KAISER PERMANENTE®

Kaiser Foundation Health Plan of the Northwest

A nonprofit corporation

Portland, Oregon

Large Group Senior Advantage with Part D Plan

Group Agreement for County of Sonoma - Retirees

Group Number: 5613 Subgroup: 002

Term of Agreement

June 1, 2012 through May 31, 2013

Anniversary date

June 1

Authorized representative

WOLGSAMAPD0112

MEDICAL BENEFITS CHART: SENIOR ADVANTAGE WITH PART D

County of Sonoma - Retirees
5613-002

For group benefits effective June 1, 2012 to May 31, 2013

Services that are covered for you	What you must pay when you get these covered services
Out-of-Pocket	
Annual out-of-pocket limit	$2,000
Inpatient Care	
Inpatient hospital care† There is no limit to the number of medically necessary hospital days or services that are generally and customarily provided by acute care general hospitals. Covered services include: • Semiprivate room (or a private room if medically necessary). • Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive care or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Multidiscplinary rehabilitation services. • Physical, occupational, and speech language therapy. • Inpatient substance abuse services for medical management of withdrawal symptoms associated with substance abuse (detoxification). • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow,	$250 per admission for a covered stay at a network hospital. Thereafter, there is no charge for the remainder of your hospital stay. Except in an emergency, your provider must tell the plan that you are going to be admitted to the hospital. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. **Note:** If you are admitted to the hospital in 2011 and are not discharged until sometime in 2012, the 2011 cost-sharing will apply to that admission until you are discharged from the hospital or transferred to a skilled nursing facility.

Services that are covered for you	What you must pay when you get these covered services
stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. If we provide transplant services at a distant location (farther away than the normal community patterns of care) and you choose to obtain transplants at this distant location, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. If you are sent outside of your community for a transplant, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood - including storage and administration. Coverage of whole blood and packed red cells and all other components of blood begins with the first pint of blood you need. • Physician services. Note: To be an "inpatient," your provider must write an order to admit you to the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an "inpatient," you should ask the hospital staff. You can also find more information in a Medicare fact sheet called, "*Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!*" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week	

† Your provider must obtain prior authorization from our plan.

Services that are covered for you	What you must pay when you get these covered services
Inpatient mental health care† Covered services include mental health care services that require a hospital stay.	$250 per admission for a Medicare-covered stay at a network hospital. Thereafter, there is no charge for the remainder of your hospital stay. Except in an emergency, your provider must tell the plan that you are going to be admitted to the hospital.
Skilled nursing facility (SNF) care† (For a definition of "skilled nursing facility care," see Chapter 12 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") We cover up to 100 days per benefit period of skilled inpatient services in a skilled nursing facility and in accord with Medicare guidelines (a prior hospital stay is not required). Covered services include: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Regular nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body such as blood clotting factors). • Blood – including storage and administration. Coverage of whole blood and packed red cells and all other components of blood begins with the first pint of blood that you need. • Medical and surgical supplies ordinarily provided by SNFs. • Laboratory tests ordinarily provided by SNFs. • X-rays and other radiology services ordinarily provided by	**No charge.**

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Services that are covered for you	What you must pay when you get these covered services
SNFs. • Use of appliances such as wheelchairs ordinarily provided by SNFs. • Physician services. Generally, you will get your SNF care from plan facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a plan provider, 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 SNF where your spouse is living at the time you leave the hospital.	
Inpatient services covered during a noncovered inpatient stay† If you have exhausted your skilled nursing facility (SNF) benefits or if the inpatient hospital stay is not reasonable and necessary, we will not cover your inpatient or SNF stay. However, in some cases, we will cover certain services while you are in the hospital or the skilled nursing facility (SNF). Covered services include:	
• Physician services.	$15 per primary office visit. $15 per specialty office visit.
• Diagnotic tests (like lab tests).	**No charge.**
• X-ray, radium, and isotope therapy including technician materials and services.	$15 for each visit for radiation treatment.
• Surgical dressings.	20% of the charges for take-home dressings.
• Splints, casts and other devices used to reduce fractures and dislocations.	**No charge** when applied by network provider during visit.
• Prosthetics and orthotics devices (other than dental) that	**No charge** for internally implanted

