listed for a county, our Service Area includes only the part of that ZIP code that is in that county. When a ZIP code spans more than one county, the part of that ZIP code that is in another county is not inside our Service Area, unless that other county is also listed above and that ZIP code is also listed for that other county. If you have a question about whether a ZIP code is in your Home Region Service Area, please call our Member Service Call Center. Also, the ZIP codes listed above may include ZIP codes for Post Office boxes and commercial rental mailboxes. A Post Office box or rental mailbox cannot be used to determine whether you meet the residence eligibility requirements for Senior Advantage. Your permanent residence address must be used to determine your Senior Advantage eligibility.

Services: Health care services or items ("health care" includes both physical health care and mental health care).

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

Spouse: The Subscriber's legal husband or wife.

Stabilize: To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

Urgent Care: Medically Necessary Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition.

Premiums, Eligibility, and Enrollment

Premiums

Your Group is responsible for paying Premiums. If you are responsible for any contribution to the Premiums, your Group will tell you the amount and how to pay your Group. In addition to any amount you must pay your Group, you must also continue to pay Medicare your monthly Medicare premium.

If you do not have Medicare Part A, you may be eligible to purchase Medicare Part A from Social Security. Please contact the Social Security Administration for more information. If you get Medicare Part A, this may reduce the amount you would be expected to pay to your Group, please check with your Group's benefits administrator.

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

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

If you disagree about paying an extra amount because of your income, you can ask the Social Security Administration to review the decision. To find out more

about how to do this, contact the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778), 7:00 a.m. to 7:00 p.m., Monday through Friday.

Medicare Part D late enrollment penalty. You may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage, or you experienced a continuous period of 63 days or more when you didn't have creditable prescription drug coverage. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your Initial Enrollment Period or how many full calendar months you went without creditable prescription drug coverage (this *Evidence of Coverage* is for a Part D plan). Your Group will inform you if the penalty applies to you. If you disagree with your late enrollment penalty, you can ask us to review the decision about your late enrollment penalty. Call our Member Service Call Center at the number on the front of this booklet to find out more about how to do this.

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

Medicare's Extra Help Program

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

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

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

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, seven days a week,
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778, or
- Your state Medicaid office

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

Who Is Eligible

To enroll and to continue enrollment, you must meet all of the eligibility requirements described in this "Who Is Eligible" section.

Group eligibility requirements

You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of its eligibility requirements, such as Dependent eligibility requirements.

Senior Advantage eligibility requirements

- You must have Medicare Part B
- Your Medicare coverage must be primary and your Group's health care plan must be secondary
- You may not be enrolled in another Medicare Health Plan or Medicare prescription drug plan
- You may enroll in Senior Advantage regardless of health status, except that you may not enroll if you have end-stage renal disease. This restriction does not apply to you if you are currently a Health Plan Northern California or Southern California Region member and you developed end-stage renal disease while a member
- You may not be able to enroll if Senior Advantage has reached a capacity limit that the Centers for Medicare & Medicaid Services has approved. This limitation does not apply if you are currently a Health Plan Northern California or Southern California Region member who is eligible for Medicare (for example, when you turn age 65)

Note: If you are enrolled in a Medicare plan and lose Medicare eligibility, you may be able to enroll under your Group's non-Medicare plan if that is permitted by your Group (please ask your Group for details).

Service Area eligibility requirements

You must live in our Service Area, unless you have been continuously enrolled in Senior Advantage since December 31, 1998, and lived outside our Service Area during that entire time. In which case, you may continue your membership unless you move and are still outside our Service Area. The "Definitions" section describes our Service Area and how it may change.

Moving outside our Service Area. If you permanently move outside our Service Area, or you are temporarily absent from our Service Area for a period of more than six months in a row, you must notify us and you cannot continue your Senior Advantage membership under this *Evidence of Coverage*. Send your notice to Kaiser Foundation Health Plan, Inc., California Service Center, P.O. Box 232400, San Diego, CA 92193. It is in your best interest to notify us as soon as possible because until your Senior Advantage coverage is officially terminated by the Centers for Medicare & Medicaid Services, you will not be covered by us or Original Medicare for any care you receive from Non–Plan Providers, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Certain care when you visit the service area of another Region as described under "Visiting Other Regions" in the "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Cost Sharing" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Cost Sharing" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section
- Routine Services associated with Medicare-approved clinical trials as described under "Routine Services Associated with Clinical Trials" in the "Benefits and Cost Sharing" section

If you move to another Region's service area, please contact your Group to learn about your Group health care options. You may be able to enroll in the new service area if there is an agreement between your Group and that Region, but the plan, including coverage, premiums, and eligibility requirements might not be the same. Please call our Member Service Call Center for more information about our other Regions, including their locations in the District of Columbia and parts of Southern California, Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington.

Additional eligibility requirements

You may be eligible to enroll as a Subscriber under this *Evidence of Coverage* if you are one of the following persons:

- An employee of your Group
- A proprietor or partner of your Group
- Otherwise entitled to coverage under a trust agreement, retirement benefit program, or employment contract (unless the Internal Revenue Service considers you self-employed)

If you are a Subscriber enrolled under this *Evidence of Coverage* or a subscriber enrolled in a non-Medicare plan offered by your Group, the following persons may be eligible to enroll as your Dependents under this *Evidence of Coverage* if they meet all of the other requirements described under "Group eligibility requirements," "Senior Advantage eligibility requirements," and "Service Area eligibility requirements" in this "Who Is Eligible" section:

- Your Spouse
- Your or your Spouse's children (including adopted children or children placed with you or your Spouse for adoption) who are under age 26
- Children (not including foster children) for whom you or your Spouse is the court-appointed guardian (or was when the person reached age 18) if they are under age 26
- Dependents who meet the Dependent eligibility requirements, except for the age limit, are eligible as disabled dependents if they meet all of the following requirements:
  - your Group permits enrollment of dependent children
  - they are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred before they reached the age limit for Dependents
  - they receive 50 percent or more of their support and maintenance from you or your Spouse
  - you give us proof of their incapacity and dependency within 60 days after we request it (see "Disabled dependent certification" below in this "Additional eligibility requirements" section)
- Certain Dependents may continue their memberships for a limited time after membership would otherwise terminate as a result of the Subscriber's death if

permitted by your Group (please ask your Group for details)

Note: If you have dependents who do not have Medicare Part B coverage or for some other reason are not eligible to enroll under this *Evidence of Coverage*, you may be able to enroll them as your dependents under a non-Medicare plan offered by your Group. Please contact your Group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

Disabled dependent certification. One of the requirements for a dependent to be eligible for membership as a disabled dependent is that the Subscriber must provide us documentation of the dependent's incapacity and dependency as follows:

- If the Dependent is a Member, we will send the Subscriber a notice of the Dependent's membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. The Dependent's membership will terminate as described in our notice unless the Subscriber provides us documentation of the Dependent's incapacity and dependency within 60 days of receipt of our notice and we determine that the Dependent is eligible as a disabled dependent. If the Subscriber provides us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination. If we determine that the Dependent does not meet the eligibility requirements as a disabled dependent, we will notify the Subscriber that the Dependent is not eligible and let the Subscriber know the membership termination date. If we determine that the Dependent is eligible as a disabled dependent, there will be no lapse in coverage. Also, starting two years after the date that the Dependent reached the age limit, the Subscriber must provide us documentation of the Dependent's incapacity and dependency annually within 60 days after we request it so that we can determine if the Dependent continues to be eligible as a disabled dependent
- If the dependent is not a Member and the Subscriber is requesting enrollment, the Subscriber must provide us documentation of the dependent's incapacity and dependency within 60 days after we request it so that we can determine if the dependent is eligible to enroll as a disabled dependent. If we determine that the dependent is eligible as a disabled dependent, the Subscriber must provide us documentation of the Dependent's incapacity and dependency annually within 60 days after we request it so that we can determine if the Dependent continues to be eligible as a disabled dependent

When You Can Enroll and When Coverage Begins

Your Group is required to inform you when you are eligible to enroll and what your effective date of coverage is under this *Evidence of Coverage*. If you are eligible to enroll as described under "Who Is Eligible" in this "Premiums, Eligibility, and Enrollment" section, then as described in this "When You Can Enroll and When Coverage Begins" section, enrollment is permitted and membership begins at the beginning (12:00 a.m.) of the effective date of coverage, except that:

- Your Group may have additional requirements that we have approved, which allow enrollment in other situations
- The effective date of your Senior Advantage coverage under this *Evidence of Coverage* must be confirmed by the Centers for Medicare & Medicaid Services, as described under "Effective date of Senior Advantage coverage" in this "When You Can Enroll and When Coverage Begins" section

If you are a Subscriber under this *Evidence of Coverage* and you have dependents who do not have Medicare Part B coverage or for some other reason are not eligible to enroll under this *Evidence of Coverage*, you may be able to enroll them as your dependents under a non-Medicare plan offered by your Group. Please contact your Group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

If you are eligible to be a Dependent under this *Evidence of Coverage* but the subscriber in your family is enrolled under a non-Medicare plan offered by your Group, the subscriber must follow the rules applicable to Subscribers who are enrolling Dependents in this "When You Can Enroll and When Coverage Begins" section.

Effective date of Senior Advantage coverage

After we receive your completed Senior Advantage Election Form, we will submit your enrollment request to the Centers for Medicare & Medicaid Services for confirmation and send you a notice indicating the proposed effective date of your Senior Advantage coverage under this *Evidence of Coverage*.

If the Centers for Medicare & Medicaid Services confirms your Senior Advantage enrollment and effective date, we will send you a notice that confirms your enrollment and effective date. If the Centers for Medicare & Medicaid Services tells us that you do not have Medicare Part B coverage, we will notify you that you will be disenrolled from Senior Advantage.

New employees

When your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a Health Plan–approved enrollment application, and a Senior Advantage Election Form for each person, to your Group within 31 days.

Effective date of Senior Advantage coverage. The effective date of Senior Advantage coverage for new employees and their eligible family Dependents is the date of hire, subject to confirmation by the Centers for Medicare & Medicaid Services.

Adding new Dependents to an existing account

To enroll a Dependent who first becomes eligible to enroll after you became a Subscriber (such as a new Spouse, a newborn child, or a newly adopted child), you must submit a Health Plan–approved change of enrollment form and a Senior Advantage Election Form to your Group within 31 days after the Dependent first becomes eligible.

Effective date of Senior Advantage coverage. The effective date of coverage for newly acquired Dependents is the date of acquisition, subject to confirmation by the Centers for Medicare & Medicaid Services.

Group open enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan–approved enrollment application, and a Senior Advantage Election Form for each person to your Group during your Group's open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the effective date of coverage, which is subject to confirmation by the Centers for Medicare & Medicaid Services.

Special enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless one of the following is true:

- You become eligible as described in this "Special enrollment" section
- You did not enroll in any coverage offered by your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future. Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person, from the Subscriber

Special enrollment due to new Dependents. You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, within 30 days after marriage, establishment of domestic partnership, birth, adoption, or placement for adoption by submitting to your Group a Health Plan–approved enrollment application, and a Senior Advantage Election Form for each person.

Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from marriage is no later than the first day of the month following the date your Group receives an enrollment application, and a Senior Advantage Election Form for each person, from the Subscriber. Subject to confirmation by the Centers for Medicare & Medicaid Services, enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, adoption, or placement for adoption.

Special enrollment due to loss of other coverage. You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, if all of the following are true:

- The Subscriber or at least one of the Dependents had other coverage when he or she previously declined all coverage through your Group
- The loss of the other coverage is due to one of the following:
  - exhaustion of COBRA coverage
  - termination of employer contributions for non-COBRA coverage
  - loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, moving out of the plan's service area, reaching the age limit for dependent children, or the subscriber's death, termination of employment, or reduction in hours of employment
  - loss of eligibility (but not termination for cause) for Medicaid coverage (known as Medi-Cal in California), Children's Health Insurance Program coverage (known as the Healthy Families Program in California), or Access for Infants and Mothers Program coverage
  - reaching a lifetime maximum on all benefits

Note: If you are enrolling yourself as a Subscriber along with at least one eligible Dependent, only one of you must meet the requirements stated above.

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person, to your Group within 30 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for Medicaid, Children's Health Insurance Program, or Access for Infants and Mothers Program coverage. Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application, and Senior Advantage Election Form for each person, from the Subscriber.

Special enrollment due to court or administrative order. Within 31 days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or child as a Dependent by submitting to your Group a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person.

Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of coverage resulting from a court or administrative order is the first of the month following the date we receive the enrollment request, unless your Group specifies a different effective date (if your Group specifies a different effective date, the effective date cannot be earlier than the date of the order).

Special enrollment due to eligibility for premium assistance. You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, if you or a dependent become eligible for premium assistance through the Medi-Cal program. Premium assistance is when the Medi-Cal program pays all or part of premiums for employer group coverage for a Medi-Cal beneficiary. To request enrollment in your Group's health care coverage, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 60 days after you or a dependent become eligible for premium assistance. Please contact the California Department of Health Care Services to find out if premium assistance is available and the eligibility requirements.

Special enrollment due to reemployment after military service. If you terminated your health care coverage because you were called to active duty in the military service, you may be able to reenroll in your Group's health plan if required by state or federal law. Please ask your Group for more information.

How to Obtain Services

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in this "How to Obtain Services" section
- Certain care when you visit the service area of another Region as described under "Visiting Other Regions" in this "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Cost Sharing" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Cost Sharing" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section
- Routine Services associated with Medicare-approved clinical trials as described under "Routine Services Associated with Clinical Trials" in the "Benefits and Cost Sharing" section

Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital care, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in the "Benefits and Cost Sharing" section.

Routine Care

If you need to make a routine care appointment, please refer to *Your Guidebook to Kaiser Permanente Services (Your Guidebook)* for appointment telephone numbers, or go to our website at **kp.org** to request an appointment online. Routine appointments are for medical needs that aren't urgent (such as routine preventive care and school

physicals). Try to make your routine care appointments as far in advance as possible.

Urgent Care

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice telephone number at a Plan Facility. Please refer to *Your Guidebook* for appointment and advice telephone numbers.

For information about Out-of-Area Urgent Care, please refer to "Urgent Care" in the "Emergency Services and Urgent Care" section.

Our Advice Nurses

We know that sometimes it's difficult to know what type of care you need. That's why we have telephone advice nurses available to assist you. Our advice nurses are registered nurses specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. Whether you are calling for advice or to make an appointment, you can speak to an advice nurse. They can often answer questions about a minor concern, tell you what to do if a Plan Medical Office is closed, or advise you about what to do next, including making a same-day Urgent Care appointment for you if it's medically appropriate. To reach an advice nurse, please refer to *Your Guidebook* for the telephone numbers.

Your Personal Plan Physician

Personal Plan Physicians provide primary care and play an important role in coordinating care, including hospital stays and referrals to specialists.

We encourage you to choose a personal Plan Physician. You may choose any available personal Plan Physician. Parents may choose a pediatrician as the personal Plan Physician for their child. Most personal Plan Physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians). Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal Plan Physicians. For example, some specialists in internal medicine and obstetrics/gynecology who are not designated as Primary Care Physicians may be available as personal Plan Physicians.

To learn how to select a personal Plan Physician, please refer to *Your Guidebook* or call our Member Service Call Center. You can find a directory of our Plan Physicians on our website at **kp.org**. For the current list of physicians that are available as Primary Care Physicians, please call the personal physician selection department at the phone number listed in *Your Guidebook.* You can change your personal Plan Physician for any reason.

Getting a Referral

Referrals to Plan Providers

A Plan Physician must refer you before you can receive care from specialists, such as specialists in surgery, orthopedics, cardiology, oncology, urology, dermatology, and physical, occupational, and speech therapies. However, you do not need a referral or prior authorization to receive care from any of the following:

- Your personal Plan Physician
- Generalists in internal medicine, pediatrics, and family practice
- Specialists in optometry, psychiatry, chemical dependency, and obstetrics/gynecology

Although a referral or prior authorization is not required to receive care from these providers, the provider may have to get prior authorization for certain Services in accord with "Medical Group authorization procedure for certain referrals" in this "Getting a Referral" section.

Medical Group authorization procedure for certain referrals

The following Services require prior authorization by the Medical Group for the Services to be covered ("prior authorization" means that the Medical Group must approve the Services in advance):

- **Durable medical equipment.** If your Plan Physician prescribes durable medical equipment, he or she will submit a written referral to the Plan Hospital's durable medical equipment coordinator, who will authorize the durable medical equipment if he or she determines that your durable medical equipment coverage includes the item and that the item is listed on our formulary for your condition. If the item doesn't appear to meet our durable medical equipment formulary or Medicare guidelines, then the durable medical equipment coordinator will contact the Plan Physician for additional information. If the durable medical equipment request still doesn't appear to meet our durable medical equipment formulary or Medicare guidelines, it will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is

Medically Necessary. For more information about our durable medical equipment formulary, please refer to "Durable Medical Equipment for Home Use" in the "Benefits and Cost Sharing" section

- **Ostomy and urological supplies.** If your Plan Physician prescribes ostomy or urological supplies, he or she will submit a written referral to the Plan Hospital's designated coordinator, who will authorize the item if he or she determines that it is covered in accord with Medicare guidelines or on our soft goods formulary for your condition. If the item doesn't appear to meet our soft goods formulary guidelines, then the coordinator will contact the Plan Physician for additional information. If the request still doesn't appear to meet our soft goods formulary or Medicare guidelines, it will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our soft goods formulary, please refer to "Ostomy and Urological Supplies" in the "Benefits and Cost Sharing" section
- **Services not available from Plan Providers.** If your Plan Physician decides that you require covered Services not available from Plan Providers, he or she will recommend to the Medical Group that you be referred to a Non–Plan Provider inside or outside our Service Area. The appropriate Medical Group designee will authorize the Services if he or she determines that they are Medically Necessary and are not available from a Plan Provider. Referrals to Non–Plan Physicians will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your Plan Physician what Services have been authorized
- **Transplants.** If your Plan Physician makes a written referral for a transplant, the Medical Group's regional transplant advisory committee or board (if one exists) will authorize the Services if it determines that they are Medically Necessary or covered in accord with Medicare guidelines. In cases where no transplant committee or board exists, the Medical Group will refer you to physician(s) at a transplant center, and the Medical Group will authorize the Services if the transplant center's physician(s) determine that they are Medically Necessary or covered in accord with Medicare guidelines. Note: A Plan Physician may provide or authorize a corneal transplant without using this Medical Group transplant authorization procedure

Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

Medical Group's decision time frames. The applicable Medical Group designee will make the authorization decision within the time frame appropriate for your condition, but no later than five business days after receiving all of the information (including additional examination and test results) reasonably necessary to make the decision, except that decisions about urgent Services will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision. If the Medical Group needs more time to make the decision because it doesn't have information reasonably necessary to make the decision, or because it has requested consultation by a particular specialist, you and your treating physician will be informed about the additional information, testing, or specialist that is needed, and the date that the Medical Group expects to make a decision.

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your physician will be informed of the scope of the authorized Services. If the Medical Group does not authorize all of the Services, Health Plan will send you a written decision and explanation within two business days after the decision is made. The letter will include information about your appeal rights, which are described in the "Coverage Decisions, Appeals, and Complaints" section. Any written criteria that the Medical Group uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request.

Cost Sharing. The Cost Sharing for these referral Services is the Cost Sharing required for Services provided by a Plan Provider as described in the "Benefits and Cost Sharing" section.

More information. This description is only a brief summary of the authorization procedure. The policies and procedures (including a description of the authorization procedure or information about the authorization procedure applicable to some Plan Providers other than Kaiser Foundation Hospitals and the Medical Group) are available upon request from our Member Service Call Center. Please refer to "Post-Stabilization Care" under "Emergency Services" in the "Emergency Services and Urgent Care" section for authorization requirements that apply to Post-Stabilization Care from Non–Plan Providers.

Second Opinions

If you want a second opinion, you can either ask your Plan Physician to help you arrange one, or you can make an appointment with another Plan Physician. If there isn't

a Plan Physician who is an appropriately qualified medical professional for your condition, the appropriate Medical Group designee will authorize a consultation with a non-Plan Physician for a second opinion. For purposes of this "Second Opinions" provision, an "appropriately qualified medical professional" is a physician who is acting within his or her scope of practice and who possesses a clinical background related to the illness or condition associated with the request for a second medical opinion.

Here are some examples of when a second opinion may be provided or authorized:

- Your Plan Physician has recommended a procedure and you are unsure about whether the procedure is reasonable or necessary
- You question a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions
- The clinical indications are not clear or are complex and confusing
- A diagnosis is in doubt due to conflicting test results
- The Plan Physician is unable to diagnose the condition
- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have concerns about the diagnosis or plan of care

Cost Sharing. The Cost Sharing for these referral Services is the Cost Sharing required for Services provided by a Plan Provider as described in the "Benefits and Cost Sharing" section.

Contracts with Plan Providers

How Plan Providers are paid

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways, such as salary, capitation, per diem rates, case rates, fee for service, and incentive payments. To learn more about how Plan Physicians are paid to provide or arrange medical and hospital care for Members, please ask your Plan Physician or call our Member Service Call Center.

Financial liability

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the full price of noncovered Services you obtain from Plan Providers or Non–Plan Providers.

Termination of a Plan Provider's contract and completion of Services

If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered care you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements.

Completion of Services. If you are undergoing treatment for specific conditions from a Plan Physician (or certain other providers) when the contract with him or her ends (for reasons other than medical disciplinary cause, criminal activity, or the provider's voluntary termination), you may be eligible to continue receiving covered care from the terminated provider for your condition. The conditions that are subject to this continuation of care provision are:

- Certain conditions that are either acute, or serious and chronic. We may cover these Services for up to 90 days, or longer if necessary for a safe transfer of care to a Plan Physician or other contracting provider as determined by the Medical Group
- A high-risk pregnancy or a pregnancy in its second or third trimester. We may cover these Services through postpartum care related to the delivery, or longer if Medically Necessary for a safe transfer of care to a Plan Physician as determined by the Medical Group

The Services must be otherwise covered under this *Evidence of Coverage*. Also, the terminated provider must agree in writing to our contractual terms and conditions and comply with them for Services to be covered by us. The Cost Sharing for the Services of a terminated provider is the Cost Sharing required for Services provided by a Plan Provider as described in the "Benefits and Cost Sharing" section.

For more information about this provision, or to request the Services, please call our Member Service Call Center.

Visiting Other Regions

If you visit the service area of another Region temporarily (not more than 90 days), you can receive certain care from designated providers in that service area. The care you can get in other Kaiser Permanente regions and your out-of-pocket costs may differ from the covered Services and Cost Sharing described in this *Evidence of Coverage*.

The 90-day limit does not apply to Members who attend an accredited college or accredited vocational school.

The service area and facilities where you may obtain care outside our Service Area may change at any time without notice.

Please call our Member Service Call Center for more information about getting care in other Kaiser Permanente regions, including facility locations in the service area of another Region in the District of Columbia and parts of Southern California, Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington.

Your ID Card

Each Member's Kaiser Permanente ID card has a medical record number on it, which you will need when you call for advice, make an appointment, or go to a provider for covered care. When you get care, please bring your Kaiser Permanente ID card and a photo ID. Your medical record number is used to identify your medical records and membership information. Your medical record number should never change. Please call our Member Service Call Center if we ever inadvertently issue you more than one medical record number or if you need to replace your Kaiser Permanente ID card.

Your ID card is for identification only. To receive covered Services, you must be a current Member. Anyone who is not a Member will be billed as a non-Member for any Services he or she receives. If you let someone else use your ID card, we may keep your ID card and terminate your membership as described under "Termination for Cause" in the "Termination of Membership" section.

Your Medicare card

As a Member, you will not need your red, white, and blue Medicare card to get covered Services, but do keep it in a safe place in case you need it later.

Getting Assistance

We want you to be satisfied with the health care you receive from Kaiser Permanente. If you have any questions or concerns, please discuss them with your personal Plan Physician or with other Plan Providers who are treating you. They are committed to your satisfaction and want to help you with your questions.

Member Services

Most Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, our Member Service Call Center representatives are available to assist you seven days a week from 8 a.m. to 8 p.m. toll free at 1-800-443-0815 or 1-800-777-1370 (TTY for the deaf, hard of hearing, or speech impaired). For your convenience, you can also contact us through our website at **kp.org**.

Member Services representatives at our Plan Facilities and Member Service Call Center can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace your ID card. These representatives can also help you if you need to file a claim as described in the "Requests for Payment" section.

Interpreter services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services are available 24 hours a day, seven days a week, at no cost to you. For more information on the interpreter services we offer, please call our Member Service Call Center.

Plan Facilities

At most of our Plan Facilities, you can usually receive all of the covered Services you need, including specialty care, pharmacy, and lab work. You are not restricted to a particular Plan Facility, and we encourage you to use the facility that will be most convenient for you:

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Services are available from Plan Hospital Emergency Departments as described in *Your Guidebook* (please refer to *Your Guidebook* for Emergency Department locations in your area)
- Same–day Urgent Care appointments are available at many locations (please refer to *Your Guidebook* for Urgent Care locations in your area)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services Department (refer to *Your Guidebook* for locations in your area)
- Plan Pharmacies are located at most Plan Medical Offices (refer to *Kaiser Permanente Medicare Part D Pharmacy Directory* for pharmacy locations)

Plan Hospitals and Plan Medical Offices

The following is a list of Plan Hospitals and most Plan Medical Offices in our Service Area. Please refer to *Your Guidebook* for the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services. Additional Plan Medical Offices are listed in *Your Guidebook* and on our website at **kp.org**. This list is subject to change at any time without notice. If there is a change to this list of Plan Facilities, we will update this list in any Plan evidence of coverage issued after that date. If you have any questions about the current locations of Plan Facilities, please call our Member Service Call Center.

Alameda

- Medical Offices: 2417 Central Ave.

Antioch

- Hospital and Medical Offices: 4501 Sand Creek Rd.
- Medical Offices: 3400 Delta Fair Blvd.

Campbell

- Medical Offices: 220 E. Hacienda Ave.

Clovis

- Medical Offices: 2071 Herndon Ave.

Daly City

- Medical Offices: 395 Hickey Blvd.

Davis

- Medical Offices: 1955 Cowell Blvd.

Elk Grove

- Medical Offices: 9201 Big Horn Blvd.

Fairfield

- Medical Offices: 1550 Gateway Blvd.

Folsom

- Medical Offices: 2155 Iron Point Rd.

Fremont

- Hospital and Medical Offices: 39400 Paseo Padre Pkwy.

Fresno

- Hospital and Medical Offices: 7300 N. Fresno St.

Gilroy

- Medical Offices: 7520 Arroyo Circle

Hayward

- Hospital and Medical Offices: 27400 Hesperian Blvd.

Lincoln

- Medical Offices: 1900 Dresden Dr.

Livermore

- Medical Offices: 3000 Las Positas Rd.

Manteca

- Hospital and Medical Offices: 1777 W. Yosemite Ave.
- Medical Offices: 1721 W. Yosemite Ave.

Martinez

- Medical Offices: 200 Muir Rd.

Milpitas

- Medical Offices: 770 E. Calaveras Blvd.

Modesto

- Hospital and Medical Offices: 4601 Dale Rd.
- Medical Offices: 3800 Dale Rd.
- Please refer to *Your Guidebook* for other Plan Providers in Stanislaus County

Mountain View

- Medical Offices: 555 Castro St.

Napa

- Medical Offices: 3285 Claremont Way

Novato

- Medical Offices: 97 San Marin Dr.

Oakhurst

- Medical Offices: 40595 Westlake Dr.

Oakland

- Hospital and Medical Offices: 280 W. MacArthur Blvd.

Petaluma

- Medical Offices: 3900 Lakeville Hwy.

Pinole

- Medical Offices: 1301 Pinole Valley Rd.

Pleasanton

- Medical Offices: 7601 Stoneridge Dr.

Rancho Cordova

- Medical Offices: 10725 International Dr.

Redwood City

- Hospital and Medical Offices: 1150 Veterans Blvd.

Richmond

- Hospital and Medical Offices: 901 Nevin Ave.

Rohnert Park

- Medical Offices: 5900 State Farm Dr.

Roseville

- Hospital and Medical Offices: 1600 Eureka Rd.
- Medical Offices: 1001 Riverside Ave.

Sacramento

- Hospitals and Medical Offices: 2025 Morse Ave. and 6600 Bruceville Rd.
- Medical Offices: 1650 Response Rd. and 2345 Fair Oaks Blvd.

San Bruno

- Medical Offices: 901 El Camino Real

San Francisco

- Hospital and Medical Offices: 2425 Geary Blvd.

San Jose

- Hospital and Medical Offices: 250 Hospital Pkwy.

San Mateo

- Medical Offices: 1000 Franklin Pkwy.

San Rafael

- Hospital and Medical Offices: 99 Montecillo Rd.
- Medical Offices: 1033 3rd St.

Santa Clara

- Hospital and Medical Offices: 700 Lawrence Expwy.

Santa Rosa

- Hospital and Medical Offices: 401 Bicentennial Way

Selma

- Medical Offices: 2651 Highland Ave.

South San Francisco

- Hospital and Medical Offices: 1200 El Camino Real

Stockton

- Hospital: 525 W. Acacia St. (Dameron Hospital)
- Medical Offices: 7373 West Ln.

Tracy

- Medical Offices: 2185 W. Grant Line Rd.

Turlock

- Hospital: 825 Delbon Ave. (Emanuel Medical Center)

Union City

- Medical Offices: 3553 Whipple Rd.

Vacaville

- Hospital and Medical Offices: 1 Quality Dr.

Vallejo

- Hospital and Medical Offices: 975 Sereno Dr.

Walnut Creek

- Hospital and Medical Offices: 1425 S. Main St.
- Medical Offices: 320 Lennon Ln.

Your Guidebook to Kaiser Permanente Services (Your Guidebook)

Plan Medical Offices and Plan Hospitals for your area are listed in greater detail in *Your Guidebook to Kaiser Permanente Services (Your Guidebook)*. *Your Guidebook* describes the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services. It includes additional facilities that are not listed in this "Plan Facilities" section. Also, it explains how to use our Services and make appointments, lists hours of operation, and includes a detailed telephone directory for appointments and advice. *Your Guidebook* provides other important information, such as preventive care guidelines and your Member rights and responsibilities. *Your Guidebook* is subject to change and is periodically updated. We mail it annually and you can get a copy by visiting our website at **kp.org** or by calling our Member Service Call Center.

Provider Directory

We will send you annually either a provider directory or an update to your provider directory that lists our Plan Providers. If you don't have the provider directory, you can request a copy from our Member Service Call Center. Also, a complete list of Plan Providers in your area is available on our website at **kp.org**.

Pharmacy Directory

The *Kaiser Permanente Medicare Part D Pharmacy Directory* lists the locations of Plan Pharmacies, which are also called "network pharmacies." The pharmacy directory provides additional information about obtaining prescription drugs. It is subject to change and periodically updated. We mail it annually and you can get a copy by calling our Member Service Call Center or by visiting our website at **kp.org/seniormedrx**.

Emergency Services and Urgent Care

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital Emergency Department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non–Plan Providers anywhere in the world as long as the Services would have been covered under the "Benefits and Cost Sharing" section (subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section) if you had received them from Plan Providers.

In addition, Emergency Services are available from Plan Hospital Emergency Departments 24 hours a day, seven days a week.

Post-Stabilization Care

Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that your condition is Stabilized.

To request authorization to receive Post-Stabilization Care from a Non–Plan Provider, the Non–Plan Provider must call us toll free at **1-800-225-8883** (TTY users call 711) or the notification telephone number on your Kaiser Permanente ID card *before* you receive the care. After we are notified, we will discuss your condition with the Non–Plan Provider. If we decide that you require Post-Stabilization Care and that this care would be covered if you received it from a Plan Provider, we will authorize your care from the Non–Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care with the treating physician's concurrence. If we decide to have a Plan Hospital, Plan Skilled Nursing Facility, or designated Non–Plan Provider provide your care, we may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered.

Be sure to ask the Non–Plan Provider to tell you what care (including any transportation) we have authorized because we will not cover unauthorized Post-Stabilization Care or related transportation provided by Non–Plan Providers, except as otherwise described in this section. Also, you will only be held financially liable if you are notified by the Non–Plan Provider or us about your potential liability.

Cost Sharing

The Cost Sharing for covered Emergency Services and Post-Stabilization Care is the Cost Sharing required for Services provided by Plan Providers as described in the "Benefits and Cost Sharing" section:

- Please refer to "Outpatient Care" for the Cost Sharing for Emergency Department visits
- The Cost Sharing for other covered Emergency Services and Post-Stabilization Care is the Cost Sharing that you would pay if the Services were not Emergency Services or Post-Stabilization Care. For example, if you are admitted as an inpatient to a Non–Plan Hospital for Post-Stabilization Care and we give prior authorization for that care, your Cost Sharing would be the Cost Sharing listed under "Hospital Inpatient Care"

Services not covered under this "Emergency Services" section

Coverage for the following Services is described in other sections of this *Evidence of Coverage*:

- Follow-up care and other Services that are not Emergency Services or Post-Stabilization Care described in this "Emergency Services" section (refer to the "Benefits and Cost Sharing" section for coverage, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- Out-of-Area Urgent Care (refer to "Out-of-Area Urgent" care under "Urgent Care" in this "Emergency Services and Urgent Care" section)

Urgent Care

Inside the Service Area

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice telephone number at a Plan Facility. Please refer to *Your Guidebook* for appointment and advice telephone numbers.

In the event of unusual circumstances that delay or render impractical the provision of Services under this *Evidence of Coverage* (such as major disaster, epidemic, war, riot, and civil insurrection), we cover Urgent Care inside our Service Area from a Non–Plan Provider.

Out-of-Area Urgent Care

If you have an Urgent Care need due to an unforeseen illness or unforeseen injury, we cover Medically Necessary Services to prevent serious deterioration of your health from a Non–Plan Provider if all of the following are true:

- You receive the Services from Non–Plan Providers while you are temporarily outside our Service Area
- You reasonably believed that your health would seriously deteriorate if you delayed treatment until you returned to our Service Area

You do not need prior authorization for Out-of-Area Urgent Care. We cover Out-of-Area Urgent Care you receive from Non–Plan Providers as long as the Services would have been covered under the "Benefits and Cost Sharing" section (subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section) if you had received them from Plan Providers.

Cost Sharing

The Cost Sharing for covered Urgent Care is the Cost Sharing required for Services provided by Plan Providers as described in the "Benefits and Cost Sharing" section:

- Please refer to "Outpatient Care" for the Cost Sharing for Urgent Care consultations, exams, and treatment
- The Cost Sharing for other covered Urgent Care is the Cost Sharing that you would pay if the Services were not Urgent Care. For example, if the Urgent Care you receive includes an X-ray, your Cost Sharing for the X-ray would be the Cost Sharing for an X-ray listed under "Outpatient Imaging, Laboratory, and Special Procedures"

Services not covered under this "Urgent Care" section

Coverage for the following Services is described in other sections of this *Evidence of Coverage*:

- Follow-up care and other Services that are not Urgent Care or Out-of-Area Urgent Care described in this "Urgent Care" section (refer to the "Benefits and Cost Sharing" section for coverage, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Urgent Care from a Non–Plan Provider as described in this "Emergency Services and Urgent Care" section, or emergency ambulance Services described under "Ambulance Services" in the "Benefits and Cost Sharing" section, ask the Non–Plan Provider to submit a claim to us within 60 days or as soon as possible, but no later than 15 months after receiving the care (or up to 27 months according to Medicare rules, in some cases). If the provider refuses to bill us, send us the unpaid bill with a claim form. Also, if you receive Services from a Plan Provider that are prescribed by a Non–Plan Provider as part of covered Emergency Services, Post-Stabilization Care, and Urgent Care (for example, drugs), you may be required to pay for the Services and file a claim. To request payment or reimbursement, you must file a claim as described in the "Requests for Payment" section.

We will reduce any payment we make to you or the Non–Plan Provider by applicable Cost Sharing. Also, in accord with applicable law, we will reduce our payment by any amounts paid or payable (or that in the absence of this plan would have been payable) for the Services under any insurance policy, or any other contract or coverage, or any government program except Medicaid.

Benefits and Cost Sharing

We cover the Services described in this "Benefits and Cost Sharing" section, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section, only if all of the following conditions are satisfied:

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
  - health care items and services for preventive care
  - health care items and services for diagnosis, assessment, or treatment
  - health education covered under "Health Education" in this "Benefits and Cost Sharing" section
  - other health care items and services
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except where specifically noted to the contrary in the sections listed below for the following Services:
  - certain care when you visit the service area of another Region as described under "Visiting Other Regions" in the "How to Obtain Services" section
  - drugs prescribed by dentists as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section
  - emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Cost Sharing" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section

- eyeglasses and contact lenses prescribed by Non–Plan Providers as described under "Vision Services" in this "Benefits and Cost Sharing" section
- out-of-area dialysis care as described under "Dialysis Care" in this "Benefits and Cost Sharing" section
- routine Services associated with Medicare-approved clinical trials as described under "Routine Services Associated with Clinical Trials" in this "Benefits and Cost Sharing" section

- You receive the Services from Plan Providers inside our Service Area, except where specifically noted to the contrary in the sections listed below for the following Services:
  - authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
  - certain care when you visit the service area of another Region as described under "Visiting Other Regions" in the "How to Obtain Services" section
  - emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Cost Sharing" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
  - out-of-area dialysis care as described under "Dialysis Care" in this "Benefits and Cost Sharing" section
  - prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section
  - routine Services associated with Medicare-approved clinical trials as described under "Routine Services Associated with Clinical Trials" in this "Benefits and Cost Sharing" section
- The Medical Group has given prior authorization for the Services if required under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

The only Services we cover under this *Evidence of Coverage* are those that this "Benefits and Cost Sharing" section says that we cover, subject to exclusions and limitations described in this "Benefits and Cost Sharing" section and to all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. The "Exclusions, Limitations, Coordination of Benefits, and Reductions" section describes exclusions, limitations, reductions, and coordination of benefits provisions that apply to all Services that would otherwise be covered. When an exclusion or limitation applies only to a particular benefit, it is listed in the description of that benefit in this "Benefits and Cost Sharing" section. Also, please refer to:

- The "Emergency Services and Urgent Care" section for information about how to obtain covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care
- *Your Guidebook* for the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services

Cost Sharing

General rules, examples, and exceptions

Your Cost Sharing for covered Services will be the Cost Sharing in effect on the date you receive the Services, except as follows:

- If you are receiving covered inpatient hospital or Skilled Nursing Facility Services on the effective date of this *Evidence of Coverage*, you pay the Cost Sharing in effect on your admission date until you are discharged if the Services were covered under your prior Health Plan evidence of coverage and there has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Cost Sharing in effect on the date you receive the Services
- For items ordered in advance, you pay the Cost Sharing in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription

Receiving a bill. In most cases, we will ask you to make a payment toward your Cost Sharing at the time you check in. Keep in mind that this payment may cover only a portion of the total Cost Sharing for the covered Services you receive, and we will bill you for any additional Cost Sharing amounts that are due. The following are examples of when you may get a bill:

- You receive Services during your visit that were not scheduled when you made your payment at check-in. For example, if you are scheduled to receive treatment for an existing condition, at check-in we will ask you to pay the Cost Sharing that applies to these Services. If during your visit your provider finds another problem with your health, your provider

may perform or order additional unscheduled Services to diagnose your problem. You may have to pay separate Cost Sharing amounts for each of these additional unscheduled Services, in addition to the Cost Sharing amount you paid at check-in for the treatment of your existing condition

- You receive Services from a second provider during your visit that were not scheduled when you made your payment at check-in. For example, if you are scheduled to receive a diagnostic exam, at check-in we will ask you to pay the Cost Sharing that applies to these Services. If during your diagnostic exam your provider confirms a problem with your health, your provider may request the assistance of another provider to perform additional unscheduled Services (such as an outpatient procedure). You may have to pay separate Cost Sharing amounts for the unscheduled Services of the second provider, in addition to the Cost Sharing amount you paid at check-in for your diagnostic exam
- You go in for Preventive Care Services and receive non-preventive Services during your visit that were not scheduled when you made your payment at check-in. For example, if you go in for a routine physical maintenance exam, at check-in we will ask you to pay the Cost Sharing that applies to these Services (the Cost Sharing may be "no charge"). If during your routine physical maintenance exam your provider finds a problem with your health, your provider may order non-preventive Services to diagnose your problem (such as laboratory tests). You may have to pay separate Cost Sharing amounts for the non-preventive Services performed to diagnose your problem, in addition to the Cost Sharing amount you paid at check-in for your routine physical maintenance exam
- At check-in, you request that we bill you for some or all of the Cost Sharing for the Services you will receive, and we agree to bill you

In some cases, we will not ask you to make a payment at check-in, and we will bill you for any Cost Sharing. For example, some Laboratory Departments do not collect payments at check-in, and we will instead bill you for any Cost Sharing.

Infertility Services. Before starting or continuing a course of infertility Services, you may be required to pay initial and subsequent deposits toward your Cost Sharing for some or all of the entire course of Services, along with any past-due infertility-related Cost Sharing. Any unused portion of your deposit will be returned to you. When a deposit is not required, you must pay the Cost Sharing for the procedure, along with any past-due infertility-related Cost Sharing, before you can schedule an infertility procedure.

Noncovered Services. If you receive Services that are not covered under this *Evidence of Coverage*, you may be liable for the full price of those Services. Payments you make for noncovered Services are not Cost Sharing.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service is described in this "Benefits and Cost Sharing" section.

Annual out-of-pocket maximum

There is a limit to the total amount of Cost Sharing you must pay under this *Evidence of Coverage* in a calendar year for all of the covered Services listed below that you receive in the same calendar year. The limit is one of the following amounts:

- **$1,500** per calendar year for self-only enrollment (a Family of one Member)
- **$1,500** per calendar year for any one Member in a Family of two or more Members
- **$3,000** per calendar year for an entire Family of two or more Members

If you are a Member in a Family of two or more Members, you reach the annual out-of-pocket maximum either when you meet the maximum for any one Member, or when your Family reaches the Family maximum. For example, suppose you have reached the **$1,500** maximum. For Services subject to the maximum, you will not pay any more Cost Sharing during the rest of the calendar year, but every other Member in your Family must continue to pay Cost Sharing during the calendar year until your Family reaches the **$3,000** maximum.

Payments that count toward the maximum. The Copayments and Coinsurance you pay for the following Services apply toward the annual out-of-pocket maximum:

- Ambulance Services
- Blood
- Dental Services covered by Medicare
- Durable medical equipment
- Emergency Department and Out-of-Area Urgent Care visits
- Home health care
- Hospice care
- Hospital care

- Imaging, laboratory, and special procedures
- Medicare Part B drugs
- Mental health care, including intensive psychiatric treatment programs
- Outpatient surgery
- Prosthetic and orthotic devices
- Rehabilitation Services, including care in a Comprehensive Outpatient Rehabilitation Facility
- Routine costs associated with Medicare approved clinical trials
- Services performed during an office visit (including professional Services such as dialysis treatment, diabetes monitoring, health education counseling and programs, and manual manipulation of the spine to correct subluxation in accord with Medicare guidelines)
- Skilled Nursing Facility care
- Transitional residential recovery Services for chemical dependency

Copayments and Coinsurance you pay for Services that are not listed above do not apply to the annual out-of-pocket maximum. For these Services, you must pay Copayments or Coinsurance even if you have already reached your annual out-of-pocket maximum.

Preventive Care Services

We cover a variety of Preventive Care Services. This "Preventive Care Services" section lists Medicare-covered Preventive Care Services, but it does not explain coverage. These Preventive Care Services are subject to all coverage requirements described in other parts of this "Benefits and Cost Sharing" section and all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section.

The following Medicare-covered Preventive Care Services are covered as described in other parts of this "Benefits and Cost Sharing" section:

- Abdominal aortic aneurysm screening if prescribed during the one-time Welcome to Medicare Exam
- Bone mass measurement
- Breast cancer screening (mammograms)
- Cardiovascular disease testing
- Cervical and vaginal cancer screenings (pap tests and pelvic exam)
- Colorectal cancer screenings (fecal occult blood test, barium enema, flexible sigmoidoscopies, and colonoscopies)
- Diabetes screening (pre-diabetes fasting plasma glucose and challenge tests for persons at risk of getting diabetes)
- Diabetes self-management training
- Hepatitis B, influenza, and pneumococcal vaccines
- HIV screening
- Medical nutrition therapy services for end-stage renal disease and diabetes
- Prostate cancer screening exams
- Smoking cessation (counseling to stop smoking)
- Welcome to Medicare Exam
- Annual Wellness Visit

Outpatient Care

We cover the following outpatient care subject to the Cost Sharing indicated:

- Primary and specialty care consultations, exams, and treatment (other than those described below in this "Outpatient Care" section): **a $10 Copayment per visit**
- Preventive Care Services:
  - Annual Wellness Visit and the Welcome to Medicare Exam in accord with Medicare guidelines: **no charge**
  - family planning counseling, or consultations to obtain internally implanted time-release contraceptives or intrauterine devices (IUDs) prescribed in accord with our drug formulary guidelines: **a $10 Copayment per visit**
  - after confirmation of pregnancy, the normal series of regularly scheduled preventive prenatal care exams and the first postpartum follow-up consultation and exam: **a $10 Copayment per visit**
  - immunizations (including the vaccine) covered by Medicare Part B such as Hepatitis B, influenza, and pneumococcal vaccines that are administered to you in a Plan Medical Office: **no charge**
  - colorectal cancer screenings, such as flexible sigmoidoscopies and colonoscopies in accord with Medicare guidelines: **no charge**
- Allergy injections (including allergy serum): **a $3 Copayment per visit**
- Outpatient surgery and other outpatient procedures: **a $10 Copayment per procedure**

- Voluntary termination of pregnancy: **a $10 Copayment per procedure**
- Physical, occupational, and speech therapy in accord with Medicare guidelines: **a $10 Copayment per visit**
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program in accord with Medicare guidelines: **a $10 Copayment per day**
- Manual manipulation of the spine to correct subluxation, in accord with Medicare guidelines, is covered when prescribed or authorized by a Plan Physician and performed by a Plan or referral Provider who is an osteopath or chiropractor: **a $10 Copayment per visit**
- Urgent Care consultations, exams, and treatment: **a $10 Copayment per visit**
- Emergency Department visits: **a $50 Copayment per visit**. The Emergency Department Copayment does not apply if you are admitted to the hospital as an inpatient within 24 hours for the same condition for covered Services, or if you are admitted directly to the hospital as an inpatient for covered Services (for inpatient care, please refer to "Hospital Inpatient Care" in this "Benefits and Cost Sharing" section). However, the Emergency Department Copayment does apply if you are admitted as anything other than an inpatient (for example, if you are admitted for observation)
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician: **no charge**
- Acupuncture Services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain): **a $10 Copayment per visit**
- Blood, blood products, and their administration: **no charge**
- Administered drugs (drugs, injectables, radioactive materials used for therapeutic purposes, and allergy test and treatment materials) prescribed in accord with our drug formulary guidelines, if administration or observation by medical personnel is required and they are administered to you in a Plan Medical Office or during home visits: **no charge**
- Wound care supplies in accord with Medicare guidelines for use in the home: **20 percent Coinsurance**
- Medical nutrition therapy services for end-stage renal disease and diabetes: **no charge**
- Some types of outpatient consultations, exams, and treatment may be available as group appointments, which we cover at **a $5 Copayment per visit**

Note: Vaccines covered by Medicare Part D are not covered under this "Outpatient Care" section (instead, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section).