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Services that are covered for you	What you must pay when you get these covered services
replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices.	devices.
• Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition.	20% of the charges.
• Physical therapy, speech therapy, and occupational therapy.	$15
Home health agency care† Covered services include: • Part-time or intermittent skilled nursing and home health aide services. To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week. • Physical therapy, occupational therapy, and speech therapy. • Medical and social services. • Medical equipment and supplies.	**No charge.** Services must be received within the service area.
Hospice care† You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out-of-network 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 the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. Covered services include: • Drugs for symptom control and pain relief. • Short-term respite care. • Home care. You are still a member of our plan. If you need nonhospice care (care that is not related to your terminal condition), you	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, not our plan.

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Services that are covered for you	What you must pay when you get these covered services
have options. • You can obtain your nonhospice 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 nonhospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your nonhospice care through our network providers will lower your share of the costs for the services.	
Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	**No charge.**
Outpatient Services	
Physician services, including doctor's office visits† Covered services include:	
• Medically necessary medical or surgical services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location. • Office visits, including medical and surgical care in a physician's office. • Medical or surgical services furnished in a certified ambulatory surgical center or in a hospital outpatient setting. • Consultation, diagnosis, and treatment by a specialist. • Basic hearing and balance exams performed by your primary care provider or plan specialist, if your doctor orders it to see if you need medical treatment.	$15 for each primary care visit. $0 for each prenatal and postnatal care visit. $15 for each specialty care visit. $100 for each visit for outpatient procedures or surgery performed in an ambulatory surgical center or outpatient hospital setting.
• Telehealth office visits including consultation, diagnosis, and treatment by a specialist.	**No charge.**

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Services that are covered for you	What you must pay when you get these covered services
• Second opinion by another network provider prior to surgery.	$15 for a second opinion by another primary care plan provider. $15 for a second opinion by another plan specialist. Copayment is based on the medical department where service is provided not the type of provider. "Providers" include but are not limited to physicians, physician assistants and nurse practitioners. Also, see Preventive Care and Screening Tests section of this Medical Benefits Chart.
• Non-routine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician.)	In general, you pay 100% for dental services. Coverage is limited to only what is covered under Medicare coverage guidelines. If you are treated at a plan medical facility or dental facility, you would not pay an additional dental copayment. However, the applicable medical copayment may apply. A dentist may need to authorize dental care.
Outpatient hospital services† We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include:	
• Services in an emergency department or outpatient clinic, including same-day surgery.	$50 (Waived if admitted) for each emergency department visit (prior authorization not required). $15 for each urgent care visit (prior

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Services that are covered for you	What you must pay when you get these covered services
	authorization not required). $100 for each visit for outpatient procedures or surgery performed in an ambulatory surgical center or outpatient hospital setting.
• Laboratory tests billed by the hospital.	**No charge** for lab tests.
• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it.	Half of the inpatient hospitalization cost-sharing per admit to partial hospitalization program.
• X-rays and other radiology services billed by the hospital.	**No charge** for X-rays; $0 for special imaging procedures. $15 for each radiation treatment.
• Medical supplies such as splints and casts.	20% of the charges for take home dressing/supplies.
• Certain screenings and preventive services.	$0 (includes annual physical exam) for preventive care.
• Certain drugs and biologicals that you can't give yourself.	No additional charge beyond the applicable visit copayment for drugs administered in an outpatient setting.
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called, "*Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!*" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for	