Services not covered under this "Outpatient Care" section

The following types of outpatient Services are covered only as described under these headings in this "Benefits and Cost Sharing" section:

- Bariatric Surgery
- Chemical Dependency Services
- Dental Services for Radiation Treatment and Dental Anesthesia
- Dialysis Care
- Durable Medical Equipment for Home Use
- Health Education
- Hearing Services
- Home Health Care
- Hospice Care
- Infertility Services
- Mental Health Services
- Ostomy and Urological Supplies
- Outpatient Imaging, Laboratory, and Special Procedures
- Outpatient Prescription Drugs, Supplies, and Supplements
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Routine Services Associated with Clinical Trials
- Transplant Services
- Vision Services

Hospital Inpatient Care

We cover the following inpatient Services at **no charge** in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals inside our Service Area:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units

- General and special nursing care
- Operating and recovery rooms
- Services of Plan Physicians, including consultation and treatment by specialists
- Anesthesia
- Drugs prescribed in accord with our drug formulary guidelines (for discharge drugs prescribed when you are released from the hospital, please refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section)
- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and special procedures
- Blood, blood products, and their administration
- Obstetrical care and delivery (including cesarean section). Note: If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge (for visits after you are released from the hospital, please refer to "Outpatient Care" in this "Benefits and Cost Sharing" section)
- Physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program) in accord with Medicare guidelines
- Respiratory therapy
- Medical social services and discharge planning

Services not covered under this "Hospital Inpatient Care" section

The following types of inpatient Services are covered only as described under the following headings in this "Benefits and Cost Sharing" section:

- Bariatric Surgery
- Chemical Dependency Services
- Dental Services for Radiation Treatment and Dental Anesthesia
- Dialysis Care
- Hospice Care
- Infertility Services
- Mental Health Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Religious Nonmedical Health Care Institution Services
- Routine Services Associated with Clinical Trials
- Skilled Nursing Facility Care
- Transplant Services

Ambulance Services

Emergency

We cover at **a $50 Copayment per trip** Services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) in the following situations:

- A reasonable person would have believed that the medical condition was an Emergency Medical Condition which required ambulance Services
- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

If you receive emergency ambulance Services that are not ordered by a Plan Provider, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us. Please refer to "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section for how to file a claim for reimbursement.

Nonemergency

Inside our Service Area, we cover nonemergency ambulance Services in accord with Medicare guidelines at **a $50 Copayment per trip** if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to or from covered Services in accord with Medicare guidelines.

Ambulance Services exclusion

- Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider

Bariatric Surgery

We cover hospital inpatient care related to bariatric surgical procedures (including room and board, imaging, laboratory, special procedures, and Plan Physician

Services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

- You complete the Medical Group–approved pre-surgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success
- A Plan Physician who is a specialist in bariatric care determines that the surgery is Medically Necessary

For covered Services related to bariatric surgical procedures that you receive, you will pay the **Cost Sharing you would pay if the Services were not related to a bariatric surgical procedure**. For example, see "Hospital Inpatient Care" in this "Benefits and Cost Sharing" section for the Cost Sharing that applies for hospital inpatient care.

If you live 50 miles or more from the facility to which you are referred for a covered bariatric surgery, we will reimburse you for certain travel and lodging expenses if you receive prior written authorization from the Medical Group and send us adequate documentation including receipts. We will not, however, reimburse you for any travel or lodging expenses if you were offered a referral to a facility that is less than 50 miles from your home. We will reimburse authorized and documented travel and lodging expenses as follows:

- Transportation for you to and from the facility up to $130 per round trip for a maximum of three trips (one pre-surgical visit, the surgery, and one follow-up visit), including any trips for which we provided reimbursement under any other evidence of coverage offered by your Group
- Transportation for one companion to and from the facility up to $130 per round trip for a maximum of two trips (the surgery and one follow-up visit), including any trips for which we provided reimbursement under any other evidence of coverage offered by your Group
- One hotel room, double-occupancy, for you and one companion not to exceed $100 per day for the pre-surgical visit and the follow-up visit, up to two days per trip, including any hotel accommodations for which we provided reimbursement under any other evidence of coverage offered by your Group
- Hotel accommodations for one companion not to exceed $100 per day for the duration of your surgery stay, up to four days, including any hotel accommodations for which we provided reimbursement under any other evidence of coverage offered by your Group

Services not covered under this "Bariatric Surgery" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Chemical Dependency Services

Inpatient detoxification

We cover hospitalization at **no charge** in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

Outpatient chemical dependency care

We cover the following Services for treatment of chemical dependency:

- Day-treatment programs
- Intensive outpatient programs
- Individual and group chemical dependency counseling
- Medical treatment for withdrawal symptoms

You pay the following for these covered Services:

- Individual chemical dependency evaluation and treatment: **a $10 Copayment per visit**
- Group chemical dependency treatment: **a $5 Copayment per visit**

We cover methadone maintenance treatment at **no charge** for pregnant Members during pregnancy and for two months after delivery at a licensed treatment center approved by the Medical Group. We do not cover methadone maintenance treatment in any other circumstances.

Transitional residential recovery Services

We cover chemical dependency treatment in a nonmedical transitional residential recovery setting approved in writing by the Medical Group. We cover these Services at **no charge**. These settings provide counseling and support services in a structured environment.

Services not covered under this "Chemical Dependency Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Inpatient care received in an acute care general hospital (refer to "Hospital Inpatient Care")
- Outpatient self-administered drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")

Chemical dependency Services exclusion

- Services in a specialized facility for alcoholism, drug abuse, or drug addiction except as otherwise described in this "Chemical Dependency Services" section

Dental Services for Radiation Treatment and Dental Anesthesia

Dental Services for radiation treatment

We cover services in accord with Medicare guidelines, including dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental anesthesia

For dental procedures at a Plan Facility, we provide general anesthesia and the facility's Services associated with the anesthesia if all of the following are true:

- You are under age 7, or you are developmentally disabled, or your health is compromised
- Your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center
- The dental procedure would not ordinarily require general anesthesia

We do not cover any other Services related to the dental procedure, such as the dentist's Services, unless the Service is covered in accord with Medicare guidelines.

Cost Sharing for dental Services for radiation treatment and dental anesthesia

You pay the following for dental and orthodontic Services covered under this "Dental Services for Radiation Treatment and Dental Anesthesia" section:

- Hospital inpatient care: **no charge**
- Outpatient consultations, exams, and treatment: **a $10 Copayment per visit**
- Outpatient surgery and other outpatient procedures: **a $10 Copayment per procedure**

Services not covered under this "Dental Services for Radiation Treatment and Dental Anesthesia" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Dialysis Care

We cover acute and chronic dialysis Services if all of the following requirements are met:

- You satisfy all medical criteria developed by the Medical Group
- The facility is certified by Medicare
- A Plan Physician provides a written referral for your dialysis treatment except for out-of-area dialysis care

We also cover hemodialysis and peritoneal home dialysis (including equipment, training, and medical supplies).

Out-of-area dialysis care

We cover dialysis (kidney) Services that you get at a Medicare-certified dialysis facility when you are temporarily outside our Service Area. If possible, before you leave the Service Area, please let us know where you are going so we can help arrange for you to have maintenance dialysis while outside our Service Area.

The procedure for obtaining reimbursement for out-of-area dialysis care is described in the "Requests for Payment" section.

You pay the following for these covered Services related to dialysis:

- Inpatient dialysis care: **no charge**
- One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, exam, or treatment: **no charge**

- Hemodialysis treatment: **no charge**
- All other outpatient consultations, exams, and treatment: **a $10 Copayment per visit**

Services not covered under this "Dialysis Care" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Durable medical equipment for home use (refer to "Durable Medical Equipment for Home Use")
- Kidney disease education (refer to "Health Education")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Dialysis Care exclusions

- Comfort, convenience, or luxury equipment, supplies and features
- Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel

Durable Medical Equipment for Home Use

We cover durable medical equipment for use in your home (or another location used as your home as defined by Medicare) in accord with our durable medical equipment formulary and Medicare guidelines. Durable medical equipment for home use is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home.

Coverage is limited to the standard item of equipment that adequately meets your medical needs. Covered durable medical equipment (including repair or replacement of covered equipment, unless due to misuse) is provided at **20 percent Coinsurance**. We decide whether to rent or purchase the equipment, and we select the vendor.

Durable medical equipment for diabetes

The following diabetes blood-testing supplies and equipment and insulin-administration devices are provided at **no charge**:

- Blood glucose monitors and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Insulin pumps and supplies to operate the pump

About our durable medical equipment formulary

Our durable medical equipment formulary includes the list of durable medical equipment that is covered by Medicare or has been approved by our Durable Medical Equipment Formulary Executive Committee for our Members. Our durable medical equipment formulary was developed by a multidisciplinary clinical and operational work group with review and input from Plan Physicians and medical professionals with durable medical equipment expertise (for example: physical, respiratory, and enterostomal therapists and home health). A multidisciplinary Durable Medical Equipment Formulary Executive Committee is responsible for reviewing and revising the durable medical equipment formulary. Our durable medical equipment formulary is periodically updated to keep pace with changes in medical technology, Medicare guidelines, and clinical practice. To find out whether a particular item is included in our durable medical equipment formulary, please call our Member Service Call Center.

Our formulary guidelines allow you to obtain nonformulary durable medical equipment (equipment not listed on our durable medical equipment formulary for your condition) if the equipment would otherwise be covered and the Medical Group determines that it is Medically Necessary as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

Services not covered under this "Durable Medical Equipment for Home Use" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Dialysis equipment and supplies required for home hemodialysis and home peritoneal dialysis (refer to "Dialysis Care")
- Diabetes urine testing supplies and insulin-administration devices other than insulin pumps (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

- Durable medical equipment related to the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")

Durable medical equipment for home use exclusions

- Comfort, convenience, or luxury equipment or features
- Exercise or hygiene equipment
- Dental appliances
- Nonmedical items, such as sauna baths or elevators
- Modifications to your home or car
- Devices for testing blood or other body substances (except diabetes blood glucose monitors and their supplies)
- Electronic monitors of the heart or lungs except infant apnea monitors

Health Education

We cover a variety of health education counseling, programs, and materials that your personal Plan Physician or other Plan Providers provide during a visit covered under another part of this "Benefits and Cost Sharing" section.

We also cover a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for tobacco cessation, stress management, and chronic conditions (such as diabetes and asthma). Kaiser Permanente also offers health education counseling, programs, and materials that are not covered, and you may be required to pay a fee.

For more information about our health education counseling, programs, and materials, please contact your local Health Education Department or our Member Service Call Center, refer to *Your Guidebook,* or go to our website at **kp.org**.

Note: Our Health Education Department offers a comprehensive self-management workshop to help members learn the best choices in exercise, diet, monitoring, and medications to manage and control diabetes. Members may also choose to receive diabetes self-management training from a program outside our Plan that is recognized by the American Diabetes Association (ADA) and approved by Medicare. Also, our Health Education Department offers education to teach kidney care and help members make informed decisions about their care.

You pay the following for these covered Services:

- Covered health education programs, which may include programs provided online and counseling over the phone: **no charge**
- Individual counseling during an office visit related to smoking cessation: **no charge**
- Individual counseling during an office visit related to diabetes management: **no charge**
- Other covered individual counseling when the office visit is solely for health education: **a $10 Copayment per visit**
- Health education provided during an outpatient consultation or exam covered in another part of this "Benefits and Cost Sharing" section: **no additional Cost Sharing beyond the Cost Sharing required in that other part of this "Benefits and Cost Sharing" section**
- Covered health education materials: **no charge**

Hearing Services

We do not cover hearing aids (other than internally-implanted devices as described in the "Prosthetic and Orthotic Devices" section). However, we do cover the following:

- Hearing exams to determine the need for hearing correction: **a $10 Copayment per visit**

Services not covered under this "Hearing Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Services related to the ear or hearing other than those described in this section, such as outpatient care to treat an ear infection and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits and Cost Sharing" section)
- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")

Hearing Services exclusions

- Hearing aids and tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid

Home Health Care

"Home health care" means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists.

We cover part-time or intermittent home health care in accord with Medicare guidelines at **no charge** only if all of the following are true:

- You are substantially confined to your home
- Your condition requires the Services of a nurse, physical therapist, or speech therapist or continued need for an occupational therapist (home health aide Services are not covered unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide)
- A Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home and that the Services can be safely and effectively provided in your home
- The Services are provided inside our Service Area
- The Services are covered in accord with Medicare guidelines, such as part-time or intermittent skilled nursing care and part-time or intermittent Services of a home health aide

The following types of Services are covered only as described under these headings in this "Benefits and Cost Sharing" section:

- Dialysis Care
- Durable Medical Equipment for Home Use
- Ostomy and Urological Supplies
- Outpatient Prescription Drugs, Supplies, and Supplements
- Prosthetic and Orthotic Devices

Home health care exclusion

- Care in the home if the home is not a safe and effective treatment setting

Hospice Care

Hospice care is a specialized form of interdisciplinary health care designed to provide palliative care and to alleviate the physical, emotional, and spiritual discomforts of a Member experiencing the last phases of life due to a terminal illness. It also provides support to the primary caregiver and the Member's family. A Member who chooses hospice care is choosing to receive palliative care for pain and other symptoms associated with the terminal illness, but not to receive care to try to cure the terminal illness. You may change your decision to receive hospice care benefits at any time.

We cover the hospice Services listed below at **no charge** only if all of the following requirements are met:

- You are not entitled to Medicare Part A (if you are entitled to Medicare Part A, see the "Special note if you have Medicare Part A" for more information)
- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The Services are provided inside our Service Area (or inside California but within 15 miles or 30 minutes from our Service Area if you live outside our Service Area, and you have been a Senior Advantage Member continuously since before January 1, 1999, at the same home address)
- The Services are provided by a licensed hospice agency that is a Plan Provider
- The Services are necessary for the palliation and management of your terminal illness and related conditions

If all of the above requirements are met, we cover the following hospice Services, which are available on a 24-hour basis if necessary for your hospice care:

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, or speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from Plan Pharmacies. Certain drugs are limited to a maximum 30-day supply in any 30-day period (please call our Member Service Call Center for the current list of these drugs)
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling

- The following care during periods of crisis when you need continuous care to achieve palliation or management of acute medical symptoms:
  - ♦ nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
  - ♦ short-term inpatient care required at a level that cannot be provided at home

Special note if you have Medicare Part A

If you have Medicare Part A, you may receive care from any Medicare-certified hospice program. Your hospice doctor can be a Plan Provider or a Non–Plan Provider. Original Medicare (rather than our Plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in a hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. Covered services include but are not limited to:

- Drugs for symptom control and pain relief
- Short-term respite care
- Home care

You are still a member of our Plan. If you need non-hospice care (care that is not related to your terminal condition), you have two options:

- You can obtain your non-hospice care from Plan Providers. In this case, you only pay Plan allowed Cost Sharing
- Or, you can get your care covered by Original Medicare. In this case, you must pay the cost-sharing amounts under Original Medicare, except for emergency or urgently needed care

Note: If you need non-hospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting non-hospice care from a Plan Provider will lower your share of the costs for the services.

For more information about Original Medicare hospice coverage, visit **www.medicare.gov**, and under "Search Tools," choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048.

Infertility Services

We cover the following Services related to involuntary infertility:

- Services for diagnosis and treatment of involuntary infertility
- Artificial insemination

You pay the following for these Services related to involuntary infertility:

- Outpatient consultations and exams: **a $10 Copayment per visit**
- Outpatient surgery and other outpatient procedures: **a $10 Copayment per procedure**
- Outpatient imaging, laboratory, and special procedures: **no charge**
- Hospital inpatient care (including room and board, imaging, laboratory, and special procedures, and Plan Physician Services): **no charge**

Services not covered under this "Infertility Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Infertility Services exclusions

- Services to reverse voluntary, surgically induced infertility
- Semen and eggs (and Services related to their procurement and storage)

Mental Health Services

We cover Services specified in this "Mental Health Services" section only when the Services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the *Diagnostic and Statistical Manual of Mental* Disorders, *Fourth Edition, Text Revision (DSM)* that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the *DSM* identifies as something other than a "mental disorder." For example, the *DSM* identifies relational problems as something other than a

"mental disorder," so we do not cover services (such as couples counseling or family counseling) for relational problems.

"Mental Disorders" include the following conditions:

- Severe Mental Illness of a person of any age. "Severe Mental Illness" means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa
- A Serious Emotional Disturbance of a child under age 18. A "Serious Emotional Disturbance" of a child under age 18 means a condition identified as a "mental disorder" in the *DSM*, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:
  - as a result of the mental disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
  - the child displays psychotic features, or risk of suicide or violence due to a mental disorder
  - the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code

Outpatient mental health Services

We cover the following Services when provided by Plan Physicians or other Plan Providers who are licensed health care professionals acting within the scope of their license:

- Individual and group mental health evaluation and treatment
- Psychological testing when necessary to evaluate a Mental Disorder
- Outpatient Services for the purpose of monitoring drug therapy

You pay the following for these covered Services:

- Individual mental health evaluation and treatment: **a $10 Copayment per visit**
- Group mental health treatment: **a $5 Copayment per visit**

Note: Outpatient intensive psychiatric treatment programs are not covered under this "Outpatient mental health Services" section (refer to "Intensive psychiatric treatment programs" under "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in this "Mental Health Services" section).

Inpatient psychiatric hospitalization and intensive psychiatric treatment programs

Inpatient psychiatric hospitalization. We cover care for acute psychiatric conditions in a Medicare-certified psychiatric hospital at **no charge**.

Intensive psychiatric treatment programs. We cover treatment in a structured multidisciplinary program as an alternative to inpatient psychiatric hospitalization at **no charge**. Hospital alternative Services include partial hospitalization and treatment in an intensive outpatient psychiatric treatment program.

Services not covered under this "Mental Health Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Inpatient care received in an acute care general hospital (refer to "Hospital Inpatient Care")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")

Ostomy and Urological Supplies

Inside our Service Area, we cover ostomy and urological supplies prescribed in accord with our soft goods formulary and Medicare guidelines at **20 percent Coinsurance**. We select the vendor, and coverage is limited to the standard supply that adequately meets your medical needs.

About our soft goods formulary

Our soft goods formulary includes the list of ostomy and urological supplies that are covered in accord with Medicare guidelines or have been approved by our Soft

Goods Formulary Executive Committee for our Members. Our Soft Goods Formulary Executive Committee is responsible for reviewing and revising the soft goods formulary. Our soft goods formulary is periodically updated to keep pace with changes in medical technology, Medicare guidelines, and clinical practice. To find out whether a particular ostomy or urological supply is included in our soft goods formulary, please call our Member Service Call Center.

Our formulary guidelines allow you to obtain nonformulary ostomy and urological supplies (those not listed on our soft goods formulary for your condition) if they would otherwise be covered and the Medical Group determines that they are Medically Necessary as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

Ostomy and urological supplies exclusion

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Special Procedures

We cover the following Services at the Cost Sharing indicated only when prescribed as part of care covered under other headings in this "Benefits and Cost Sharing" section:

- Imaging Services that are Preventive Care Services:
  - preventive mammograms: **no charge**
  - preventive aortic aneurysm screenings prescribed during the one-time Welcome to Medicare Exam: **no charge**
  - bone mass measurement screenings: **no charge**
  - barium enema: **no charge**
- All other CT scans, and all MRIs and PET scans: **no charge**
- All other imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds: **no charge** except that certain imaging procedures are covered at **a $10 Copayment per procedure** if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort
- Nuclear medicine: **no charge**
- Laboratory tests:
  - laboratory tests to monitor the effectiveness of dialysis: **no charge**
  - fecal occult blood tests: **no charge**
  - routine laboratory tests and screenings that are Preventive Care Services, such as preventive cervical cancer screenings, prostate specific antigen tests, cardiovascular disease testing (cholesterol tests including lipid panel and profile), diabetes screening (fasting blood glucose tests), certain sexually transmitted disease (STD) tests, and HIV tests: **no charge**
  - all other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available): **no charge**
- Routine preventive retinal photography screenings: **no charge**
- All other diagnostic procedures provided by Plan Providers who are not physicians (such as EKGs and EEGs): **no charge** except that certain diagnostic procedures are covered at **a $10 Copayment per procedure** if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort
- Radiation therapy: **no charge**
- Ultraviolet light treatments: **no charge**

Services not covered under this "Outpatient Imaging, Laboratory, and Special Procedures" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Services related to diagnosis and treatment of infertility (refer to "Infertility Services")

Outpatient Prescription Drugs, Supplies, and Supplements

We cover outpatient drugs, supplies, and supplements specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section if all of the following are true:

- The item is prescribed either (a) by a Plan Physician, or (b) by a dentist or a Non–Plan Physician in the following circumstances unless a Plan Physician determines that the item is not Medically Necessary or is for a sexual dysfunction disorder:
  - a Non–Plan Physician prescribes the item after the Medical Group authorizes a written referral to the Non–Plan Physician (in accord with "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section) and the item is covered as part of that referral
  - a Non–Plan Physician prescribes the item as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section
  - a dentist prescribes the drug for dental care
- The item meets the requirements of our applicable drug formulary guidelines (our Medicare Part D formulary or our formulary applicable to non–Part D items)
- You obtain the item at a Plan Pharmacy or through our mail-order service, except as otherwise described under "Certain items from Non–Plan Pharmacies" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section. Please refer to our *Kaiser Permanente Medicare Part D Pharmacy Directory* for the locations of Plan Pharmacies in your area. Plan Pharmacies can change without notice and if a pharmacy is no longer a Plan Pharmacy, you must obtain covered items from another Plan Pharmacy, except as otherwise described under "Certain items from Non–Plan Pharmacies" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section

Obtaining refills by mail

Most refills are available through our mail-order service, but there are some restrictions. A Plan Pharmacy, our *Kaiser Permanente Medicare Part D Pharmacy Directory*, or our website at **kp.org/rxrefill** can give you more information about obtaining refills through our mail-order service. Please check with your local Plan Pharmacy if you have a question about whether or not your prescription can be mailed. Items available through our mail-order service are subject to change at any time without notice.

Certain items from Non–Plan Pharmacies

Generally, we only cover drugs filled at a Non–Plan Pharmacy in limited, nonroutine circumstances when a Plan Pharmacy is not available. Below are the situations when we may cover prescriptions filled at a Non–Plan Pharmacy. **Before you fill your prescription in these situations, call our Member Service Call Center to see if there is a Plan Pharmacy in your area where you can fill your prescription**.

- The drug is related to covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section. Note: Prescription drugs prescribed and provided outside of the United States and its territories as part of covered Emergency Services or Urgent Care are covered up to a 30-day supply in a 30-day period. These drugs are covered under Part C benefits, and are not covered under Medicare Part D. Therefore, payments for these drugs do not count toward reaching the Part D Catastrophic Coverage Stage
- For Medicare Part D covered drugs, the following are additional situations when a Part D drug may be covered:
  - If you are traveling within the United States and its territories, but outside our Service Area, and you become ill or run out of your covered Part D prescription drugs. We will cover prescriptions that are filled at a Non–Plan Pharmacy according to our Medicare Part D formulary guidelines
  - If you are unable to obtain a covered drug in a timely manner within our Service Area because there is no Plan Pharmacy within a reasonable driving distance that provides 24-hour service. We may not cover your prescription if a reasonable person could have purchased the drug at a Plan Pharmacy during normal business hours
  - If you are trying to fill a prescription for a drug that is not regularly stocked at an accessible Plan Pharmacy or available through our mail-order pharmacy (including high-cost drugs)

Payment and reimbursement. If you go to a Non–Plan Pharmacy for the reasons listed, you may have to pay the full cost (rather than paying just your Copayment or Coinsurance) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a request for reimbursement as described in the "Requests for Payment" section. If we pay for the drugs you obtained from a Non–Plan Pharmacy, you may still pay more for your drugs than what you would have paid if you had gone to a Plan Pharmacy because you may be responsible for paying the difference between

Plan Pharmacy Charges and the price that the Non–Plan Pharmacy charged you.

Medicare Part D drugs

Medicare Part D covers most outpatient prescription drugs if they are sold in the United States and approved for sale by the federal Food and Drug Administration. Our Part D formulary includes all drugs that can be covered under Medicare Part D according to Medicare requirements. Please refer to "Medicare Part D drug *Formulary (List of Covered Drugs)*" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section for more information about this formulary.

Cost Sharing for Medicare Part D drugs. Unless you reach the Catastrophic Coverage Stage in a calendar year, you will pay the following Cost Sharing for covered Medicare Part D drugs:

- Generic drugs: **a $5 Copayment** for up to a 100-day supply
- For brand-name and specialty drugs: **a $10 Copayment** for up to a 100-day supply
- Injectable Part D vaccines: **no charge**
- Emergency contraceptive pills: **no charge**
- The following insulin-administration devices at **a $5 Copayment** for up to a 100-day supply: needles, syringes, alcohol swabs, and gauze

Note: Medicare's Coverage Gap Discount Program may provide manufacturer discounts on brand name drugs if (1) you are not already receiving Extra Help, (2) Medicare is not secondary for you, and (3) the amount that you and any Medicare Part D plan spend for your covered Part D drugs reaches $2,930 in a calendar year.

When applicable, we will automatically apply Medicare's discount when you pay your prescription Copayment or Coinsurance and your *Explanation of Benefits* will show any discount provided. The amount discounted by the manufacturer counts toward your out-of-pockets costs as if you had paid the amount.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact our Member Service Call Center.

Catastrophic Coverage Stage. All Medicare prescription drug plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend **$4,700** out-of-pocket during 2012. When the total amount you have paid for your Cost Sharing reaches **$4,700**, you will pay the following for the remainder of 2012:

- **a $3 Copayment** per prescription for insulin administration devices and generic drugs
- **a $10 Copayment** per prescription for brand-name and specialty drugs
- Injectible Part D vaccines: **no charge**
- Emergency contraceptive pills: **no charge**

Note: Each year, effective on January 1, the Centers for Medicare & Medicaid Services may change coverage thresholds and catastrophic coverage Copayments that apply for the calendar year. We will notify you in advance of any change to your coverage.

These payments <u>are</u> included in your out-of-pocket costs. When you add up your out-of-pocket costs, you can include the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in this "Outpatient Prescription Drugs, Supplies, and Supplements" section):

- The amount you pay for drugs when you are in the Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our Plan

It matters who pays:

- If you make these payments yourself, they are included in your out-of-pocket costs
- These payments are also included if they are made on your behalf by certain other individuals or organizations. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, or by the Indian Health Service. Payments made by Medicare's Extra Help Program are also included
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand-name drugs is included

These payments are <u>not</u> included in your out-of-pocket costs. When you add up your out-of-pocket costs, you are not allowed to include any of these types of payments for prescription drugs:

- The amount you contribute, if any, toward your group's Premium
- Drugs you buy outside the United States and its territories
- Drugs that are not covered by our Plan

- Drugs you get at an out-of-network pharmacy that do not meet our Plan's requirements for out-of-network coverage
- Prescription drugs covered by Part A or Part B
- Payments you make toward prescription drugs not normally covered in a Medicare prescription drug plan
- Payments for your drugs that are made by group health plans, including employer health plans
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Administration
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for Part D drugs, you are required to tell our Plan. Call our Member Service Call Center to let us know (phone numbers are on the cover of this *Evidence of Coverage*).

Keeping track of Medicare Part D drugs. The *Explanation of Benefits* is a document you will get for each month you use your Part D prescription drug coverage. The *Explanation of Benefits* will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your prescription drugs. An *Explanation of Benefits* is also available upon request from our Member Service Call Center.

Medicare's Extra Help Program

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

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

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

- 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048, 24 hours a day, seven days a week;
- The Social Security Office at 1-800-772-1213, between 7 am to 7 pm, Monday through Friday. TTY users should call 1-800-325-0778; or
- Your state Medicaid office

If you believe you have qualified for Extra Help and you believe that you are paying an incorrect Cost Sharing amount when you get your prescription at a Plan Pharmacy, we have established a process that allows you either to request assistance in obtaining evidence of your proper Cost Sharing level, or, if you already have the evidence, to provide this evidence to us. If you aren't sure what evidence to provide us, please contact a Plan Pharmacy or our Member Service Call Center. The evidence is often a letter from either your state Medicaid office or your Social Security office that confirms you are qualified for Extra Help.

You or your appointed representative may need to provide the evidence to a Plan Pharmacy when obtaining covered Part D prescriptions so that we may charge you the appropriate Cost Sharing amount until the Centers for Medicare & Medicaid Services updates its records to reflect your current status. Once the Centers for Medicare & Medicaid Services updates its records, you will no longer need to present the evidence to the Plan Pharmacy. Please provide your evidence in one of the following ways so we can forward it to the Centers for Medicare & Medicaid Services for updating:

- Write to Kaiser Permanente at:
  California Service Center
  Attn: Best Available Evidence
  P.O. Box 232407
  San Diego, CA 92193-2407
- Fax it toll free to 1-877-528-8579
- Take it to a Plan Pharmacy or your local Member Service office at a Plan Facility

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

If you qualify for Extra Help, we will send you an *Evidence of Coverage Rider for those who Receive Extra*

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

Medicare Part D drug *Formulary (List of Covered Drugs)*

Our Medicare Part D formulary is a list of covered drugs selected by our Plan in consultation with a team of health care providers, that represents the prescription therapies believed to be a necessary part of a quality treatment program. Our formulary must meet requirements set by Medicare and is approved by Medicare. Our formulary includes all drugs that can be covered under Medicare Part D according to Medicare requirements. For a complete, current listing of the Medicare Part D prescription drugs we cover, please visit our website at **kp.org/seniormedrx** or call our Member Service Call Center.

The presence of a drug on our formulary does not necessarily mean that your Plan Physician will prescribe it for a particular medical condition. Our drug formulary guidelines allow you to obtain Medicare Part D prescription drugs if a Plan Physician determines that they are medically necessary for your condition. If you disagree with your Plan Physician's determination, refer to "Your Part D Prescription Drugs: How to Ask For a Coverage Decision or Make an Appeal" in the "Coverage Decisions, Appeals, and Complaints" section.

Preferred and nonpreferred generic drugs listed in the formulary will be subject to the generic drug Copayment or Coinsurance listed under "Copayment and Coinsurance for Medicare Part D drugs" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section. Preferred and nonpreferred brand-name drugs, specialty drugs, and vaccines listed in the formulary will be subject to the brand-name Copayment or Coinsurance listed under "Copayment and Coinsurance for Medicare Part D drugs" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section.

You can get updated information about the drugs our Plan covers by visiting our website at **kp.org/seniormedrx**. You may also call our Member Service Call Center to find out if your drug is on the formulary or to request an updated copy of our formulary.

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

- Adding or removing drugs from the formulary
- Adding prior authorizations or other restrictions on a drug

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

If your prescription isn't listed on your copy of our formulary, you should first check the formulary on our website, which we update when there is a change. In addition, you may contact our Member Service Call Center to be sure it isn't covered. If Member Services confirms that we don't cover your drug, you have two options:

- You may ask your Plan Physician if you can switch to another drug that is covered by us
- You or your Plan Physician may ask us to make an exception (a type of coverage determination) to cover your Medicare Part D drug. See the "Coverage Decisions, Complaints, and Appeals" section for more information on how to request an exception

Transition policy. If you recently joined our Plan, you may be able to get a temporary supply of a Medicare Part D drug you were previously taking that may not be on our formulary or has other restrictions, during the first 90 days of your membership. Current members may also be affected by changes in our formulary from one year to the next. Members should talk to their Plan Physicians to decide if they should switch to a different drug that we cover or request a Part D formulary exception in order to get coverage for the drug. Please refer to our formulary

or our website, **kp.org/seniormedrx**, for more information about our Part D transition coverage.

Medicare Part D exclusions (non–Part D drugs). By law, certain types of drugs are not covered by Medicare Part D. If a drug is not covered by Medicare Part D, any amounts you pay for that drug will not count toward reaching the Catastrophic Coverage Stage. A Medicare Prescription Drug Plan can't cover a drug under Medicare Part D in the following situations:

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

In addition, by law, certain types of drugs or categories of drugs are not covered under Medicare Part D. These drugs include:

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

Note: In addition to the coverage provided under this Medicare Part D plan, you also have coverage for non–Part D drugs described under "Outpatient drugs covered by Medicare Part B" and "Other outpatient drugs, supplies, and supplements" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section. If a drug is not covered under Medicare Part D, please refer to those headings for information about your non–Part D drug coverage.

Other prescription drug coverage. If you have additional health care or drug coverage from another plan, you must provide that information to our Plan. The information you provide helps us calculate how much you and others have paid for your prescription drugs. In addition, if you lose or gain additional health care or prescription drug coverage, please call our Member Service Call Center to update your membership records.

Outpatient drugs covered by Medicare Part B

In addition to Medicare Part D drugs, we also cover the limited number of outpatient prescription drugs that are covered by Medicare Part B in accord with our Part D drug formulary. The following are the types of drugs that Medicare Part B covers:

- Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services
- Drugs you take using durable medical equipment (such as nebulizers) that was prescribed by a Plan Physician
- Clotting factors you give yourself by injection if you have hemophilia
- Immunosuppressive drugs, if Medicare paid for the transplant (or a group plan was required to pay before Medicare paid for it)
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Antigens
- Certain oral anticancer drugs and antinausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when Medically Necessary, topical anesthetics, and erythropoiesis-stimulating agents
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases

Cost Sharing for Medicare Part B drugs. You pay the following for Medicare Part B drugs:

- Generic drugs: **a $5 Copayment** for up to a 100-day supply
- Brand-name drugs, specialty drugs, and compounded products: **a $10 Copayment** for up to a 100-day supply

Note: Home infusion drugs covered by Medicare Part B are not described under this section (instead, please refer to "Certain intravenous drugs, supplies, and supplements").

Other outpatient drugs, supplies, and supplements

If a drug, supply, or supplement is not covered by Medicare Part B or D, we cover the following additional items in accord with our non–Part D drug formulary:

- Drugs for which a prescription is required by law that are not covered by Medicare Part B or D. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary applicable to non–Part D items
- Diaphragms, cervical caps, contraceptive rings, and contraceptive patches
- Disposable needles and syringes needed for injecting covered drugs, pen delivery devices, and visual aids required to ensure proper dosage (except eyewear), that are not covered by Medicare Part B or D
- Inhaler spacers needed to inhale covered drugs
- Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing
- Continuity non–Part D drugs: If this *Evidence of Coverage* is amended to exclude a non–Part D drug that we have been covering and providing to you under this *Evidence of Coverage*, we will continue to provide the non–Part D drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the federal Food and Drug Administration

Cost Sharing for other outpatient drugs, supplies, and supplements. The Cost Sharing for these items is as follows:

- Generic items (other than those described below in this "Cost Sharing for outpatient drugs, supplies, and supplements" section): **a $5 Copayment** for up to a 100-day supply
- Brand-name items, specialty drugs, and compounded products (other than those described below in this "Cost Sharing for outpatient drugs, supplies, and supplements" section): **a $10 Copayment** for up to a 100-day supply
- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria) and elemental dietary enteral formula when used as a primary therapy for regional enteritis: **no charge** for up to a 30-day supply
- Continuity drugs: **50 percent Coinsurance** for up to a 30-day supply in a 30-day period
- Diabetes urine-testing supplies: **no charge** for up to a 100-day supply
- Diaphragms and cervical caps: **a $10 Copayment per item**

Non–Part D drug formulary. Our non–Part D drug formulary includes the list of drugs that have been approved by our Pharmacy and Therapeutics Committee for our Members. Our Pharmacy and Therapeutics Committee, which is primarily composed of Plan Physicians, selects drugs for the drug formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature. The Pharmacy and Therapeutics Committee meets quarterly to consider additions and deletions based on new information or drugs that become available. If you would like to request a copy of our non–Part D drug formulary, please call our Member Service Call Center. Note: The presence of a drug on our drug formulary does not necessarily mean that your Plan Physician will prescribe it for a particular medical condition.

Our drug formulary guidelines allow you to obtain nonformulary prescription drugs (those not listed on our drug formulary for your condition) if they would otherwise be covered and a Plan Physician determines that they are Medically Necessary. If you disagree with your Plan Physician's determination that a nonformulary prescription drug is not Medically Necessary, you may file an appeal as described in the "Coverage Decisions, Appeals, and Complaints" section. Also, our non–Part D formulary guidelines may require you to participate in a behavioral intervention program approved by the Medical Group for specific conditions and you may be required to pay for the program.

Certain intravenous drugs, supplies, and supplements

We cover certain self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as an intravenous or intraspinal-infusion) at **no charge** for up to a 30-day supply. In addition, we cover the supplies and equipment required for the administration of these drugs at **no charge**.

Drug utilization review

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

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

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

Medication therapy management programs

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

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.

ID card at Plan Pharmacies

You must present your Kaiser Permanente ID card when obtaining covered items from Plan Pharmacies that are not owned and operated by Kaiser Permanente. If you do not have your ID card, the Plan Pharmacy may require you to pay Charges for your covered items, and you will have to file a claim for reimbursement as described in the "Requests for Payment" section.

Notes:

- If Charges for a covered item are less than the Copayment, you will pay the lesser amount
- Durable medical equipment used to administer drugs, such as diabetes insulin pumps (and their supplies), and diabetes blood-testing equipment (and their supplies) are not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section (instead, refer to "Durable Medical Equipment for Home Use" in this "Benefits and Cost Sharing" section)
- Except for vaccines covered by Medicare Part D, drugs administered to you in a Plan Medical Office or during home visits are not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section (instead, refer to "Outpatient Care" in this "Benefits and Cost Sharing" section)
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility are not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section (instead, refer to "Hospital Inpatient Care" and "Skilled Nursing Facility Care" in this "Benefits and Cost Sharing" section)

Outpatient prescription drugs, supplies, and supplements limitations

Day supply limit. Plan Physicians determine the amount of a drug or other item that is Medically Necessary for a particular day supply for you. Upon payment of the Cost Sharing specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section, you will receive the supply prescribed up to a 100-day supply in a 100-day period. However, the Plan Pharmacy may reduce the day supply dispensed to a 30-day supply in any 30-day period at the Cost Sharing listed in this "Outpatient Prescription Drugs, Supplies, and Supplements" section if the Plan Pharmacy determines that the drug is in limited supply in the market or a 31-day supply in any 31-day period if the item is dispensed by a long term care facility's pharmacy. Plan Pharmacies may also limit the quantity dispensed as described under "Utilization management." If you wish to receive more than the covered day supply limit, then the additional amount is not covered and you must pay Charges for any prescribed quantities that exceed the day supply limit. The amount you pay for noncovered drugs does not count toward reaching the Catastrophic Coverage Stage.

Utilization management. For certain items, we have additional coverage requirements and limits that help promote effective drug use and help us control drug plan costs. Examples of these utilization management tools are:

- **Quantity limits:** The Plan Pharmacy may reduce the day supply dispensed at the Cost Sharing specified in this "Outpatient Drugs, Supplies, and Supplements" section to a 30-day supply in any 30-day period for specific drugs. Your Plan Pharmacy can tell you if a drug you take is one of these drugs. In addition, we cover episodic drugs prescribed for the treatment of sexual dysfunction up to a maximum of 8 doses in any 30-day period, up to 16 doses in any 60-day period, or up to 27 doses in any 100-day period. Also, when there is a shortage of a drug in the marketplace and the amount of available supplies, we may reduce the quantity of the drug dispensed accordingly and charge one cost share
- **Generic substitution:** When there is a generic version of a brand-name drug available, Plan Pharmacies will automatically give you the generic version, unless your Plan Physician has specifically requested a formulary exception because it is Medically Necessary for you to receive the brand-name drug instead of the formulary alternative

Outpatient prescription drugs, supplies, and supplements exclusions

- Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging
- Compounded products unless the active ingredient in the compounded product is listed on one of our drug formularies
- Drugs prescribed to shorten the duration of the common cold

Prosthetic and Orthotic Devices

We cover the prosthetic and orthotic devices specified in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor that we select

Coverage includes fitting and adjustment of these devices, their repair or replacement (unless due to misuse), and Services to determine whether you need a prosthetic or orthotic device. If we cover a replacement device, then you pay the Cost Sharing that you would pay for obtaining that device.

Internally implanted devices

We cover at **no charge** internal devices implanted during covered surgery, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, in accord with Medicare guidelines.

External devices

We cover the following external prosthetic and orthotic devices at **20 percent Coinsurance**:

- Prosthetics and orthotics in accord with Medicare guidelines. These include braces, prosthetic shoes, artificial limbs, and therapeutic footwear for severe diabetes-related foot disease in accord with Medicare guidelines
- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect
- Other covered prosthetic and orthotic devices:
  - prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity
  - orthotic devices required to support or correct a defective body part in accord with Medicare guidelines

Services not covered under this "Prosthetic and Orthotic Devices" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Eyeglasses and contact lenses (refer to "Vision Services")

Prosthetic and orthotic devices exclusions

- Dental appliances
- Nonrigid supplies not covered by Medicare, such as elastic stockings and wigs, except as otherwise described above in this "Prosthetic and Orthotic Devices" section
- Comfort, convenience, or luxury equipment or features
- Shoes or arch supports, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications
- Nonconventional intraocular lenses (IOLs) following cataract surgery (for example, presbyopia-correcting IOLs). You may request and we may provide insertion of presbyopia-correcting IOLs or astigmatism-correcting IOLs following cataract surgery in lieu of conventional IOLs. However, you must pay the difference between Charges for nonconventional IOLs and associated services and Charges for insertion of conventional IOLs following cataract surgery

Reconstructive Surgery

We cover the following reconstructive surgery Services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Plan Physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible
- Following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas

You pay the following for covered reconstructive surgery Services:

- Outpatient consultations, exams, and treatment: **a $10 Copayment per visit**
- Outpatient surgery: **a $10 Copayment per procedure**
- Hospital inpatient care (including room and board, drugs, and Plan Physician Services): **no charge**

Services not covered under this "Reconstructive Surgery" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")

Reconstructive surgery exclusions

- Surgery that, in the judgment of a Plan Physician specializing in reconstructive surgery, offers only a minimal improvement in appearance
- Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance

Religious Nonmedical Health Care Institution Services

Care in a Medicare-certified Religious Nonmedical Health Care Institution (RNHCI) is covered by our Plan under certain conditions. Covered Services in an RNHCI are limited to nonreligious aspects of care. To be eligible for covered Services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital or Skilled Nursing Facility care. You may get Services furnished in the home, but only items and Services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "nonexcepted" medical treatment. ("Excepted" medical treatment is a Service or treatment that you receive involuntarily or that is required under federal, state, or local law. "Nonexcepted" medical treatment is any other Service or treatment.) Your stay in the RNHCI is not covered by us unless you obtain authorization (approval) in advance from us.

Note: Covered Services are subject to the same limitations and Cost Sharing required for Services

provided by Plan Providers as described in this "Benefits and Cost Sharing" section.

Routine Services Associated with Clinical Trials

If you participate in a Medicare-approved clinical trial, Original Medicare (and not Senior Advantage) pays most of the routine costs for the covered Services you receive as part of the trial. When you are in a clinical trial, you may stay enrolled in Senior Advantage and continue to get the rest of your care (the care that is not related to the trial) through our plan.

If you want to participate in a Medicare-approved clinical trial, you don't need to get a referral from a Plan Provider, and the providers that deliver your care as part of the clinical trial don't need to be Plan Providers. Although you don't need to get a referral from a Plan Provider, you do need to tell us before you start participating in a clinical trial so we can keep track of your Services.

Once you join a Medicare-approved clinical trial, you are covered for routine Services you receive as part of the trial. Routine Services include room and board for a hospital stay that Medicare would pay for even if you weren't in a trial, an operation or other medical procedure if it is part of the trial, and treatment of side effects and complications arising from the new care.

Original Medicare pays most of the cost of the covered Services you receive as part of the trial. After Medicare has paid its share of the cost for these Services, we will pay the difference between the cost sharing of Original Medicare and your Cost Sharing as a Member of our plan. This means you will pay the same amount for the routine Services you receive as part of the trial as you would if you received these Services from our Plan.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the trial and how much you owe. Please see the "Requests for Payment" section for more information about submitting requests for payment.

To learn more about joining a clinical trial, please refer to the "Medicare and Clinical Research Studies" brochure. To get a free copy, call Medicare directly, toll free at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048) 24 hours a day, seven days a week, or visit **www.medicare.gov** on the Web.