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Services that are covered for you	What you must pay when you get these covered services
free, 24 hours a day, 7 days a week.	
• Pain management office visits.	$15 for each individual visit. Half of specialty office visit copayment for each group visit.
Chiropractic services (referred) † Covered services, include: • We cover only manual manipulation of the spine to correct subluxation. These Medicare-covered services are provided by a participating chiropractor of The CHP Group. A referral by a plan provider is required.	$15 for each visit.
Podiatry services† Covered services include: • Treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	$15 for each visit.
Outpatient mental health care Covered services include: • Mental health services provided by a doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws. • Outpatient intensive treatment.	$15 for each individual therapy visit. Half of office visit copayment for each group therapy visit. $15 per day for intensive outpatient treatment services. Copayment is based on the medical department where the service is provided, not the type of provider.
Partial hospitalization services† "Partial hospitalization" is a structured program of active psychiatric treatment provided in a hospital outpatient setting or by a community mental health center that is more intense	Half of the inpatient hospitalization cost-sharing per admit to partial hospitalization treatment program.

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Services that are covered for you	What you must pay when you get these covered services
than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.	Thereafter, there is no charge for the remainder of your stay. See the end of this Medical Benefits Chart for residential mental health treatment.
Outpatient substance abuse services	$15 for each individual therapy visit Half of office visit copayment for each group therapy visit $15 per day for day treatment services See the end of this Medical Benefits Chart for residential substance abuse treatment
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers† **Note:** We cover reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defect, developmental abnormalities, accidental injury, 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, including reconstructive surgery following a mastectomy. We do not cover reconstructive surgery that offers only a minimal improvement in appearance or is performed to alter or reshape normal structures of the body in order to improve appearance.	$100 for each visit for outpatient procedure or surgery performed in an ambulatory surgical center or hospital outpatient setting.
Ambulance services Coverage is worldwide. • Covered ambulance services include fixed wing, rotary wing, and group ambulance services, to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated	$100 for each one way trip for medically necessary services.

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Services that are covered for you	What you must pay when you get these covered services
(could endanger the person's health) or if authorized by the plan. The member's condition must require both the ambulance transportation itself and the level of service provided in order for the billed service to be considered medically necessary. • In addition to Original Medicare's coverage described above, we cover the services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the **911** emergency response system where available) if one of the following is true: ♦ You reasonably believe that you have an emergency medical condition and you reasonably believe that your condition requires the clinical support of ambulance transport 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. ♦ You may need to file a claim for reimbursement unless the provider agrees to bill us (chapter 7). We do not cover 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 network provider. • Non-emergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required. †	
Emergency care Emergency care is care that is needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine believe that you have medical symptoms that require	$50 (Waived if admitted) for each emergency room visit. This copayment does not apply if you are admitted directly to the

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Services that are covered for you	What you must pay when you get these covered services
immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. You have worldwide emergency coverage.	hospital as an inpatient (it does apply if you are admitted for anything other than inpatient care, for example, it does apply if you are admitted for observation). If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by the plan and your cost is the cost-sharing you would pay at a network hospital.
Urgently needed care Urgently needed care is care provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care, but our plan's network of providers is temporarily unavailable or inaccessible. **Inside our service area.** You must obtain urgent care from network providers, except in unusual and extraordinary circumstances (e.g., major disaster), if our provider network is temporarily unavailable or inaccessible. **Outside our service area.** You have worldwide urgent care coverage when you travel if you need medical attention right away for an unforeseen illness or injury when it isn't reasonable to get the care from a network provider See Chapter 3, Section 3, for more information.	$15 for each visit.

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Services that are covered for you	What you must pay when you get these covered services
Outpatient rehabilitation services† Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	$15 for each visit. $15 per day.
Cardiac rehabilitation services† Comprehensive programs that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral. The plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	$15 for each visit.
Pulmonary rehabilitation services† Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating their chronic respiratory disease. In addition to Original Medicare's coverage described above, we also cover pulmonary rehabilitation services when medically necessary.	$15 for each visit.
Durable medical equipment and related supplies† (For a definition of "durable medical equipment," see Chapter 12 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.	For Medicare-covered items: 20% of the charges for each formulary item when provided within the service area. **No charge** for certain items such as home ventilators, and home IV infusion pump, equipment and supplies.

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Services that are covered for you	What you must pay when you get these covered services
Prosthetic devices and related supplies† Devices (other than dental) that replaces a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery – see "Vision care" later in this section for more detail.	20% of the charges of each external device. **No charge** for each internally implanted device.
Diabetes self-management training and diabetic services and supplies† For all people who have diabetes (insulin and non-insulin users), covered services include: • Blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.	**No charge** for diabetes self-management items and supplies.
• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the non-customized removable inserts provided with such shoes).Coverage includes fitting.	20% of the charges for shoes and inserts. Office visit copayment may apply.
• Diabetes self-management training is covered under certain conditions.	**No charge** for training through Health Education Department or for ADA certified classes (see *Health Living* catalog for classes).
• For persons at risk of diabetes: Fasting plasma glucose tests when medically necessary.	**No charge.**

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Services that are covered for you	What you must pay when you get these covered services
Outpatient diagnostic tests and therapeutic services and supplies † Covered services include, but are not limited to: • X-rays.	For Medicare covered services: **No charge.**
• Radiation (radium and isotope) therapy, including technician materials and supplies.	$15 per visit.
• Surgical supplies, such as dressings.	**No charge** for surgical dressings and supplies when applied by a network provider during a visit.
• Splints, casts, and other devices used to reduce fractures and dislocations.	20% of the charges for take-home dressings and supplies.
• Laboratory tests.	**No charge** for lab tests. $15 for each specialty office visit during which a clinical diagnostic test is provided.
• Blood. Coverage begins with the first pint of blood that you need including coverage of storage and administration.	**No charge** for blood administration.
Other outpatient diagnostic test:	
• Special diagnostic procedures such as electrocardiograms and Holter monitoring.	**No charge.**
• Special imaging procedures, for example, MRI, CT, PET scans.	$0 for each visit.
• Certain services provided by Nursing Services, such as suture removal or nurse education on self administered drugs.	Office visit copayment will apply.
• Allergy shots and other injections administered by Nursing Services.	$10 for each visit (except immunizations).
• Allergy shots and other injections administered in other outpatient settings (for example, urgent care).	Copayment is based on the medical department where the service is provided.

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Services that are covered for you	What you must pay when you get these covered services
• Phototherapy sessions.	$5 for each visit.
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and conditions of the eye. Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. However, our plan does cover the following exams: ♦ Routine eye exams (eye refraction exams) to determine the need for vision correction and to provide a prescription for eyeglass lenses. ♦ For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year.	$15 for each visit with optometrist for routine eye exam, including glaucoma screening. $15 for each visit with ophthalmologist for eye exams, including glaucoma screening.
♦ One pair of basic eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Corrective lenses/frames needed after a cataract removal without a lens implant. **Note:** You may request insertion of presbyopia-correcting intraocular lenses (IOL) in place of a conventional IOL following cataract surgery. You pay that portion of the charge for the IOL and associated services that exceed the charge for insertion of a conventional IOL following cataract surgery.	**No charge** for Medicare-covered eyewear (one pair of eyeglasses or contact lenses after each cataract surgery).
• Prescription eyewear (glasses and contact lenses).	Balance after $100 allowance every 24 months Eyewear must be purchased at a Vision Essentials by Kaiser Permanente location. (If covered, see rider document in *EOC* for additional information).