Routine Services associated with clinical trials exclusions

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

- The new item or service that the study is testing, unless Medicare would cover the item or service even if you were not in a study
- Items or services provided only to collect data, and not used in your direct health care
- Services that are customarily provided by the research sponsors free of charge to enrollees in the clinical trial

Skilled Nursing Facility Care

Inside our Service Area, we cover at **no charge** up to 100 days per benefit period of skilled inpatient Services in a Plan Skilled Nursing Facility and in accord with Medicare guidelines. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care (defined in accord with Medicare guidelines). A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required. Note: If your Cost Sharing changes during a benefit period, you will continue to pay the previous Cost Sharing amount until a new benefit period begins.

We cover the following Services:

- Physician and nursing Services
- Room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment in accord with our durable medical equipment formulary and Medicare guidelines if Skilled Nursing Facilities ordinarily furnish the equipment
- Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Blood, blood products, and their administration

- Medical supplies
- Physical, occupational, and speech therapy in accord with Medicare guidelines
- Respiratory therapy

Services not covered under this "Skilled Nursing Facility Care" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Outpatient imaging, laboratory, and special procedures (refer to "Outpatient Imaging, Laboratory, and Special Procedures")

Non–Plan Skilled Nursing Facility care

Generally, you will get your Skilled Nursing Facility care from Plan Facilities. However, under certain conditions listed below, you may be able to receive covered care from a non–Plan facility, if the facility accepts our Plan's amounts for payment.

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

Transplant Services

We cover transplants of organs, tissue, or bone marrow in accord with Medicare guidelines and if the Medical Group provides a written referral for care to a transplant facility as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

After the referral to a transplant facility, the following applies:

- If either the Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will only cover Services you receive before that determination is made
- Health Plan, Plan Hospitals, the Medical Group, and Plan Physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with our guidelines for Services for living transplant donors, we provide certain donation-related Services for a donor, or an individual identified by the Medical Group as a potential donor, whether or not the donor is a Member. These Services must be directly related to a covered transplant for you, which may include certain Services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Our guidelines for donor Services are available by calling our Member Service Call Center

For covered transplant Services that you receive, you will pay the **Cost Sharing you would pay if the Services were not related to a transplant**. For example, see "Hospital Inpatient Care" in this "Benefits and Cost Sharing" section for the Cost Sharing that applies for hospital inpatient care.

We provide or pay for donation-related Services for actual or potential donors (whether or not they are Members) in accord with our guidelines for donor Services at **no charge**.

Services not covered under this "Transplant Services" section

Coverage for the following Services is described under these headings in this "Benefits and Cost Sharing" section:

- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Vision Services

We cover the following:

- Glaucoma screenings in accord with Medicare guidelines and eye exams for refraction to determine the need for vision correction and to provide a prescription for eyeglass lenses: **a $10 Copayment per visit**

Optical Services

We cover the Services described in this "Optical Services" section at Plan Medical Offices or Plan Optical Sales Offices.

The date we provide an Allowance toward (or otherwise cover) an item described in this "Optical Services" section is the date on which you order the item. For example, if we last provided an Allowance toward an item you ordered on May 1, 2010, and if we provide an Allowance not more than once every 24 months for that type of item, then we would not provide another Allowance toward that type of item until on or after May 1, 2012. You can use the Allowances under this "Optical

Services" section only when you first order an item. If you use part but not all of an Allowance when you first order an item, you cannot use the rest of that Allowance later.

Eyeglasses and contact lenses. We provide a single **$150 Allowance** toward the purchase price of any or all of the following not more than once every 24 months when a physician or optometrist prescribes an eyeglass lens (for eyeglass lenses and frames) or contact lens (for contact lenses):

- Eyeglass lenses when a Plan Provider puts the lenses into a frame
- Eyeglass frames when a Plan Provider puts two lenses (at least one of which must have refractive value) into the frame
- Contact lenses, fitting, and dispensing

We will not provide the Allowance if we have provided an Allowance toward (or otherwise covered) eyeglass lenses or frames within the previous 24 months.

Replacement lenses. If you have a change in prescription of at least .50 diopter in one or both eyes within 12 months of the initial point of sale of an eyeglass lens or contact lens that we provided an Allowance toward (or otherwise covered) we will provide an Allowance toward the purchase price of a replacement item of the same type (eyeglass lens, or contact lens, fitting, and dispensing) for the eye that had the .50 diopter change. The Allowance toward one of these replacement lenses is **$30** for a single vision eyeglass lens or for a contact lens (including fitting and dispensing) and **$45** for a multifocal or lenticular eyeglass lens.

Special contact lenses for aniridia and aphakia. We cover the following special contact lenses when prescribed by a Plan Physician or Plan Optometrist:

- Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris): **no charge**. We will not cover an aniridia contact lens if we provided an Allowance toward (or otherwise covered) more than one aniridia contact lens for that eye within the previous 12 months (including when we provided an Allowance toward, or otherwise covered, one or more aniridia contact lenses under any other evidence of coverage offered by your Group)
- In accord with Medicare guidelines, we cover at **no charge** corrective lenses (including contact lens fitting and dispensing) and frames (and replacements) for Members who are aphakic (for example, who have had a cataract removed but do not have an implanted intraocular lens (IOL) or who have congenital absence of the lens)

Special contact lenses that provide a significant vision improvement not obtainable with eyeglasses. If a Plan Physician or Plan Optometrist prescribes contact lenses (other than contact lenses for aniridia or aphakia) that will provide a significant improvement in your vision that eyeglass lenses cannot provide, we cover either one pair of contact lenses (including fitting and dispensing) or an initial supply of disposable contact lenses (including fitting and dispensing) not more than once every 24 months at **no charge**. We will not cover any contact lenses under this "Special contact lenses that provide a significant vision improvement not obtainable with eyeglasses" section if we provided an Allowance toward (or otherwise covered) a contact lens within the previous 24 months, but not including any of the following:

- Contact lenses for aniridia or aphakia
- Contact lenses we provided an Allowance toward (or otherwise covered) under "Eyeglasses and contact lenses following cataract surgery" in this "Vision Services" section as a result of cataract surgery

Eyeglasses and contact lenses following cataract surgery. We cover at **no charge** one pair of eyeglasses or contact lenses (including fitting or dispensing) following each cataract surgery that includes insertion of an intraocular lens when prescribed by a physician or optometrist. When multiple cataract surgeries are needed, and you do not obtain eyeglasses or contact lenses between procedures, we will only cover one pair of eyeglasses or contact lenses after any surgery. If the eyewear you purchase costs more than what Medicare covers for someone who has Original Medicare (also known as "Fee-for-Service Medicare"), you pay the difference.

Services not covered under this "Vision Services" section

Coverage for the following Services is described under other headings in this "Benefits and Cost Sharing" section:

- Services related to the eye or vision other than Services covered under this "Vision Services" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits and Cost Sharing" section)

Vision Services exclusions

- Industrial frames

- Lenses and sunglasses without refractive value, except that this exclusion does not apply to any of the following:
  - a clear balance lens if only one eye needs correction
  - tinted lenses when Medically Necessary to treat macular degeneration or retinitis pigmentosa
- Replacement of lost, broken, or damaged contact lenses, eyeglass lenses, and frames, but not including eyeglass lenses or frames we covered under "Eyeglasses and contact lenses following cataract surgery" in this "Vision Services" section
- Eyeglass or contact lens adornment, such as engraving, faceting, or jeweling
- Low-vision devices
- Items that do not require a prescription by law (other than eyeglass frames), such as eyeglass holders, eyeglass cases, and repair kits

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this *Evidence of Coverage* regardless of whether the services are within the scope of a provider's license or certificate. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the "Benefits and Cost Sharing" section.

Certain exams and Services

Physical exams and other Services (1) required for obtaining or maintaining employment or participation in employee programs, (2) required for insurance or licensing, or (3) on court order or required for parole or probation. This exclusion does not apply if a Plan Physician determines that the Services are Medically Necessary.

Chiropractic Services

Chiropractic Services and the Services of a chiropractor except for manual manipulation of the spine as described under "Outpatient Care" in the "Benefits and Cost Sharing" section.

Conception by artificial means

Except for artificial insemination covered under "Infertility Services" in the "Benefits and Cost Sharing" section, all other Services related to conception by artificial means, such as ovum transplants, gamete intrafallopian transfer (GIFT), semen and eggs (and Services related to their procurement and storage), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT).

Cosmetic Services

Services that are intended primarily to change or maintain your appearance, except that this exclusion does not apply to any of the following:

- Services covered under "Reconstructive Surgery" in the "Benefits and Cost Sharing" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "Benefits and Cost Sharing" section: testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after a mastectomy, and prostheses to replace all or part of an external facial body part

Custodial care

Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice for Members who do not have Part A, Skilled Nursing Facility, or inpatient hospital care.

Dental care

Dental care and dental X-rays, such as dental Services following accidental injury to teeth, dental appliances, dental implants, orthodontia, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment, except for Services covered in accord with Medicare guidelines or under "Dental Services for Radiation Treatment and Dental Anesthesia" in the "Benefits and Cost Sharing" section.

Disposable supplies

Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies.

This exclusion does not apply to disposable supplies covered in accord with Medicare guidelines or under "Durable Medical Equipment for Home Use," "Home Health Care," "Hospice Care," "Ostomy and Urological Supplies," and "Outpatient Prescription Drugs, Supplies,

and Supplements" in the "Benefits and Cost Sharing" section.

Experimental or investigational Services

A Service is experimental or investigational if we, in consultation with the Medical Group, determine that one of the following is true:

- Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients)
- It requires government approval that has not been obtained when the Service is to be provided

Hair loss or growth treatment

Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Intermediate care

Care in a licensed intermediate care facility. This exclusion does not apply to Services covered under "Durable Medical Equipment," "Home Health Care," and "Hospice Care" in the "Benefits and Cost Sharing" section.

Items and services that are not health care items and services

For example, we do not cover:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services that increase academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching you how to read, whether or not you have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play, or swimming
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy, except when ordered as part of a physical therapy program in accord with Medicare guidelines

Items and services to correct refractive defects of the eye

Items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism.

Massage therapy

Oral nutrition

Outpatient oral nutrition, such as dietary supplements, herbal supplements, weight loss aids, formulas, and food.

This exclusion does not apply to any of the following:

- Amino acid–modified products and elemental dietary enteral formula covered under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section
- Enteral formula covered under "Prosthetic and Orthotic Devices" in the "Benefits and Cost Sharing" section

Residential care

Care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a Skilled Nursing Facility, inpatient respite care covered in the "Hospice Care" section for Members who do not have Part A, a licensed facility providing crisis residential Services covered under "Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in the "Mental Health Services" section, or a licensed facility providing transitional residential recovery Services covered under the "Chemical Dependency Services" section.

Routine foot care items and services

Routine foot care items and services, except for Medically Necessary Services covered in accord with Medicare guidelines.

Services not approved by the federal Food and Drug Administration

Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other Services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S., but are not approved by the FDA. This exclusion applies to Services provided anywhere, even outside the U.S., unless the Services are covered under the "Emergency Services and Urgent Care" section.

Services not covered by Medicare

Services that aren't reasonable and necessary, according to the standards of the Original Medicare plan, unless these Services are otherwise listed in this *Evidence of Coverage* as a covered Service.

Services performed by unlicensed people

Services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the Member's condition does not require that the services be provided by a licensed health care provider.

Services related to a noncovered Service

When a Service is not covered, all Services related to the noncovered Service are excluded, except for Services we would otherwise cover to treat complications of the noncovered Service or if covered in accord with Medicare guidelines. For example, if you have a noncovered cosmetic surgery, we would not cover Services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and we would cover any Services that we would otherwise cover to treat that complication.

Surrogacy

Services for anyone in connection with a surrogacy arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. Please refer to "Surrogacy arrangements" under "Reductions" in this "Exclusions, Limitations, Coordination of Benefits, and Reductions" section for information, including your obligation to reimburse us for any Services we cover.

Transgender surgery

Travel and lodging expenses

Travel and lodging expenses, except for the following:

- In some situations if the Medical Group refers you to a Non–Plan Provider as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines. Our travel and lodging guidelines are available from our Member Service Call Center
- Reimbursement for travel and lodging expenses provided under "Bariatric Surgery" in the "Benefits and Cost Sharing" section

Limitations

We will make a good faith effort to provide or arrange for covered Services within the remaining availability of facilities or personnel in the event of unusual circumstances that delay or render impractical the provision of Services under this *Evidence of Coverage*, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor disputes. Under these circumstances, if you have an Emergency Medical Condition, call 911 or go to the nearest hospital as described under "Emergency Services" in the "Emergency Services and Urgent Care" section, and we will provide coverage and reimbursement as described in that section.

Additional limitations that apply only to a particular benefit are listed in the description of that benefit in the "Benefits and Cost Sharing" section.

Coordination of Benefits

If you have other medical or dental coverage, it is important to use your other coverage in combination with your coverage as a Senior Advantage Member to pay for the care you receive. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

You must tell us if you have other health care coverage, and let us know whenever there are any changes in your additional coverage. The types of additional coverage that you might have include the following:

- Coverage that you have from an employer's group health care coverage for employees or retirees, either through yourself or your spouse
- Coverage that you have under workers' compensation because of a job-related illness or injury, or under the Federal Black Lung Program
- Coverage you have for an accident where no-fault insurance or liability insurance is involved
- Coverage you have through Medicaid
- Coverage you have through the "TRICARE for Life" program (veteran's benefits)
- Coverage you have for dental insurance or prescription drugs
- "Continuation coverage" you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their

dependents keep their group health coverage for a time after they leave their group health plan under certain conditions)

When you have additional health care coverage, how we coordinate your benefits as a Senior Advantage Member with your benefits from your other coverage depends on your situation. With coordination of benefits, you will often get your care as usual from Plan Providers, and the other coverage you have will simply help pay for the care you receive. In other situations, such as benefits that we don't cover, you may get your care outside of our Plan directly through your other coverage.

In general, the coverage that pays its share of your bills first is called the "primary payer." Then the other company or companies that are involved (called the "secondary payers") each pay their share of what is left of your bills. Often your other coverage will settle its share of payment directly with us and you will not have to be involved. However, if payment owed to us is sent directly to you, you are required under Medicare law to give this payment to us. When you have additional coverage, whether we pay first or second, or at all, depends on what type or types of additional coverage you have and the rules that apply to your situation. Many of these rules are set by Medicare. Some of them take into account whether you have a disability or have end-stage renal disease, or how many employees are covered by an employer's group plan.

If you have additional health coverage, please call our Member Service Call Center to find out which rules apply to your situation, and how payment will be handled.

Reductions

Employer responsibility

For any Services that the law requires an employer to provide, we will not pay the employer; and, when we cover any such Services, we may recover the value of the Services from the employer.

Government agency responsibility

For any Services that the law requires be provided only by or received only from a government agency, we will not pay the government agency; and, when we cover any such Services, we may recover the value of the Services from the government agency.

Injuries or illnesses alleged to be caused by third parties

Third parties who cause you injury or illness (and/or their insurance companies) usually must pay first before Medicare or our Plan. Therefore, we are entitled to pursue these primary payments. If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered Services, you must pay us Charges for those Services, except that the amount you must pay will not exceed the maximum amount allowed under California Civil Code Section 3040. Note: This "Injuries or illnesses alleged to be caused by third parties" section does not affect your obligation to pay Cost Sharing for these Services, but we will credit any such payments toward the amount you must pay us under this section.

To the extent permitted or required by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney, but we will be subrogated only to the extent of the total of Charges for the relevant Services.

To secure our rights, we will have a lien on the proceeds of any judgment or settlement you or we obtain against a third party. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred.

Within 30 days after submitting or filing a claim or legal action against a third party, you must send written notice of the claim or legal action to:

Healthcare Recoveries, Inc.
Subrogation mailbox
9390 Bunsen Parkway
Louisville, KY 40220

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay us directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on your injury or illness, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate,

parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

Surrogacy arrangements

If you enter into a surrogacy arrangement, you must pay us Charges for covered Services you receive related to conception, pregnancy, or delivery in connection with that arrangement ("Surrogacy Health Services"), except that the amount you must pay will not exceed the compensation you are entitled to receive under the surrogacy arrangement. A surrogacy arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. Note: This "Surrogacy arrangements" section does not affect your obligation to pay Cost Sharing for these Services, but we will credit any such payments toward the amount you must pay us under this paragraph.

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or your chosen payee under the surrogacy arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments. Those payments shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Within 30 days after entering into a surrogacy arrangement, you must send written notice of the arrangement, including the names and addresses of the other parties to the arrangement, and a copy of any contracts or other documents explaining the arrangement, to:

Healthcare Recoveries, Inc.
Surrogacy mailbox
9390 Bunsen Parkway
Louisville, KY 40220

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy arrangements" section and to satisfy those rights. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on the surrogacy arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

U.S. Department of Veterans Affairs

For any Services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs, and when we cover any such Services we may recover the value of the Services from the Department of Veterans Affairs.

Workers' compensation or employer's liability benefits

Workers' compensation usually must pay first before Medicare or our Plan. Therefore, we are entitled to pursue primary payments under workers' compensation or employer's liability law. You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered Services from the following sources:

- From any source providing a Financial Benefit or from whom a Financial Benefit is due
- From you, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law

Requests for Payment

Requests for Payment of Covered Services or Part D drugs

If you pay our share of the cost of your covered Services or Part D drugs, or if you receive a bill, you can ask us for payment

Sometimes when you get a Service or a Part D drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of our Plan. In either case, you can ask us to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our Plan whenever you've paid more than your share of the cost for Services or Part D drugs that are covered by our Plan.

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

Here are examples of situations in which you may need to ask us to pay you back or to pay a bill you have received:

- **When you've received emergency, urgent, or dialysis care from a Non–Plan Provider.** You can receive emergency services from any provider, whether or not the provider is a Plan Provider. When you receive emergency, urgent, or dialysis care from a Non–Plan Provider, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill our Plan for our share of the cost
  - if you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made
  - at times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made. If the provider is owed anything, we will pay the provider directly. If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost
- **When a Plan Provider sends you a bill you think you should not pay.** Plan Providers should always bill us directly, and ask you only for your share of the cost
  - whenever you get a bill from a Plan Provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem
  - if you have already paid a bill to a Plan Provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under our Plan
- **If you are retroactively enrolled in our Plan.** Sometimes a person's enrollment in our Plan is retroactive. ("Retroactive" means that the first day of their enrollment has already past. The enrollment date may even have occurred last year.) If you were retroactively enrolled in our Plan and you paid out-of-pocket for any of your covered Services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement. Please call our Member Service Call Center for additional information about how to ask us to pay you back and deadlines for making your request
- **When you use a Non–Plan Pharmacy to get a prescription filled.** If you go to a Non–Plan Pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. We cover prescriptions filled at Non–Plan Pharmacies only in a few special situations. Please see "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section to learn more
  - save your receipt and send a copy to us when you ask us to pay you back for our share of the cost
- **When you pay the full cost for a prescription because you don't have your Plan membership card with you.** If you do not have your Plan membership card with you, you can ask the pharmacy to call us or to look up your Plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself
  - save your receipt and send a copy to us when you ask us to pay you back for our share of the cost
- **When you pay the full cost for a prescription in other situations.** You may pay the full cost of the prescription because you find that the drug is not covered for some reason
  - for example, the drug may not be on our Plan's *Formulary (List of Covered Drugs)*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it
  - save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost
- **When you pay copayments under a drug manufacturer patient assistance program.** If you get help from, and pay copayments under, a drug manufacturer patient assistance program outside our plan's benefit, you may submit a paper claim to have your out-of-pocket expense count toward qualifying you for catastrophic coverage

- save your receipt and send a copy to us

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. The "Coverage Decisions, Appeals, and Complaints" section has information about how to make an appeal.

How to Ask Us to Pay You Back or to Pay a Bill You Have Received

How and where to send us your request for payment

To file a claim, this is what you need to do:

- As soon as possible, request our claim form by calling our Member Service Call Center toll free at 1-800-443-0815 or 1-800-390-3510 (TTY users call 1-800-777-1370). One of our representatives will be happy to assist you if you need help completing our claim form
- If you have paid for Services, you must send us your request for reimbursement. Please attach any bills and receipts from the Non–Plan Provider
- You must complete and return to us any information that we request to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled. For example, we may require documents such as travel documents or original travel tickets to validate your claim
- The completed claim form must be mailed to the following address as soon as possible, but no later than 15 months after receiving the care (or up to 27 months according to Medicare rules, in some cases). Please do not send any bills or claims to Medicare. Any additional information we request should also be mailed to this address:

  Kaiser Foundation Health Plan, Inc.
  Claims Department
  P.O. Box 24010
  Oakland, CA 94623-1010

Note: If you are requesting payment of a Part D drug that was prescribed by a Plan Provider and obtained from a Plan Pharmacy, write to:

Kaiser Foundation Health Plan, Inc.
Part D Unit
P.O. Box 23170
Oakland, CA 94623-0170

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

We Will Consider Your Request for Payment and Say *Yes* or *No*

We check to see whether we should cover the Service or Part D drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the Service or Part D drug is covered and you followed all of the rules for getting the care or Part D drug, we will pay for our share of the cost. If you have already paid for the Service or Part D drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the Service or Part D drug yet, we will mail the payment directly to the provider
- If we decide that the Service or Part D drug is not covered, or you did not follow all of the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision

If we tell you that we will not pay for all or part of the Service or Part D drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment, or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details on how to make this appeal, go to the "Coverage Decisions, Appeals, and Complaints" section. The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading "A Guide to the Basics of Coverage Decisions and Appeals" in the "Coverage Decisions, Appeals, and Complaints" section, which is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then, after you have read "A Guide to the Basics of Coverage Decisions and Appeals," you can go to the section in "Coverage Decisions, Appeals, and Complaints" that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a Service, go to "Step-by-step: How to make

a Level 2 appeal" under "Your Medical Care: How to Ask for a Coverage Decision or Make an Appeal" in the "Coverage Decisions, Appeals, and Complaints" section

- If you want to make an appeal about getting paid back for a Part D drug, go to "Step-by-step: How to make a Level 2 appeal" under "Your Part D Prescription Drugs: How to Ask for a Coverage Decision or Make an Appeal" in the "Coverage Decisions, Appeals, and Complaints" section

Other Situations in Which You Should Save Your Receipts and Send Copies to Us

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

There are some situations when you should let us know about payments you have made for your covered Part D prescription drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here is one situation when you should send us copies of receipts to let us know about payments you have made for your drugs:

- **When you get a drug through a patient assistance program offered by a drug manufacturer.** Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside our Plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program
  - ♦ save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage
  - ♦ note: Because you are getting your drug through the patient assistance program and not through our Plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly

Since you are not asking for payment in the case described above, this situation is not considered a coverage decision. Therefore, you cannot make an appeal if you disagree with our decision.

Coverage Decisions, Appeals, and Complaints

What to Do if You Have a Problem or Concern

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

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

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

Which one do you use? That depends upon the type of problem you are having. The guide under "To Deal with Your Problem, Which Process Should You Use?" in this "Coverage Decisions, Appeals, and Complaints" section will help you identify the right process to use.

Other dispute resolution options

Benefits not covered by Medicare. Your Group may have chosen to cover benefits under this Senior Advantage *Evidence of Coverage* that are not covered by Medicare. For any such benefits, Medicare rules do not apply (including the Medicare appeal process). If you have an issue relating to a benefit covered by your Group plan that is not covered by Medicare, please contact our Member Service Call Center for information about our non-Medicare appeal process for non-Medicare coverage issues.

Hospice care. If you have Medicare Part A, your hospice care is covered by Original Medicare and it is **not covered** under this *Evidence of Coverage*. Therefore, any complaints related to the coverage of hospice care must be resolved directly with Medicare and not through any complaint or appeal procedure discussed in this *Evidence of Coverage*. Medicare complaint and appeal procedures are described in the Medicare handbook *Medicare & You*, which is available from your local Social Security office, at www.medicare.gov, or by calling toll free 1-800-MEDICARE/1-800-633-4227 (TTY users call 1-877-486-2048) 24 hours a day, seven days a week. If you do not have Medicare Part A, Original Medicare does not cover hospice care. Instead, we will provide hospice care, and any complaints related to hospice care

are subject to this "Coverage Decisions, Appeals, and Complaints" section.

What about the legal terms?

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

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

However, it can be helpful, and sometimes quite important, for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation.

You Can Get Help from Government Organizations That Are Not Connected with Us

Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your State Health Insurance Assistance Program. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of State Health Insurance Assistance Program counselors are free. You will find phone numbers in the "Important Phone Numbers and Resources" section.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, seven days a week. TTY users should call 1-877-486-2048
- You can visit the Medicare website (www.medicare.gov)

To Deal with Your Problem, Which Process Should You Use?

Should you use the process for coverage decisions and appeals? Or, should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this section that apply to your situation. The guide that follows will help.

To figure out which part of this section will help you with your specific problem or concern, START HERE:

- **Is your problem or concern about your benefits or coverage?** (This includes problems about whether particular Services or Part D drugs are covered or not, the way in which they are covered, and problems related to payment for Services or Part D drugs)
  - **yes, my problem is about benefits or coverage:** Go on to "A Guide to the Basics of Coverage Decisions and Appeals"
  - **no, my problem is not about benefits or coverage:** Skip ahead to "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns"

A Guide to the Basics of Coverage Decisions and Appeals

Asking for coverage decisions and making appeals—*The big picture*

The process for coverage decisions and making appeals deals with problems related to your benefits and coverage for Services and Part D drugs, including problems related to payment. This is the process you use for issues such as whether something is covered or not, and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Services or Part D drugs. For example, your Plan Physician makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your Plan Physician refers you to a medical specialist. You can also contact us and ask for a coverage decision if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a service or Part D drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you make an appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision.

If we say ***no*** to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an independent organization that is not connected with us. (In some situations, your case will be automatically sent to the independent organization for a Level 2 Appeal. If this happens, we will let you know. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You can call our Member Service Call Center (phone numbers are on the cover of this *Evidence of Coverage*)
- To get free help from an independent organization that is not connected with us, contact your State Health Insurance Assistance Program (see the "Important Phone Numbers and Resources" section)
- Your doctor or other provider can make a request for you. Your doctor or other provider can request a coverage decision or a Level 1 Appeal on your behalf. To request any appeal after Level 1, your doctor or other provider must be appointed as your representative
- You can ask someone to act on your behalf. If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal
  - there may be someone who is already legally authorized to act as your representative under state law
  - if you want a friend, relative, your doctor or other provider, or other person to be your representative, call our Member Service Call Center and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and by the person whom you would like to act on your behalf. You must give us a copy of the signed form
- You also have the right to hire a lawyer to act for you. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision

Which section gives the details for your situation?

There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- "Your Medical Care: How to Ask for a Coverage Decision or Make an Appeal"
- "Your Part D prescription Drugs: How to Ask for a Coverage Decision or Make an Appeal"
- "How to Ask Us to Cover a Longer Inpatient Hospital Stay if You Think the Doctor Is Discharging You Too Soon"
- "How to Ask Us to Keep Covering Certain Medical Services if You Think Your Coverage is Ending Too Soon" (applies to these Services only: home health

care, Skilled Nursing Facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) Services)

If you're not sure which section you should be using, please call our Member Service Call Center (phone numbers are on the cover of this *Evidence of Coverage*). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (the "Important Phone Numbers and Resources" section has the phone numbers for this program).

Your Medical Care: How to Ask for a Coverage Decision or Make an Appeal

This section tells what to do if you have problems getting coverage for Services or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for Services. These benefits are described in the "Benefits and Cost Sharing" section.

This section tells what you can do if you are in any of the five following situations:

1) You are not getting certain Services you want, and you believe that this care is covered by our Plan.
2) Our Plan will not approve the Services your doctor or other medical provider wants to give you, and you believe that this care is covered by our Plan.
3) You have received Services that you believe should be covered by us, but we have said we will not pay for this care.
4) You have received and paid for Services that you believe should be covered by us, and you want to ask us to reimburse you for this care.
5) You are being told that coverage for certain Services you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
    - Note: If the coverage that will be stopped is for hospital care, home health care, Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) Services, you need to read a separate section because special rules apply to these types of care. Here's what to read in those situations:
        - go to "How to Ask Us to Cover a Longer Inpatient Hospital Stay if You Think the Doctor Is Discharging You Too Soon"
        - go to "How to Ask Us to Keep Covering Certain Medical Services if You Think Your Coverage Is Ending Too Soon." This section is about three Services only: home health care, Skilled Nursing Facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) Services

For all other situations that involve being told that the Services you have been getting will be stopped, use this "Your Medical Care: How to Ask for a Coverage Decision or Make an Appeal" section as your guide for what to do.

Which of these situations are you in?

- Do you want to find out whether we will cover the Services you want?
    - you can ask us to make a coverage decision for you. **Go to "Step-by-step: How to ask for a coverage decision"**
- Have we already told you that we will not cover or pay for a Service in the way that you want it to be covered or paid for?
    - you can make an appeal. (This means you are asking us to reconsider.) **Skip ahead to "Step-by-step: How to make a Level 1 Appeal"**
- Do you want to ask us to pay you back for Services you have already received and paid for?
    - you can send us the bill. **Skip ahead to "What if you are asking us to pay you for our share of a bill you have received for Services?"**

Step-by-step: How to ask for a coverage decision (how to ask us to authorize or provide the Services you want)

Step 1: You ask us to make a coverage decision on the Services you are requesting. If your health requires a quick response, you should ask us to make a "fast decision." A "fast decision" is also called an "expedited determination."

How to request coverage for the Services you want

- Start by calling, writing, or faxing our Plan to make your request for us to provide coverage for the Services you want. You, your doctor, or your representative can do this
- For the details on how to contact us, go to "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your Services" in the "Important Phone Numbers and Resources" section

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard decision means we will give you an answer within 14 calendar days after we receive your request.

- However, we can take up to 14 more calendar days if you ask for more time, or if we need information (such as medical records) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section)

If your health requires it, ask us to give you a "fast decision"

- **A fast decision means we will answer within 72 hours**
  - however, we can take up to 14 more calendar days if we find that some information that may benefit you is missing, or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing
  - if you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section.) We will call you as soon as we make the decision
- **To get a fast decision, you must meet two requirements:**
  - you can get a fast decision only if you are asking for coverage for Services you have not yet received. (You cannot get a fast decision if your request is about payment for Services you have already received)
  - you can get a fast decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function
- **If your doctor tells us that your health requires a "fast decision,"** we will automatically agree to give you a fast decision
- **If you ask for a fast decision on your own, without your doctor's support,** we will decide whether your health requires that we give you a fast decision
  - if we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead)
  - this letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision
  - the letter will also tell how you can file a "fast complaint" about our decision to give you a standard decision instead of the fast decision you requested. (For more information about the process for making complaints, including fast complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section)

Step 2: We consider your request for Services and give you our answer

Deadlines for a "fast" coverage decision

- Generally, for a fast decision, we will give you our answer within 72 hours
  - as explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing
  - if you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section)
  - if we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. "Step-by-step: How to make a Level 1 Appeal" below tells how to make an appeal
- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the Services we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period

- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said ***no***

Deadlines for a "standard" coverage decision

- Generally, for a standard decision, we will give you our answer within 14 calendar days of receiving your request
  - we can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the decision, we will tell you in writing
  - if you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section)
  - if we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), you have the right to appeal. "Step-by-step: How to make a Level 1 Appeal" below tells how to make an appeal
- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 14 calendar days after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said ***no***

Step 3: If we say *no* to your request for coverage for Services, you decide if you want to make an appeal

- If we say ***no***, you have the right to ask us to reconsider, and perhaps change this decision by making an appeal. Making an appeal means making another try to get the Services you want
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see "Step-by-step: How to make a Level 1 Appeal" below)

Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our Plan)

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a "fast appeal"

An appeal to our Plan about a medical care coverage decision is called a Plan "reconsideration."

What to do

- **To start an appeal, you, your doctor, or your representative must contact us.** For details on how to reach us for any purpose related to your appeal, go to "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your Services" in the "Important Phone Numbers and Resources" section
- If you are asking for a standard appeal, **make your standard appeal in writing by submitting a signed request**
  - if you have someone appealing our decision for you other than your doctor, your appeal must include an Appointment of Representative form authorizing this person to represent you. (To get the form, call Member Services and ask for the "Appointment of Representative" form. It is also available on Medicare's website at http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.) While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form within 44 days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be sent to the Independent Review Organization for dismissal
- **If you are asking for a fast appeal, make your appeal in writing or call us** (see "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your Services" in the "Important Phone Numbers and Resources" section)
- **You must make your appeal request within 60 calendar days from the date on the written notice** we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal

- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal**
  - you have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you
  - if you wish, you and your doctor may give us additional information to support your appeal

If your health requires it, ask for a "fast appeal" (you can make a request by calling us)

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal"
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast decision." To ask for a fast appeal, follow the instructions for asking for a fast decision. (These instructions are given earlier in this section)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal

Step 2: We consider your appeal and we give you our answer

- When we are reviewing your appeal, we take another careful look at all of the information about your request for coverage of Services. We check to see if we were following all of the rules when we said ***no*** to your request
- We will gather more information if we need it. We may contact you or your doctor to get more information

Deadlines for a "fast" appeal

A "fast appeal" is also called an "expedited reconsideration."

- When we are using the fast deadlines, we must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires us to do so
  - however, if you ask for more time, or if we need to gather more information that may benefit you, we can take up to 14 more calendar days. If we decide to take extra days to make the decision, we will tell you in writing
  - if we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process
- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal
- If our answer is ***no*** to part or all of what you requested, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal

Deadlines for a "standard" appeal

- If we are using the standard deadlines, we must give you our answer within 30 calendar days after we receive your appeal if your appeal is about coverage for Services you have not yet received. We will give you our decision sooner if your health condition requires us to
  - however, if you ask for more time, or if we need to gather more information that may benefit you, we can take up to 14 more calendar days
  - if you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section)
  - if we do not give you an answer by the deadline above (or by the end of the extended time period if we took extra days), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent, outside organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process
- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 30 calendar days after we receive your appeal
- If our answer is ***no*** to part or all of what you requested, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal

Step 3: If our Plan says ***no*** to part or all of your appeal, your case will automatically be sent on to the next level of the appeals process

- To make sure we were following all of the rules when we said ***no*** to your appeal, we are required to send your appeal to the Independent Review Organization. When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2

Step-by-step: How to make a Level 2 Appeal

If we say ***no*** to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the Independent Review Organization reviews the decision we made when we said ***no*** to your first appeal. This organization decides whether the decision we made should be changed. The formal name for the Independent Review Organization is the "Independent Review Entity." It is sometimes called the "IRE."

Step 1: The Independent Review Organization reviews your appeal

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work. (For more information about this organization, refer to the "Important Phone Numbers and Resources" section)
- We will send the information about your appeal to this organization. This information is called your "case file." You have the right to ask us for a copy of your case file. We are allowed to charge you a fee for copying and sending this information to you
- You have a right to give the Independent Review Organization additional information to support your appeal
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal

If you had a "fast" appeal at Level 1, you will also have a "fast" appeal at Level 2

- If you made a fast appeal to our Plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 72 hours of when it receives your appeal
- However, if the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days

If you had a "standard" appeal at Level 1, you will also have a "standard" appeal at Level 2

- If you made a standard appeal to our Plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 30 calendar days of when it receives your appeal
- However, if the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days

Step 2: The Independent Review Organization gives you their answer

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- If the review organization says ***yes*** to part or all of what you requested, we must authorize the Services within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization
- If this organization says ***no*** to part or all of your appeal, it means they agree with us that your request (or part of your request) for coverage for Services should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal")
  - the written notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the Services you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal)
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal
- The Level 3 Appeal is handled by an administrative law judge. "Taking Your Appeal to Level 3 and Beyond" in this "Coverage Decisions, Appeals, and

Complaints" section tells more about Levels 3, 4, and 5 of the appeals process

What if you are asking us to pay you for our share of a bill you have received for Services?

If you want to ask us for payment for Services, start by reading the "Requests for Payment" section, which describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see "Asking for coverage decisions and making appeals—*The big picture*" in this "Coverage Decisions, Appeals, and Complaints" section). To make this coverage decision, we will check to see if the Service you paid for is a covered Service (see the "Benefits and Cost Sharing" section). We will also check to see if you followed all of the rules for using your coverage for Services (these rules are given in the "How to Obtain Services" section.

We will say *yes* or *no* to your request

- If the Service you paid for is covered and you followed all of the rules, we will send you the payment for our share of the cost of your Services within 60 calendar days after we receive your request. Or, if you haven't paid for the Services, we will send the payment directly to the provider. (When we send the payment, it's the same as saying ***yes*** to your request for a coverage decision)
- If the Service is not covered, or you did not follow all of the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the Services and the reasons why. (When we turn down your request for payment, it's the same as saying ***no*** to your request for a coverage decision)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, you can make an appeal. If you make an appeal, it means you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe under "Step-by-step: How to make a Level 1 Appeal." Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for Services you have already received and paid for yourself, you are not allowed to ask for a fast appeal)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is ***yes*** at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days

Your Part D Prescription Drugs: How to Ask for a Coverage Decision or Make an Appeal

What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our Plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs "Part D drugs." You can get these drugs as long as they are included in our Plan's *Formulary (List of Covered Drugs)* and the use of the drug is a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books.

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time
- For details about what we mean by Part D drugs, the *Formulary (List of Covered Drugs)*, rules and restrictions on coverage, and cost information, see "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section

Part D coverage decisions and appeals

As discussed under "A Guide to the Basics of Coverage Decisions and Appeals" in this "Coverage Decisions, Appeals, and Complaints" section, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. An initial

coverage decision about your Part D drugs is also called a "coverage determination."

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

- You ask us to make an exception, including:
  - asking us to cover a Part D drug that is not on our Plan's *Formulary (List of Covered Drugs)*
  - asking us to waive a restriction on our Plan's coverage for a drug (such as limits on the amount of the drug you can get)
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on our Plan's *List of Covered Drugs* but we require you to get approval from us before we will cover it for you)
  - note: if your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment

If you disagree with a coverage decision we have made, you can appeal our decision.

Which of these situations are you in?

This section tells you both how to ask for coverage decisions and how to request an appeal. Use this guide to help you determine which part has information for your situation:

- **Request a Coverage Decision:**
  - do you need a drug that isn't on our *Drug List* or need us to waive a rule or restriction on a drug we cover? You can ask us to make an exception. (This is a type of coverage decision.) **Start with "What is a Part D exception?"**
  - do you want us to cover a drug for you that is on our *Drug List* and you believe you meet any Plan rules or restrictions (such as getting approval in advance) for the drug you need? You can us for a coverage decision. **Skip ahead to "Step-by-step: How to ask for a coverage decision, including a Part D exception"**
  - do you want to ask us to pay you back for a drug you have already received and paid for? You can ask us to pay you back. (This is a type of coverage decision.) **Skip ahead to "Step-by-step: How to ask for a coverage decision, including a Part D exception "**
- **Make an Appeal:**
  - Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for? You can make an appeal. (This means you are asking us to reconsider.) **Skip ahead to "Step-by-step: How to make a Level 1 Appeal"**

What is a Part D exception?

If a Part D drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are two examples of exceptions that you or your doctor or other prescriber can ask us to make:

1. **Covering a Part D drug for you that is not on our *Formulary (List of Covered Drugs).*** (We call it the "Drug List" for short.) Asking for coverage of a drug that is not on the *Drug List* is sometimes called asking for a "formulary exception."
   - If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the Cost Sharing amount that applies to drugs in the brand-name drug tier. You cannot ask for an exception to the Copayment or Coinsurance amount we require you to pay for the drug
   - You cannot ask for coverage of any "excluded drugs" or other non–Part D drugs that Medicare does not cover. (For more information about excluded drugs, see "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section)
2. **Removing a restriction on our coverage for a covered Part D drug**. There are extra rules or restrictions that apply to certain drugs on our Plan's *Formulary (List of Covered Drugs)* (for more information, go to "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section). Asking for a removal of a restriction on coverage for a drug is sometimes called asking for a "formulary exception."
   - The extra rules and restrictions on coverage for certain drugs include:
     - getting **Plan approval in advance** before we will agree to cover the drug for you. (This is sometimes called "prior authorization")
   - If we agree to make an exception and waive a restriction for you, you can ask for an exception

to the Copayment or Coinsurance amount we require you to pay for the Part D drug

Important things to know about asking for a Part D exception

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting a Part D exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception.

We can say ***yes*** or ***no*** to your request

- If we approve your request for a Part D exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition
- If we say ***no*** to your request for a Part D exception, you can ask for a review of our decision by making an appeal. The "Step-by-step: How to make a Level 1 Appeal" section tells how to make an appeal if we say no

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

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

Step 1: You ask us to make a coverage decision about the drug(s) or payment you need.

If your health requires a quick response, you must ask us to make a "fast decision." You **cannot** ask for a fast decision if you are asking us to pay you back for a drug you already bought.

What to do

- Request the type of coverage decision you want. Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to "How to contact us when you are asking for a coverage decision or making an appeal or a complaint about your Part D prescription drugs" in the "Important Phone Numbers and Resources" section. Or, if you are asking us to pay you back for a drug, go to "Where to send a request asking us to pay for our share of the cost for a Service or a Part D drug you have received" in the "Important Phone Numbers and Resources" section
- You or your doctor or someone else who is acting on your behalf can ask for a coverage decision. The "A Guide to the Basics of Coverage Decisions and Appeals" section tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf
- If you want to ask us to pay you back for a drug, start by reading the "Requests for Payment" section, which describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for
- If you are requesting a Part D exception, provide the "doctor's statement." Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "doctor's statement.") Your doctor or other prescriber can fax or mail the statement to us. Or, your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See "What is a Part D exception?" and "Important things to know about asking for a Part D exception" for more information about exception requests

If your health requires it, ask us to give you a "fast decision"

A "fast decision" is also called an "expedited coverage determination."

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

- If you ask for a fast decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast decision
  - if we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead)
  - this letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision
  - the letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section

Step 2: We consider your request and we give you our answer

Deadlines for a "fast" coverage decision

- If we are using the fast deadlines, we must give you our answer within 24 hours
  - generally, this means within 24 hours after we receive your request. If you are requesting a Part D exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to
  - if we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent, outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2
- If our answer is ***yes*** to part or all of what you requested, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said no

Deadlines for a "standard" coverage decision about a Part D drug you have not yet received

- If we are using the standard deadlines, we must give you our answer within 72 hours
  - generally, this means within 72 hours after we receive your request. If you are requesting a Part D exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to
  - if we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2
- If our answer is ***yes*** to part or all of what you requested:
  - if we approve your request for coverage, we must provide the coverage we have agreed to provide within 72 hours after we receive your request or doctor's statement supporting your request
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said no

Deadlines for a "standard" coverage decision about payment for a drug you have already bought

- We must give you our answer within 14 calendar days after we receive your request
  - if we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent, organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2
- If our answer is ***yes*** to part or all of what you requested, we are also required to make payment to you within 30 calendar days after we receive your request
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said no

Step 3: If we say ***no*** to your coverage request, you decide if you want to make an appeal

- If we say ***no***, you have the right to request an appeal. Requesting an appeal means asking us to reconsider – and possibly change – the decision we made

Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our Plan)

An appeal to our Plan about a Part D drug coverage decision is also called a plan "redetermination."

Step 1: You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a "fast appeal."

What to do

- To start your appeal, you (or your representative or your doctor or other prescriber) must contact us
  - for details on how to reach us by phone, fax, or mail for any purpose related to your appeal, go to "How to contact us when you are asking for a coverage decision or making an appeal or a complaint about your Part D prescription drugs" in the "Important Phone Numbers and Resources" section
- If you are asking for a standard appeal, make your appeal by submitting a written request
- If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown under "How to contact us when you are asking for a coverage decision or making an appeal or a complaint about your Part D prescription drugs" in the "Important Phone Numbers and Resources" section
- You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal
- You can ask for a copy of the information in your appeal and add more information
  - you have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you
  - if you wish, you and your doctor or other prescriber may give us additional information to support your appeal

If your health requires it, ask for a "fast appeal"

A "fast appeal" is also called an "expedited redetermination."

- If you are appealing a decision our Plan made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal"
- The requirements for getting a "fast appeal" are the same as those for getting a "fast decision" in "Step-by-step: How to ask for a coverage decision, including a Part D exception"

Step 2: Our Plan considers your appeal and we give you our answer

- When our Plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all of the rules when we said ***no*** to your request. We may contact you or your doctor or other prescriber to get more information

Deadlines for a "fast" appeal

- If we are using the fast deadlines, we must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires it
  - if we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process
- If our answer is ***yes*** to part or all of what you requested, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said ***no*** and how to appeal our decision

Deadlines for a "standard" appeal

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for a "fast" appeal
- If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and

explain what happens at Level 2 of the appeals process

- If our answer is ***yes*** to part or all of what you requested:
  - if we approve a request for coverage, we must provide the coverage we have agreed to provide as quickly as your health requires, but no later than 7 calendar days after we receive your appeal
  - if we approve a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive your appeal request
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said ***no*** and how to appeal our decision

Step 3: If we say ***no*** to your appeal, you decide if you want to continue with the appeals process and make another appeal

- If we say ***no*** to your appeal, you then choose whether to accept this decision or continue by making another appeal
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below)

Step-by-step: How to make a Level 2 Appeal

If we say ***no*** to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Organization reviews the decision we made when we said ***no*** to your first appeal. This organization decides whether the decision we made should be changed.

The formal name for the Independent Review Organization is the "Independent Review Entity." It is sometimes called the "IRE."