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Services that are covered for you	What you must pay when you get these covered services
Preventive Services	
For all preventive services that are covered at no cost under Original Medicare, we also cover the services at no cost to you. However, if you are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.	
Abdominal aortic aneurysm screening † A one-time screening ultrasound for people at risk. Our plan only covers this screening if you get a referral for it as a result of your "Welcome to Medicare" physical exam. We cover subsequent screenings when medically necessary.	**No charge**. **Note:** There is no cost-sharing for this preventive care. However, the applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Bone-mass measurements† For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	**No charge** for X-ray. **Note:** There is no cost-sharing for this preventive care. However, the applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Colorectal cancer screening† For people 50 and older, the following are covered: • Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • Fecal occult blood test, every 12 months.	**No charge**.
For people at high risk of colorectal cancer, we cover: • Screening colonoscopy (or screening barium enema as an alternative) every 24 months.	**No charge**.

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Services that are covered for you	What you must pay when you get these covered services
For people not at high risk of colorectal cancer, we cover: • Screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy.	**No charge**.
HIV screening For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover: • One screening exam every 12 months For women who are pregnant, we cover: • Up to three screening exams during a pregnancy. • HIV screening test after each exposure.	**No charge**. **Note:** There is no cost-sharing for this preventive care. However, the applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine. • Flu shots, once a year in the fall or winter. • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B. • Other vaccines if you are at risk such as tetanus toxoid when directly related to treatment of an injury.	**No charge** for vaccines covered by Part B. **Note:** There is no cost-sharing for this preventive care. However, the applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
• We also cover some vaccines under our Part D outpatient prescription drug benefit	Please see Chapter 6 for cost-sharing information for vaccines covered by Medicare Part D, for example drugs to prevent shingles.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39. • One mammogram every 12 months for women age 40	**No charge.** **Note:** There is no cost-sharing for this preventive care. However, the

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Services that are covered for you	What you must pay when you get these covered services
and older. • Clinical breast exams once every 24 months.	applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Cervical and vaginal screening Covered services include: • For all women, Pap tests and pelvic exams are covered once every 24 months. • If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months.	**No charge.** **Note:** There is no cost-sharing for this preventive care. However, the applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Prostate cancer screening exams For men age 50 and older, covered services include the following – once every 12 months: • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	**No charge.** **Note:** There is no cost-sharing for this preventive care. However, the applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Cardiovascular disease testing† Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) when medically necessary.	**No charge.** **Note:** There is no cost-sharing for this preventive care. However, the applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.

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Services that are covered for you	What you must pay when you get these covered services
"Welcome to Medicare" physical exam Our plan covers a one-time "Welcome to Medicare" physical exam, which includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** You must have the physical exam within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" physical exam.	**No charge.** **Note:** There is no cost-sharing for this preventive care. However, the applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" exam. However, you don't need to have had a "Welcome to Medicare" exam to be covered for annual wellness visits after you've had Part B for 12 months.	**No charge.** **Note:** There is no cost-sharing for this preventive care. However, the applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	**No charge.**
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a transplant when referred by	**No charge.** **Note:** There is no cost-sharing for

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Services that are covered for you	What you must pay when you get these covered services
your doctor.	this preventive care. However, the applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply to any nonpreventive services you receive during or subsequent to the visit.
Smoking and tobacco use cessation (counseling to stop smoking) If you use tobacco, but do not have signs or symptoms of tobacco related disease, we cover two counseling quit attempts within a 12 month period. Each counseling attempt includes up to four face-to-face visits. Includes up to six 1.5 hour sessions. If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco, we cover cessation counseling services. We cover two counseling quit attempts within a 12 month period. Each counseling attempt includes up to 4 face-to-face visits. See Healthy Living catalog for tobacco cessation offerings, such as up to six 1.5 hour sessions.	**No charge.** See the ***Healthy Living Classes/Products/Resources*** catalog on **kp.org** or request a copy from Membership Services.
Other Services	
Services to treat kidney disease and conditions Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.	**No charge** for Kidney Treatment Options and Pre-transplant classes, which require a referral. For information about the Kidney class offered through Health Education (no referral required), see the ***Healthy Living Classes/Products/Resources*** catalog on **kp.org** or request a copy

† Your provider must obtain prior authorization from our plan.

Services that are covered for you	What you must pay when you get these covered services
• Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3). • Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care). • Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments). • Home dialysis equipment and supplies. • Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply). Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B drugs, please go to the section below, "Medicare Part B prescription drugs.	from Membership Services. **No charge** for Medicare-covered inpatient, outpatient or home renal dialysis treatments. Refer to the "Inpatient Care" section of this Medical Benefits Chart for inpatient copayments. **No charge.**
Medicare Part B prescription drugs These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include: • Drugs that usually are not self-administered by the patient and are injected or infused while receiving physician, hospital outpatient, partial hospitalization, residential treatment, or ambulatory surgical center services.	**No charge.**
• Clotting factors you give yourself by injection if you have hemophilia.	**No charge.**

† Your provider must obtain prior authorization from our plan.

Services that are covered for you	What you must pay when you get these covered services
• Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant.	**No charge.**
• 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.	**No charge.**
• Antigens.	**No charge.**
• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoisis-stimulating agents, such as Procrit®.	**No charge.**
• Certain oral anti-cancer drugs and anti-nausea drugs.	Your applicable prescription copayment or coinsurance.
• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases.	Your applicable prescription copayment or coinsurance.
• Drugs administered in inpatient, residential treatment facility, medical offices, emergency rooms or by Home Health staff used for the therapeutic purposes that require administration or observation by medical personnel during self administration (does not include Part D covered immunizations).	No additional charge beyond the applicable visit copayment.

† Your provider must obtain prior authorization from our plan.

Services that are covered for you	What you must pay when you get these covered services
Medicare Part D prescription drugs Chapter 5 explains the Part D prescription drug benefit, including rules you must follow to have prescriptions covered. What you pay for your Part D prescription drugs through our plan is listed in Chapter 6.	$15/generic and $30/brand for up to a 30-day supply. When you use mail delivery, you get up to a 90-day supply of maintenance drugs for two copayments. After you have paid $4,700 in true out-of-pocket cost for Part D covered drugs in a calendar year, you will pay the lesser of your copayment or $3 generic and $7 brand per prescription. The better of Part D and standard formulary applies. We cover nonformulary drugs only when you meet exception criteria.
Additional Benefits	
Hearing services Basic hearing evaluations performed by your Primary Care Provider or plan provider are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. • Diagnostic hearing exams. • Routine hearing exams.	$15 per visit.
• Hearing aids.	Not covered (If covered, see rider document in the *EOC* for additional information).
Home infusion therapy† We cover home infusion supplies and drugs if all of the following are true:	**No charge.**

† Your provider must obtain prior authorization from our plan.

Services that are covered for you	What you must pay when you get these covered services
• Your prescription drug is on our Standard Formulary (or you have a formulary exception). • We approved your prescription drug for home infusion therapy. • Your prescription is written by network provider and filled at a network home-infusion pharmacy.	
Mental health and substance abuse residential treatment program†	Half of your inpatient copayment. Other outpatient cost-sharing also applies, such as prescription drugs and DME.
Health and wellness education programs These are programs focused on clinical health conditions such as high blood pressure, cholesterol, asthma, and special diets. Programs designed to enrich the health and lifestyles of members include weight management, smoking cessation, fitness, and stress management. Health education classes, smoking cessation programs, nutritional training, and other wellness programs are listed in our *Healthy Living* catalog. Copies are available in our medical offices as well as from Membership Services. Silver&Fit® fitness program: You have unlimited visits at any of the affiliated fitness facilities in our service area. The program includes the use of base or basic fitness membership services as defined by each fitness facility, as well as the ability to participate in the Silver&Fit® fitness class. A list of participating facilities is available from Membership Services.	You are covered for the following: ▪ Health education classes. ▪ Newsletter at no charge. ▪ Nutritional training. ▪ Smoking cessation classes at no charge. ▪ Nursing hotline at no charge. ▪ Disease management. ▪ Other wellness services. ▪ Health club membership/fitness classes at no charge. Copayments may apply unless noted. Contact Membership Services for more details or for a copy of the *Healthy Living* catalog.