Step 1: To make a Level 2 Appeal, you must contact the Independent Review Organization and ask for a review of your case

- If we say ***no*** to your Level 1 Appeal, the written notice we send you will include instructions on how to make a Level 2 Appeal with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." You have the right to ask us for a copy of your case file. We are allowed to charge you a fee for copying and sending this information to you
- You have a right to give the Independent Review Organization additional information to support your appeal

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it

Deadlines for "fast" appeal at Level 2

- If your health requires it, ask the Independent Review Organization for a "fast appeal"
- If the review organization agrees to give you a fast appeal, the review organization must give you an answer to your Level 2 Appeal within 72 hours after it receives your appeal request
- If the Independent Review Organization says ***yes*** to part or all of what you requested, we must provide the drug coverage that was approved by the review organization within 24 hours after we receive the decision from the review organization

Deadlines for "standard" appeal at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal within 7 calendar days after it receives your appeal
- If the Independent Review Organization says ***yes*** to part or all of what you requested:
  - if the Independent Review Organization approves a request for coverage, we must provide the drug coverage that was approved by the review organization within 72 hours after we receive the decision from the review organization
  - if the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive the decision from the review organization

What if the review organization says *no* to your appeal?

If this organization says ***no*** to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

To continue and make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal)
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal
- The Level 3 Appeal is handled by an administrative law judge. "Taking your Appeal to Level 3 and Beyond" tells more about Levels 3, 4, and 5 of the appeals process

How to Ask Us to Cover a Longer Inpatient Hospital Stay if You Think the Doctor Is Discharging You Too Soon

When you are admitted to a hospital, you have the right to get all of your covered hospital Services that are necessary to diagnose and treat your illness or injury. For more information about our Plan's coverage for your hospital care, including any limitations on this coverage, see the "Benefits and Cost Sharing" section.

During your hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "discharge date." Our Plan's coverage of your hospital stay ends on this date
- When your discharge date has been decided, your doctor or the hospital staff will let you know
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask

During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Member Service Call Center. You can also call 1-800-MEDICARE/1-800-633-4227 (TTY 1-877-486-2048), 24 hours a day, 7 days a week.

- **Read this notice carefully and ask questions if you don't understand it. It tells you about your rights as a hospital patient, including:**
  - your right to receive Medicare-covered Services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these Services are, who will pay for them, and where you can get them
  - your right to be involved in any decisions about your hospital stay, and know who will pay for it
  - where to report any concerns you have about quality of your hospital care
  - your right to appeal your discharge decision if you think you are being discharged from the hospital too soon
  - how you can "request an immediate review." Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. "Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date" tells you how you can request an immediate review
- **You must sign the written notice to show that you received it and understand your rights**
  - you or someone who is acting on your behalf must sign the notice. ("A Guide to the Basics of Coverage Decisions and Appeals" in this "Coverage Decisions, Appeals, and Complaints" section tells how you can give written permission to someone else to act as your representative)
  - signing the notice shows only that you have received the information about your rights. The notice does not give your discharge date (your

doctor or hospital staff will tell you your discharge date). Signing the notice does not mean you are agreeing on a discharge date

- **Keep your copy of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it**
  - if you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged
  - to look at a copy of this notice in advance, you can call our Member Service Call Center or 1-800 MEDICARE/1-800-633-4227 (TTY 1-877-486-2048), 24 hours a day, seven days a week. You can also see it online at www.cms.hhs.gov/BNI/12_HospitalDischargeAppealNotices.asp

Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your hospital Services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do
- **Ask for help if you need it.** If you have questions or need help at any time, please call our Member Service Call Center (phone numbers are on the cover of this *Evidence of Coverage*). Or, call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see the "Important Phone Numbers and Resources" section)

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Step 1: Contact the Quality Improvement Organization in your state and ask for a "fast review" of your hospital discharge. You must act quickly

A "fast review" is also called an "immediate review."

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our Plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or, find the name, address, and phone number of the Quality Improvement Organization for your state in the "Important Phone Numbers and Resources" section)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization before you leave the hospital and no later than your planned discharge date. (Your "planned discharge date" is the date that has been set for you to leave the hospital)
  - if you meet this deadline, you are allowed to stay in the hospital after your discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization
  - if you do not meet this deadline, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you receive after your planned discharge date
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our Plan instead. For details about this other way to make your appeal, see "What if you miss the deadline for making your Level 1 Appeal?"

Ask for a "fast review" (a "fast review" is also called an "immediate review" or an "expedited review")

- You must ask the Quality Improvement Organization for a "fast review" of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines

Step 2: The Quality Improvement Organization conducts an independent review of your case

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the Services should continue. You don't have to prepare anything in writing, but you may do so if you wish

- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them
- By noon of the day after the reviewers inform our Plan of your appeal, you will also get a written notice that gives your planned discharge date and explains the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date. This written explanation is called the *Detailed Notice of Discharge*. You can get a sample of this notice by calling our Member Service Call Center or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, seven days a week (TTY users should call 1-877-486-2048). Or, you can see a sample notice online at www.cms.hhs.gov/BNI/

Step 3: Within one full day after it has all of the needed information, the Quality Improvement Organization will give you its answer to your appeal

What happens if the answer is *yes?*

- If the review organization says ***yes*** to your appeal, we must keep providing your covered hospital Services for as long as these Services are medically necessary
- You will have to keep paying your share of the costs (such as Cost Sharing, if applicable). In addition, there may be limitations on your covered hospital Services. (See the "Benefits and Cost Sharing" section)

What happens if the answer is *no?*

- If the review organization says ***no*** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your hospital Services will end at noon on the day after the Quality Improvement Organization gives you its answer to your appeal
- If the review organization says ***no*** to your appeal and you decide to stay in the hospital, then you may have to pay the full cost of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal

Step 4: If the answer to your Level 1 Appeal is ***no***, you decide if you want to make another appeal

- If the Quality Improvement Organization has turned down your appeal and you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process

Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If they turn down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review

- You must ask for this review within 60 calendar days after the day when the Quality Improvement Organization said ***no*** to your Level 1 Appeal. You can ask for this review only if you stayed in the hospital after the date that your coverage for the care ended

Step 2: The Quality Improvement Organization does a second review of your situation

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal

Step 3: Within 14 calendar days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision

If the review organization says *yes*

- We must reimburse you for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. We must continue providing coverage for your hospital care for as long as it is medically necessary
- You must continue to pay your share of the costs, and coverage limitations may apply

If the review organization says *no*

- It means they agree with the decision they made on your Level 1 Appeal and will not change it. This is called "upholding the decision"
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge

Step 4: If the answer is ***no***, you will need to decide whether you want to take your appeal further by going on to Level 3

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge
- The "Taking Your Appeal to Level 3 and Beyond" section tells more about Levels 3, 4, and 5 of the appeals process

What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained under "Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date" in this "Coverage Decisions, Appeals, and Complaints" section, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, the first two levels of appeal are different.

Step-by-step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines. A "fast review" (or "fast appeal") is also called an "expedited appeal."

Step 1: Contact us and ask for a "fast review"

- For details on how to contact us, go to "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your Services" in the "Important Phone Numbers and Resources" section
- Be sure to ask for a "fast review." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines

Step 2: We do a "fast" review of your planned discharge date, checking to see if it was medically appropriate

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all of the rules
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal")

- If we say ***yes*** to your fast appeal, it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered Services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs, and there may be coverage limitations that apply)
- If we say ***no*** to your fast appeal, we are saying that your planned discharge date was medically appropriate. Our coverage for your hospital Services ends as of the day we said coverage would end
- If you stayed in the hospital after your planned discharge date, then you may have to pay the full cost of hospital care you received after the planned discharge date

Step 4: If we say ***no*** to your fast appeal, your case will automatically be sent on to the next level of the appeals process

- To make sure we were following all of the rules when we said ***no*** to your fast appeal, we are required to send your appeal to the Independent Review Organization. When we do this, it means that you are automatically going on to Level 2 of the appeals process

Step-by-Step: How to make a Level 2 *Alternate* Appeal

If we say ***no*** to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the Independent Review Organization reviews the decision we made when we said ***no*** to your "fast appeal." This organization decides whether the decision we made should be changed. The formal name for the Independent Review Organization is the "Independent Review Entity." It is sometimes called the "IRE."

Step 1: We will automatically forward your case to the Independent Review Organization

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying ***no*** to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section tells how to make a complaint)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work. (For more information about this organization, refer to the "Important Phone Numbers and Resources" section)
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge
- If this organization says ***yes*** to your appeal, then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue our Plan's coverage of your hospital Services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your Services
- If this organization says ***no*** to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate
  - the notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say ***no*** to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal
- "Taking Your Appeal to Level 3 and Beyond" in this "Coverage Decisions, Appeals, and Complaints" section tells more about Levels 3, 4, and 5 of the appeals process

How to Ask Us to Keep Covering Certain Medical Services if You Think Your Coverage Is Ending Too Soon

Home health care, Skilled Nursing Facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) Services

This section is only about the following types of care:

- **Home health care Services** you are getting
- **Skilled nursing care** you are getting as a patient in a Skilled Nursing Facility. (To learn about requirements for being considered a "Skilled Nursing Facility," see the "Definitions" section)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see the "Definitions" section)

When you are getting any of these types of care, you have the right to keep getting your covered Services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information about your covered Services, including your share of the cost and any limitations to coverage that may apply, see the "Benefits and Cost Sharing" section.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, we will stop paying our share of the cost for your care.

If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

We will tell you in advance when your coverage will be ending

- **You receive a notice in writing.** At least two days before our Plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice
  - the written notice tells you the date when we will stop covering the care for you
  - the written notice also tells what you can do if you want to ask us to change this decision about when to end your care, and keep covering it for a longer period of time
  - In telling you what you can do, the written notice is telling you how you can request a "fast-track appeal." Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. "Step-by-step: How to make a Level 1 Appeal to have our Plan cover your care for a longer time" tells you how you can request a fast-track appeal
  - The written notice is called the *Notice of Medicare Non-Coverage*. To get a sample copy, call our Member Service Call Center or 1-800 MEDICARE (1-800-633-4227), 24 hours a day, seven days a week (TTY users should call 1-877-486-2048). Or, see a copy online at www.cms.hhs.gov/BNI/
- **You must sign the written notice to show that you received it**
  - you or someone who is acting on your behalf must sign the notice. ("A Guide to the Basics of Coverage Decisions and Appeals" in this "Coverage Decisions, Appeals, and Complaints" section tells how you can give written permission to someone else to act as your representative.)
  - signing the notice shows only that you have received the information about when your coverage will stop. Signing it does not mean you agree with us that it's time to stop getting the care

Step-by-step: How to make a Level 1 Appeal to have our Plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our Plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section tells you how to file a complaint)
- **Ask for help if you need it**. If you have questions or need help at any time, please call our Member Service Call Center (phone numbers are on the front cover of this booklet). Or, call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see the "Important Phone Numbers and Resources" section)

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our Plan.

Step 1: Make your Level 1 Appeal: Contact the Quality Improvement Organization in your state and ask for a review. You must act quickly

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the federal government. These experts are not part of our Plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of Services

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or, find the name, address, and phone number of the Quality Improvement Organization for your state in the "Important Phone Numbers and Resources" section)

What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for us to end coverage for your medical Services

Your deadline for contacting this organization

- You must contact the Quality Improvement Organization to start your appeal no later than noon of the day after you receive the written notice telling you when we will stop covering your care
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see "Step-by-step: How to make a Level 2 Appeal to have our Plan cover your care for a longer time"

Step 2: The Quality Improvement Organization conducts an independent review of your case

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the Services should continue. You don't have to prepare anything in writing, but you may do so if you wish
- The review organization will also look at your medical information, talk with your doctor, and review information that our Plan has given to them
- By the end of the day the reviewers informed us of your appeal, and you will also get a written notice from us that gives our reasons for ending our coverage for your Services. This notice explanation is called the *Detailed Explanation of Non-Coverage*

Step 3: Within one full day after they have all of the information they need, the reviewers will tell you their decision

What happens if the reviewers say *yes* to your appeal?

- If the reviewers say ***yes*** to your appeal, then we must keep providing your covered Services for as long as it is medically necessary
- You will have to keep paying your share of the costs (such as Cost Sharing, if applicable). In addition, there may be limitations on your covered Services (see the "Benefits and Cost Sharing" section)

What happens if the reviewers say *no* to your appeal?

- If the reviewers say ***no*** to your appeal, then your coverage will end on the date we have told you. We will stop paying our share of the costs of this care
- If you decide to keep getting the home health care, or Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) Services after the date when your coverage ends, then you will have to pay the full cost of this care yourself

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal

- This first appeal you make is "Level 1" of the appeals process. If reviewers say ***no*** to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal
- Making another appeal means you are going on to "Level 2" of the appeals process

Step-by-step: How to make a Level 2 Appeal to have our Plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If they turn down your Level 2 Appeal, you may have to pay the full cost for your home health care, or Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Here are the steps for Level 2 of the appeal process:

Step 1: You contact the Quality Improvement Organization again and ask for another review

- You must ask for this review within 60 calendar days after the day when the Quality Improvement Organization said ***no*** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended

Step 2: The Quality Improvement Organization does a second review of your situation

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal

Step 3: Within 14 calendar days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision

What happens if the review organization says *yes* to your appeal?

- We must reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary
- You must continue to pay your share of the costs and there may be coverage limitations that apply

What happens if the review organization says *no*?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge
- "Taking Your Appeal to Level 3 and Beyond" in this "Coverage Decisions, Appeals, and Complaints" section tells more about Levels 3, 4, and 5 of the appeals process

What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.

Step-by-step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines. A "fast review" (or "fast appeal") is also called an "expedited appeal."

Here are the steps for a Level 1 Alternate Appeal:

Step 1: Contact us and ask for a "fast review"

- For details on how to contact us, go to "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your Services" in the "Important Phone Numbers and Resources" section
- Be sure to ask for a "fast review." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines

Step 2: We do a "fast" review of the decision we made about when to end coverage for your Services

- During this review, we take another look at all of the information about your case. We check to see if we were following all of the rules when we set the date for ending our Plan's coverage for Services you were receiving
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our Plan and ask for a "fast review," we are allowed to decide whether to agree to your request and give you a "fast review." But in this situation, the rules require us to give you a fast response if you ask for it)

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal")

- If we say ***yes*** to your fast appeal, it means we have agreed with you that you need Services longer, and will keep providing your covered Services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply)
- If we say ***no*** to your fast appeal, then your coverage will end on the date we have told you and we will not pay after this date. We will stop paying our share of the costs of this care
- If you continued to get home health care, or Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) Services after the date when we said your coverage would end, then you will have to pay the full cost of this care yourself

Step 4: If we say *no* to your fast appeal, your case will automatically go on to the next level of the appeals process

- To make sure we were following all of the rules when we said ***no*** to your fast appeal, we are required to send your appeal to the Independent Review Organization. When we do this, it means that you are automatically going on to Level 2 of the appeals process

Step-by-step: How to make a Level 2 *Alternate* Appeal

If we say ***no*** to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the Independent Review Organization reviews the decision we made when we said ***no*** to your "fast appeal." This organization decides whether the decision we made should be changed. The formal name for the Independent Review Organization is the "Independent Review Entity." It is sometimes called the "IRE."

Step 1: We will automatically forward your case to the Independent Review Organization

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying ***no*** to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeal process. "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section tells how to make a complaint)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work. (For more information about this organization, refer to the "Important Phone Numbers and Resources" section)
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal
- If this organization says ***yes*** to your appeal, then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your Services
- If this organization says ***no*** to your appeal, it means they agree with the decision we made to your first appeal and will not change it
  - the notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say ***no*** to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge
- "Taking Your Appeal to Level 3 and Beyond" in this "Coverage Decisions, Appeals, and Complaints" section tells more about Levels 3, 4, and 5 of the appeals process

Taking Your Appeal to Level 3 and Beyond

Levels of Appeal 3, 4, and 5 for Medical Service Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: A judge who works for the federal government will review your appeal and give you an answer. This judge is called an "administrative law judge"

- If the administrative law judge says ***yes*** to your appeal, the appeals process may or may not be over. We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you
  - if we decide not to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the judge's decision
  - if we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute
- If the administrative law judge says ***no*** to your appeal, the appeals process may or may not be over
  - if you decide to accept this decision that turns down your appeal, the appeals process is over

- if you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says ***no*** to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal

Level 4 Appeal: The Medicare Appeals Council will review your appeal and give you an answer. The Medicare Appeals Council works for the federal government

- If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over. We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you
  - if we decide not to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Medicare Appeals Council's decision
  - if we decide to appeal the decision, we will let you know in writing
- If the answer is ***no*** or if the Medicare Appeals Council denies the review request, the appeals process may or may not be over
  - if you decide to accept this decision that turns down your appeal, the appeals process is over
  - if you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says ***no*** to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what to do next if you choose to continue with your appeal

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

- This is the last step of the administrative appeals process

Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the Part D drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: A judge who works for the federal government will review your appeal and give you an answer. This judge is called an "administrative law judge"

- If the answer is ***yes***, the appeals process is over. What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the administrative law judge within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision
- If the answer is ***no***, the appeals process may or may not be over
  - If you decide to accept this decision that turns down your appeal, the appeals process is over
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says ***no*** to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal

Level 4 Appeal: The Medicare Appeals Council will review your appeal and give you an answer. The Medicare Appeals Council works for the federal government

- If the answer is ***yes***, the appeals process is over. What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the Medicare Appeals Council within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision
- If the answer is ***no***, the appeals process may or may not be over
  - if you decide to accept this decision that turns down your appeal, the appeals process is over
  - if you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says ***no*** to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what

to do next if you choose to continue with your appeal

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

- This is the last step of the appeals process

How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns

If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to "A Guide to the Basics of Coverage Decisions and Appeals" in this "Coverage Decisions, Appeals, and Complaints" section.

What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive.

Here are examples of the kinds of problems handled by the complaint process:

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

- **Quality of your Services**
  - are you unhappy with the quality of care you have received (including care in the hospital)?
- **Respecting your privacy**
  - do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
- **Disrespect, poor customer service, or other negative behaviors**
  - has someone been rude or disrespectful to you?
  - are you unhappy with how our Member Service Call Center has treated you?
  - do you feel you are being encouraged to leave our Plan?
- **Waiting times**
  - are you having trouble getting an appointment, or waiting too long to get it?
  - have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or, by our Member Service Call Center or other staff at our Plan? Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room
- **Cleanliness**
  - are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
- **Information you get from our Plan**
  - do you believe we have not given you a notice that we are required to give?
  - do you think written information we have given you is hard to understand?

These are more examples of possible reasons for making a complaint

These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals.

The process of asking for a coverage decision and making appeals is explained in this "Coverage Decisions, Appeals, and Complaints" section. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast response" for a coverage decision or appeal, and we have said we will not, you can make a complaint
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint
- When a coverage decision we made is reviewed and our Plan is told that we must cover or reimburse you for certain medical Services or Part D drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint

Step-by-step: Making a complaint

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

Step 1: Contact us promptly – either by phone or in writing

- Usually calling our Member Service Call Center is the first step. If there is anything else you need to do, our Member Service Call Center will let you know. Call 1-800-443-0815 (TTY users call 1-800-777-1370), seven days a week from 8:00 a.m. to 8:00 p.m.
- If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you put your complaint in writing, we will respond to your complaint in writing
  - if you have a complaint, we will try to resolve your complaint over the phone. If you ask for a written response or file a written grievance or if your complaint is related to quality of care, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. Your grievance must explain your concern, such as why you are dissatisfied with the services you received. Please see the "Important Phone Numbers and Resources" section for whom you should contact if you have a complaint
  - the grievance must be submitted to us (orally or in writing) within 60 calendar days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 calendar days after receiving your complaint. We may extend the time frame to make our decision by up to 14 calendar days if you ask for an extension, or if we justify a need for additional information and the delay is in your best interest. If our decision is not completely in your favor, we will send you our decision with an explanation and tell you about any dispute resolution options you may have.
  - you may make an oral or written request that we expedite your grievance if we:
    1. Deny your request to expedite a decision related to a service that you have not yet received
    2. Deny your request to expedite your Medicare appeal
    3. Decide to extend the time we need to make a standard or expedited decision.

    If you request an expedited grievance, we will respond to your request within 24 hours.
- Whether you call or write, you should contact our Member Service Call Center right away. The complaint must be made within 60 calendar days after you had the problem you want to complain about
- If you are making a complaint because we denied your request for a "fast response" to a coverage decision or appeal, we will automatically give you a "fast" complaint. If you have a "fast" complaint, it means we will give you an answer within 24 hours. What this section calls a "fast complaint" is also called an "expedited grievance"

Step 2: We look into your complaint and give you our answer

- If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that
- Most complaints are answered in 30 calendar days. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint
- If we do not agree with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not

You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about quality of care, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (without making the complaint to us)
  - the Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients
  - to find the name, address, and phone number of the Quality Improvement Organization for your state, look in the "Important Phone Numbers and Resources" section. If you make a complaint to this organization, we will work with them to resolve your complaint
- **Or, you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization

Binding Arbitration

For all claims subject to this "Binding Arbitration" section, both Claimants and Respondents give up the right to a jury or court trial and accept the use of binding arbitration. Insofar as this "Binding Arbitration" section applies to claims asserted by Kaiser Permanente Parties, it shall apply retroactively to all unresolved claims that accrued before the effective date of this *Evidence of Coverage*. Such retroactive application shall be binding only on the Kaiser Permanente Parties.

Scope of arbitration

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *Evidence of Coverage* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc. (Health Plan), including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of the legal theories upon which the claim is asserted
- The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
- The claim is *not* within the jurisdiction of the Small Claims Court
- If coverage under this *Evidence of Coverage* is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), the claim is *not* about an "adverse benefit determination" as defined in that regulation. Note: Claims about "adverse benefit determinations" are excluded from this binding arbitration requirement only until such time as the regulation prohibiting mandatory binding arbitration of this category of claim (29 CFR 2560.503-1(c)(4)) is modified, amended, repealed, superseded, or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without further notice
- The claim is *not* subject to a Medicare appeal procedure

As referred to in this "Binding Arbitration" section, "Member Parties" include:

- A Member
- A Member's heir, relative, or personal representative
- Any person claiming that a duty to him or her arises from a Member's relationship to one or more Kaiser Permanente Parties

"Kaiser Permanente Parties" include:

- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals
- KP Cal, LLC
- The Permanente Medical Group, Inc.
- Southern California Permanente Medical Group
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any Southern California Permanente Medical Group or The Permanente Medical Group physician
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties
- Any employee or agent of any of the foregoing

"Claimant" refers to a Member Party or a Kaiser Permanente Party who asserts a claim as described above. "Respondent" refers to a Member Party or a Kaiser Permanente Party against whom a claim is asserted.

Initiating arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and telephone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include in the Demand for Arbitration all claims against Respondents that are based on the same incident, transaction, or related circumstances.

Serving Demand for Arbitration

Health Plan, Kaiser Foundation Hospitals, KP Cal, LLC, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of:

Kaiser Foundation Health Plan, Inc.
Legal Department
1950 Franklin St., 17th Floor
Oakland, CA 94612

Service on that Respondent shall be deemed completed when received. All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

Filing fee

The Claimants shall pay a single, nonrefundable filing fee of $150 per arbitration payable to "Arbitration Account" regardless of the number of claims asserted in the Demand for Arbitration or the number of Claimants or Respondents named in the Demand for Arbitration.

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling our Member Service Call Center.

Number of arbitrators

The number of arbitrators may affect the Claimants' responsibility for paying the neutral arbitrator's fees and expenses (see the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator*).