† Your provider must obtain prior authorization from our plan.

Services that are covered for you	What you must pay when you get these covered services
Routine care out-of-area If you travel outside our service area, in the United States or its territories, we will provide coverage for preventive services and for routine, follow-up, and continuing care obtained from out-of-network providers not to exceed $1,000 in charges per calendar year. Senior Advantage will pay up to 80% of the Medicare allowable charge, if the provider accepts assignment. Senior Advantage will pay 80 % of the Medicare limiting charge, if the provider does not accept assignment. Durable medical equipment, prosthetics and orthotics and outpatient prescription drugs are not covered under this benefit. See Chapter 6 for information on our Mail-Delivery services outside the service area.	20% of Medicare allowable charges or limiting charges up to $1,000 annual benefit maximum. **Note:** Services that are covered under this travel benefit do not accrue to the annual out-of-pocket maximum.
Student out-of-area coverage A limited student out-of-area benefit is available to dependents who are temporarily away at school outside our service area if the subscriber gives us written certification that the dependent is a registered full-time student at an accredited college or accredited vocational school. We make limited payments for medically necessary routine, continuing, and follow-up medical care that a qualifying student dependent receives from non-plan providers outside our service area but inside the U.S. (which for the purpose of this benefit means the 50 states, the District of Columbia, and U.S. territories). This student out-of-area benefit cannot be combined with any other benefit we are covering elsewhere within this Medical Benefits Chart. You must certify your dependent's student status annually.	20% of the actual fee the provider, facility, or vendor charges up to $1,200 annual benefit maximum.
Alternative therapies (self-referred)	Not covered Also, see "Chiropractic Services" section in this Medical Benefits

† Your provider must obtain prior authorization from our plan.

Services that are covered for you	What you must pay when you get these covered services
	Chart. (If covered, see rider document in the *EOC* for additional information).

† Your provider must obtain prior authorization from our plan.

January 1–December 31, 2012

EVIDENCE OF COVERAGE

Your Medicare Health Benefits and Services and Prescription Drug Coverage

as a Member of **Kaiser Permanente Senior Advantage (HMO)**

This booklet gives you the details about your Medicare health and prescription drug coverage from January 1 to December 31, 2012. It explains how to get the health care you need covered. This is an important legal document. Please keep it in a safe place.

This plan, Kaiser Permanente Senior Advantage, is offered by Kaiser Foundation Health Plan of the Northwest (Health Plan). When this *Evidence of Coverage* says "we," "us," or "our," it means Health Plan. When it says "plan" or "our plan," it means Kaiser Permanente Senior Advantage (Senior Advantage).

Kaiser Permanente is a health plan with a Medicare contract.

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

This information is available in a different format for the visually impaired by calling Membership Services (phone numbers are on the back cover of this booklet).

Benefits, and/or copayments/coinsurance may change on January 1, 2013.

GPDEC0112

KAISER PERMANENTE®

2012 Evidence of Coverage

Table of Contents

This list of chapters and page numbers is just your starting point. For more help in finding information you need, go to the first page of a chapter. You will find a detailed list of topics at the beginning of each chapter.

CHAPTER 1. Getting started as a member

SECTION 1. Introduction

Section 1.1 You are enrolled in Senior Advantage, which is a Medicare HMO

You are covered by Medicare and you have chosen to get your Medicare health care and your prescription drug coverage through our plan, Kaiser Permanente Senior Advantage.

There are different types of Medicare health plans. Senior Advantage is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization). Like all Medicare health plans, this Medicare HMO is approved by Medicare and run by a private company.

Section 1.2 What is the *Evidence of Coverage* booklet about?