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing that the arbitration shall be heard by two party arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the Demand for Arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two party arbitrators, one jointly appointed by all Claimants and one jointly appointed by all Respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

Payment of arbitrators' fees and expenses

Health Plan will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* ("Rules of Procedure"). In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select party arbitrators, Claimants shall be responsible for paying the fees and expenses of their party arbitrator and Respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs

Except for the aforementioned fees and expenses of the neutral arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this "Binding Arbitration" section, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

Rules of Procedure

Arbitrations shall be conducted according to the Rules of Procedure developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from our Member Service Call Center.

General provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondent served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for non-economic losses, and the right to have an award for future damages conformed to periodic payments, shall

apply to any claims for professional negligence or any other claims as permitted or required by law.

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding Arbitration" section. In accord with the rule that applies under Sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration" section shall not be denied, stayed, or otherwise impeded because a dispute between a Member Party and a Kaiser Permanente Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with a third party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Termination of Membership

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered. (For example, if your termination date is January 1, 2013, your last minute of coverage is 11:59 p.m. on December 31, 2012). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *Evidence of Coverage* after your membership terminates, except:

- As provided under "Payments after Termination" in this "Termination of Membership" section
- If you are receiving covered Services as an acute care hospital inpatient on the termination date, we will continue to cover those hospital Services (but not physician Services or any other Services) until you are discharged

Until your membership terminates, you remain a Senior Advantage Member and must continue to receive your medical care from us, except as described in the "Emergency Services and Urgent Care" section about Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care and the "Benefits and Cost Sharing" section about out-of-area dialysis care.

Note: If you enroll in another Medicare Health Plan or a prescription drug plan, your Senior Advantage membership will terminate as described under "Disenrolling from Senior Advantage" in this "Termination of Membership" section.

Termination Due to Loss of Eligibility

If you meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership will end at 11:59 p.m. on the last day of that month. For example, if you become ineligible on December 5, 2012, your termination date is January 1, 2013, and your last minute of coverage is 11:59 p.m. on December 31, 2012.

Also we will terminate your Senior Advantage membership on the last day of the month if you:

- Are temporarily absent from our Service Area for more than six months in a row
- Permanently move outside our Service Area
- No longer have Medicare Part B
- Enroll in another Medicare Health Plan (for example, a Medicare Advantage Plan or a Medicare prescription drug plan). The Centers for Medicare & Medicaid Services will automatically terminate your Senior Advantage membership when your enrollment in the other plan becomes effective

Note: If you lose eligibility for Senior Advantage due to any of these circumstances, you may be eligible to transfer your membership to another Kaiser Permanente plan offered by your Group. Please contact your Group for information.

Termination of *Agreement*

If your Group's *Agreement* with us terminates for any reason, your membership ends on the same date. Your Group is required to notify Subscribers in writing if its *Agreement* with us terminates.

Disenrolling from Senior Advantage

You may terminate (disenroll from) your Senior Advantage membership at any time. However, before you request disenrollment, please check with your Group to determine if you are able to continue your Group membership.

If you request disenrollment during your Group's open enrollment, your disenrollment effective date is

determined by the date your written request is received by us and the date your Group coverage ends. The effective date will not be earlier than the first day of the following month after we receive your written request, and no later than three months after we receive your request.

If you request disenrollment at a time other than your Group's open enrollment, your disenrollment effective date will be the first day of the month following our receipt of your disenrollment request.

You may request disenrollment by calling toll free 1-800-MEDICARE/1-800-633-4227 (TTY users call 1-877-486-2048), 24 hours a day, seven days a week, or sending written notice to the following address:

Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 232400
San Diego, CA 92193-2400

Other Medicare Health Plans. If you want to enroll in another Medicare Health Plan or a Medicare prescription drug plan, you should first confirm with the other plan and your Group that you are able to enroll in their plan. Your new plan will tell you the date when your membership in that plan begins and your Senior Advantage membership will end on that same day (your disenrollment date).

The Centers for Medicare & Medicaid Services will let us know if you enroll in another Medicare Health Plan, so you will not need to send us a disenrollment request.

Original Medicare. If you request disenrollment from Senior Advantage and you do not enroll in another Medicare Health Plan, you will automatically be enrolled in Original Medicare when your Senior Advantage membership terminates (your disenrollment date). On your disenrollment date, you can start using your red, white, and blue Medicare card to get services under Original Medicare. You will not get anything in writing that tells you that you have Original Medicare after you disenroll. If you choose Original Medicare and you want to continue to get Medicare Part D prescription drug coverage, you will need to enroll in a prescription drug plan.

If you receive Extra Help from Medicare to pay for your prescription drugs, and you switch to Original Medicare and do not enroll in a separate Medicare Part D prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, as least as much as Medicare's standard prescription drug coverage.) See "Premiums" in the "Premiums, Eligibility, and Enrollment" section for more information about the late enrollment penalty.

Termination of Contract with the Centers for Medicare & Medicaid Services

If our contract with the Centers for Medicare & Medicaid Services to offer Senior Advantage terminates, your Senior Advantage membership will terminate on the same date. We will send you advance written notice and advise you of your health care options. Also, you may be eligible to transfer your membership to another Kaiser Permanente plan offered by your Group.

Termination for Cause

We may terminate your membership by sending you advance written notice if you commit one of the following acts:

- If you continuously behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for our other members. We cannot make you leave our Senior Advantage Plan for this reason unless we get permission first from Medicare
- If you let someone else use your Plan membership card to get medical care. If you are disenrolled for this reason, the Centers for Medicare & Medicaid Services may refer your case to the Inspector General for additional investigation
- You commit theft from Health Plan, from a Plan Provider, or at a Plan Facility
- You intentionally misrepresent membership status or commit fraud in connection with your obtaining membership
- If you become incarcerated (go to prison)
- You knowingly falsify or withhold information about other parties that provide reimbursement for your prescription drug coverage

If we terminate your membership for cause, you will not be allowed to enroll in Health Plan in the future until you have completed a Member Orientation and have signed a

statement promising future compliance. We may report fraud and other illegal acts to the authorities for prosecution.

Termination for Nonpayment of Premiums

If your Group fails to pay us Premiums for your Family, we may terminate the memberships of everyone in your Family.

Termination of a Product or all Products

We may terminate a particular product or all products offered in a small or large group market as permitted or required by law. If we discontinue offering a particular product in a market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products to groups in a small or large group market, as applicable, we may terminate your Group's *Agreement* by sending you written notice at least 180 days before the *Agreement* terminates.

Payments after Termination

If we terminate your membership for cause or for nonpayment, we will:

- Refund any amounts we owe your Group for Premiums paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Requests for Payment" section. We will deduct any amounts you owe Health Plan or Plan Providers from any payment we make to you

Review of Membership Termination

If you believe that we terminated your Senior Advantage membership because of your ill health or your need for care, you may file a complaint as described in the "Coverage Decisions, Appeals, and Complaints" section.

Continuation of Membership

If your membership under this Senior Advantage *Evidence of Coverage* ends, you may be eligible to maintain Health Plan membership without a break in coverage under this Senior Advantage *Evidence of Coverage* (group coverage) or you may be eligible to convert to an individual (nongroup) plan.

Continuation of Group Coverage

COBRA

You may be able to continue your coverage under this Senior Advantage *Evidence of Coverage* for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law (the Consolidated Omnibus Budget Reconciliation Act). COBRA applies to most employees (and most of their covered family Dependents) of most employers with 20 or more employees.

If your Group is subject to COBRA and you are eligible for COBRA coverage, in order to enroll, you must submit a COBRA election form to your Group within the COBRA election period. Please ask your Group for details about COBRA coverage, such as how to elect coverage, how much you must pay for coverage, when coverage and Premiums may change, and where to send your Premium payments.

As described in "Conversion from Group Membership to an Individual Plan" in this "Continuation of Membership" section, you may be able to convert to an individual (nongroup) plan if you don't apply for COBRA coverage, or if you enroll in COBRA and your COBRA coverage ends.

Coverage for a disabling condition

If you became Totally Disabled while you were a Member under your Group's *Agreement* with us and while the Subscriber was employed by your Group, and your Group's *Agreement* with us terminates and is not renewed, we will cover Services for your totally disabling condition until the earliest of the following events occurs:

- 12 months have elapsed since your Group's *Agreement* with us terminated
- You are no longer Totally Disabled
- Your Group's *Agreement* with us is replaced by another group health plan without limitation as to the disabling condition

Your coverage will be subject to the terms of this *Evidence of Coverage*, including Cost Sharing, but we will not cover Services for any condition other than your totally disabling condition.

For Subscribers and adult Dependents, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months and makes the person unable to engage in any employment or

occupation, even with training, education, and experience.

For Dependent children, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months and the illness or injury makes the child unable to substantially engage in any of the normal activities of children in good health of like age.

To request continuation of coverage for your disabling condition, you must call our Member Service Call Center within 30 days after your Group's *Agreement* with us terminates.

Conversion from Group Membership to an Individual Plan

After your Group notifies us to terminate your Group membership, we will send a termination letter to the Subscriber's address of record. The letter will include information about options that may be available to you to remain a Health Plan member.

Kaiser Permanente Conversion Plan

If you want to remain a Health Plan member, one option that may be available is our Senior Advantage Individual Plan. You may be eligible to enroll in our individual plan if you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section. Individual plan coverage begins when your Group coverage ends. The premiums and coverage under our individual plan are different from those under this *Evidence of Coverage* and will include Medicare Part D prescription drug coverage.

However, if you are no longer eligible for Senior Advantage and Group coverage, you may be eligible to convert to our non-Medicare individual plan, called "Kaiser Permanente Individual–Conversion Plan." You may be eligible to enroll in our Individual–Conversion Plan if we receive your enrollment application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later).

You may not be eligible to convert if your membership ends for the reasons stated under "Termination for Cause" or "Termination of *Agreement"* in the "Termination of Membership" section.

For information about converting your membership or about other individual plans, call our Member Service Call Center.

Miscellaneous Provisions

Administration of *Agreement*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of your Group's *Agreement*, including this *Evidence of Coverage.*

Advance directives

The California Health Care Decision Law offers several ways for you to control the kind of health care you will receive if you become very ill or unconscious, including the following:

- A *Power of Attorney for Health Care* lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your own views on life support and other treatments
- *Individual health care instructions* let you express your wishes about receiving life support and other treatment. You can express these wishes to your doctor and have them documented in your medical chart, or you can put them in writing and have that included in your medical chart

To learn more about advance directives, including how to obtain forms, contact your local Member Services Department at a Plan Facility. You can also refer to *Your Guidebook* for more information about advance directives.

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with the California Department of Managed Care toll free at 1-800-HMO-2219 (or 1-877-688-9891 for TTY users).

Agreement binding on Members

By electing coverage or accepting benefits under this *Evidence of Coverage*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *Evidence of Coverage*.

Amendment of *Agreement*

Your Group's *Agreement* with us will change periodically. If these changes affect this *Evidence of Coverage*, your Group is required to inform you in accord with applicable law and your Group's *Agreement*.

Applications and statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this *Evidence of Coverage*.

Assignment

You may not assign this *Evidence of Coverage* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

Attorney and advocate fees and expenses

In any dispute between a Member and Health Plan, the Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses.

Claims review authority

We are responsible for determining whether you are entitled to benefits under this *Evidence of Coverage* and we have the discretionary authority to review and evaluate claims that arise under this *Evidence of Coverage*. We conduct this evaluation independently by interpreting the provisions of this *Evidence of Coverage*. If coverage under this *Evidence of Coverage* is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), then we are a "named claims fiduciary" to review claims under this *Evidence of Coverage*.

ERISA notices

This "ERISA notices" section applies only if your Group's health benefit plan is subject to the Employee Retirement Income Security Act (ERISA). We provide these notices to assist ERISA-covered groups in complying with ERISA. Coverage for Services described in these notices is subject to all provisions of this *Evidence of Coverage*.

Newborns' and Mothers' Health Protection Act. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same Cost Sharing applicable to other medical and surgical benefits provided under this plan.

Governing law

Except as preempted by federal law, this *Evidence of Coverage* will be governed in accord with California law and any provision that is required to be in this *Evidence of Coverage* by state or federal law shall bind Members and Health Plan whether or not set forth in this *Evidence of Coverage*.

Group and Members not our agents

Neither your Group nor any Member is the agent or representative of Health Plan.

No waiver

Our failure to enforce any provision of this *Evidence of Coverage* will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

Nondiscrimination

We do not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, language, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the Service Area.

Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call our Member Service Call Center, and the Social Security Administration toll free at 1-800-772-1213 (TTY users call 1-800-325-0778) as soon as possible to report the address change. If a Member does not reside with the Subscriber, he or she should contact our Member Service Call Center to discuss alternate delivery options.

Note: When we tell your Group about changes to this *Evidence of Coverage* or provide your Group other information that affects you, your Group is required to notify the Subscriber within 30 days after receiving the information from us.

Other *Evidence of Coverage* formats

You can request a copy of this *Evidence of Coverage* in an alternate format (Braille, audio, electronic text file, or large print) by calling our Member Service Call Center.

Overpayment recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment or from any person or organization obligated to pay for the Services.

Privacy practices

Kaiser Permanente will protect the privacy of your protected health information. We also require contracting providers to protect your protected health information. Your protected health information is individually-identifiable information (oral, written, or electronic) about your health, health care services you receive, or payment for your health care. You may generally see and receive copies of your protected health information, correct or update your protected health information, and ask us for an accounting of certain disclosures of your protected health information.

We may use or disclose your protected health information for treatment, health research, payment, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give protected health information to others, such as government agencies or in judicial actions. In addition, protected health information is shared with your Group only with your authorization or as otherwise permitted by law. We will not use or disclose your protected health information for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices*, which provides additional information about our privacy practices and your rights regarding your protected health information is available and will be furnished to you upon request. To request a copy, please call our Member Service Call Center. You can also find the notice at your local Plan Facility or on our website at kp.org.

Public policy participation

The Kaiser Foundation Health Plan, Inc., Board of Directors establishes public policy for Health Plan. A list of the Board of Directors is available on our website at **kp.org** or from our Member Service Call Center. If you would like to provide input about Health Plan public policy for consideration by the Board, please send written comments to:

Kaiser Foundation Health Plan, Inc.
Office of Board and Corporate Governance Services
One Kaiser Plaza, 19th Floor
Oakland, CA 94612

Telephone access (TTY)

If you are hearing or speech impaired and use a text telephone device (TTY, also known as TDD) to communicate by phone, you can use the California Relay Service by calling 711 if a dedicated TTY number is not available for the telephone number that you want to call.

Important Phone Numbers and Resources

Kaiser Permanente Senior Advantage

How to contact our Plan's Member Services

For assistance, please call or write to our Senior Advantage Member Services. We will be happy to help you.

Member Services

Call **1-800-443-0815** (Calls to this number are free.)

8 a.m. to 8 p.m., seven days a week.

Member Services also has free language interpreter services available for non-English speakers.

TTY **1-800-777-1370**

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. (Calls to this number are free.)

8 a.m. to 8 p.m., seven days a week.

Write Member Services office at your local Plan Medical Center (see the "Plan Facilities" section or the *Provider Directory* for Medical Center locations).

Website kp.org

How to contact us when you are asking for a coverage decision or making an appeal or complaint about your Services

- A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services
- An appeal is a formal way of asking us to review and change a coverage decision we have made
- You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes

For more information about asking for coverage decisions or making appeals or complaints about your medical care, see the "Coverage Decisions, Appeals, and Complaints" section.

Coverage decisions, appeals, or complaints for Services

Call **1-800-443-0815** (Calls to this number are free.)

8 a.m. to 8 p.m., seven days a week.

If your coverage decision, appeal, or complaint **qualifies for a fast decision**, call the Expedited Review Unit at **1-888-987-7247**, 8:30 a.m. to 5 p.m., Monday through Saturday. See the "Coverage Decisions, Appeals, and Complaints" section to find out if your issue qualifies for a fast decision.

TTY **1-800-777-1370**

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. (Calls to this number are free.)

8 a.m. to 8 p.m., seven days a week.

Fax If your coverage decision, appeal, or complaint **qualifies for a fast decision**, fax your request to our Expedited Review Unit at **1-888-987-2252**.

Write For a **standard coverage decision or complaint**, write to the Member Services office at your local Plan Medical Center (see the "Plan Facilities" section or the *Provider Directory* for Medical Center locations).

For a **standard appeal**, write to the address shown on the denial notice we send you.

If your coverage decision, appeal, or complaint **qualifies for a fast decision**, write to:
Kaiser Foundation Health Plan, Inc.
Expedited Review Unit
P.O. Box 23170
Oakland, CA 94623-0170

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

- A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Part D prescription drugs
- An appeal is a formal way of asking us to review and change a coverage decision we have made

For more information about asking for coverage decisions or making appeals about your Part D prescription drugs, see the "Coverage Decisions, Appeals, and Complaints" section.

Coverage decisions or appeals for Part D prescription drugs

Call **1-866-206-2973** (Calls to this number are free.)

8:30 a.m. to 5 p.m., seven days a week.

If your coverage decision, appeal, or complaint **qualifies for a fast decision**, call the Expedited Review Unit at **1-888-987-7247**, 8:30 a.m. to 5 p.m., Monday through Saturday. See the "Coverage Decisions, Appeals, and Complaints" section to find out if your issue qualifies for a fast decision.

TTY **1-800-777-1370**

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. (Calls to this number are free.)

8 a.m. to 8 p.m., seven days a week.

Fax **1-866-206-2974**

Write Kaiser Foundation Health Plan, Inc.
Part D Unit
P.O. Box 23170
Oakland, CA 94623-0170

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

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look

at the section above about requesting coverage decisions or making appeals.) For more information about making a complaint about your Part D prescription drugs, see the "Coverage Decisions, Appeals, and Complaints" section.

Complaints for Part D prescription drugs

Call **1-800-443-0815** (Calls to this number are free.)

8 a.m. to 8 p.m., seven days a week.

If your complaint **qualifies for a fast decision**, call the Part D Unit at **1-866-206-2973**, 8:30 a.m. to 5 p.m., seven days a week. See the "Coverage Decisions, Appeals, and Complaints" section to find out if your issue qualifies for a fast decision.

TTY **1-800-777-1370**

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. (Calls to this number are free.)

8 a.m. to 8 p.m., seven days a week.

Fax If your complaint qualifies for a fast review, fax your request to our Part D Unit at **1-866-206-2974**.

Write For a **standard complaint**, write to the Member Services office at your local network Medical Center (see the "Plan Facilities" section or the *Provider Directory* for Medical Center locations).

If your complaint **qualifies for a fast decision**, write to:

Kaiser Foundation Health Plan, Inc.
Part D Unit
P.O. Box 23170
Oakland, CA 94623-0170

Website kp.org

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

For more information about situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see the "Requests for Payment" section.

Note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See the "Coverage Decisions, Appeals, and Complaints" section for more information.

Payment Requests

Call **1-800-443-0815** (Calls to this number are free.)

8 a.m. to 8 p.m., seven days a week.

Note: If you are requesting payment of a Part D drug that was prescribed by a Plan Provider and obtained from a Plan Pharmacy, call our Part D unit at **1-866-206-2973**, 8:30 a.m. to 5 p.m., seven days a week.

TTY **1-800-777-1370**

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. (Calls to this number are free.)

8 a.m. to 8 p.m., seven days a week.

Write Kaiser Foundation Health Plan, Inc.
Claims Department
P.O. Box 24010
Oakland, CA 94623-1010

If you are requesting payment of a Part D drug that was prescribed and provided by a Plan Provider, you can fax your request to **1-866-206-2974** or write us at P.O. Box 23170, Oakland, CA 94623-0170 (Attention: Part D Unit).

Medicare

How to get help and information directly from the federal Medicare program

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant). The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage organizations, including our Plan.

Medicare

Call **1-800-MEDICARE** or **1-800-633-4227**

Calls to this number are free. 24 hours a day, seven days a week.

TTY **1-877-486-2048**

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Calls to this number are free.

Website www.medicare.gov

This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state by selecting "Help and Support" and then clicking on "Useful Phone Numbers and Websites."

The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:

Medicare Eligibility Tool: Provides Medicare eligibility status information. Select "Find Out if You're Eligible."

Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare Health Plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select "Health & Drug Plans" and then "Compare Drug and Health Plans" or "Compare Medigap Policies." These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

State Health Insurance Assistance Program

Free help, information, and answers to your questions about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors for every state. For California, the State Health Insurance Assistance Program is called the Health Insurance Counseling and Advocacy Program (HICAP).

The Health Insurance Counseling and Advocacy Program is independent (not connected with any insurance company or health plan). It is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

The Health Insurance Counseling and Advocacy Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your Services or treatment, and help you straighten out problems with your Medicare bills. The Health Insurance Counseling and Advocacy Program counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Health Insurance Counseling and Advocacy Program (California's State Health Insurance Assistance Program)

Call **1-800-434-0222**

Calls to this number are free.

TTY **711**

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Write **Your HICAP office for your county.**

Website www.aging.ca.gov

Quality Improvement Organization

Paid by Medicare to check on the quality of care for people with Medicare

There is a Quality Improvement Organization in each state. In California, the Quality Improvement Organization is called the Health Services Advisory Group.

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

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

- You have a complaint about the quality of care you have received
- You think coverage for your hospital stay is ending too soon
- You think coverage for your home health care, Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon

Health Services Advisory Group (California's Quality Improvement Organization)

Call **1-800-841-1602**
Calls to this number are free. 24 hours a day, seven days a week.

TTY **1-800-881-5980**
This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Fax **1-866-800-8757**

Write Health Services Advisory Group, Inc.
Attn: Beneficiary Protection
5201 W. Kennedy Boulevard, Suite 900
Tampa, Florida 33609-1822

Website hsag.com/camedicare

Social Security

The Social Security Administration is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or end stage renal disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security Administration

Call **1-800-772-1213**

Calls to this number are free. Available 7:00 a.m. to 7:00 p.m., Monday through Friday.

You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.

TTY **1-800-325-0778**

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Calls to this number are free. Available 7:00 a.m. to 7:00 p.m., Monday through Friday.

Website www.ssa.gov

Medicaid

A joint federal and state program that helps with medical costs for some people with limited income and resources

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These programs help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other Cost Sharing
- **Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI):** Helps pay Part B premiums
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums

To find out more about Medicaid and its programs, contact Medi-Cal.

Medi-Cal (California's Medicaid program)

Call **1-800-952-5253**

24 hours a day, seven days a week.

TTY **1-800-952-8349**

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Write California Department of Social Services
P.O. Box 944243
Sacramento, CA 94244

Website cdss.ca.gov

Railroad Retirement Board

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

Railroad Retirement Board

Call **1-877-772-5772**

Calls to this number are free. Available 9:00 a.m. to 3:30 p.m., Monday through Friday.

If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.

TTY **1-312-751-4701**

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Calls to this number are *not* free.

Website www.rrb.gov

Group Insurance or Other Health Insurance from an Employer

If you have any questions about your employer-sponsored Group plan, please contact your Group's benefits administrator. You can ask about your employer or retiree health benefits, any contributions toward the group's premium, eligibility, and enrollment periods.

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