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

This plan is offered by Kaiser Foundation Health Plan of the Northwest (Health Plan). When this *Evidence of Coverage* says "we," "us," or "our," it means Health Plan. When it says "plan" or "our plan," it means Kaiser Permanente Senior Advantage (Senior Advantage).

The words "coverage" and "covered services" refer to the medical care and services and the prescription drugs available to you as a member of our plan.

Section 1.3 What does this chapter tell you?

Look through Chapter 1 of this *Evidence of Coverage* to learn:

- What makes you eligible to be a plan member?
- What is our service area?
- What materials will you get from us?
- Plan and Medicare premiums.
- How do you keep the information in your membership record up-to-date?

Section 1.4 What if you are new to Senior Advantage?

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

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

Section 1.5 Term of the *Evidence of Coverage*

This *Evidence of Coverage* explains what our plan covers in addition to your enrollment form, the *List of Covered Drugs* (Formulary), and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue to get Medicare coverage as a member of our plan only as long as your group continues to offer this plan, we choose to continue to offer our plan for the year in question, and the Centers for Medicare & Medicaid Services renews its approval of our plan.

SECTION 2. What makes you eligible to be a plan member?

Section 2.1 Your Medicare eligibility requirements

You are eligible for membership in our plan as long as:

- You live in our geographic service area (Section 2.3 below describes our service area).
- – *and* – you have Medicare Parts A and B.
- – *and* – you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

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 permitted by your group (please ask your group for details).

Section 2.2 What are Medicare Part A and Medicare Part B?

When you originally signed up for Medicare, you received information about how to get Medicare Part A and Medicare Part B. Remember:

- Medicare Part A generally covers services furnished by institutional providers such as hospitals, skilled nursing facilities, or home health agencies.
- Medicare Part B is for most other medical services (such as physician's services and other outpatient services) and certain items (such as durable medical equipment and supplies).

Section 2.3 Here is our plan service area for Senior Advantage

Although Medicare is a federal program, our plan is available only to individuals who live in our service area. To remain a member of our plan, you must keep living in this service area. The service area is described below.

- Our service area includes these counties in **Oregon**: **Clackamas**, **Columbia**, **Hood River**, **Marion**, **Multnomah**, **Polk**, **Washington**, and **Yamhill**.
- Our service area includes these parts of counties in **Oregon**:
  - **Benton**, the following ZIP codes only: 97330, 97331, 97333, 97339, 97370.
  - **Linn**, the following ZIP codes only: 97321, 97322, 97335, 97355, 97358, 97360, 97374, 97389.
- Our service area includes **Clark**, **Cowlitz**, and **Skamania** counties in **Washington**.
- Our service area includes these parts of counties in **Washington**:
  - **Lewis**, the following ZIP codes only: 98591, 98593, 98596.
  - **Wahkiakum**, the following ZIP codes only: 98612, 98647.

If you plan to move out of the service area, please contact Membership Services.

Section 2.4 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 (for example, your spouse).

Subscriber. You may be eligible to enroll as a Subscriber if you are one of the following persons:

- An employee of your group.
- Otherwise entitled to coverage through your group under a trust agreement, retirement benefit program, 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 the other requirements described under this Section 2:

- Your spouse.
- A person who is under the general or student limiting age specified by your group and who is any of the following:
  - Your or your spouse's child (including adopted children or children placed with you or your spouse for adoption) who are under age 26. A child adopted by you or your spouse, or for whom you or your spouse have assumed a legal obligation in anticipation of adoption.
  - Any other person for whom you or your spouse is a court-appointed guardian.

Note: Children born to an eligible Dependent other than the Subscriber or the Subscriber's Spouse are not eligible for coverage beyond the first 31 days unless the Subscriber or the Subscriber's Spouse adopts them or becomes their court-appointed guardian.

- A person who is under the student dependent limiting age specified by your group and who is a full-time registered student at an accredited college or accredited vocational school and is any of the following:
  - Your or your spouse's child.
  - A child adopted by you or your spouse, or for whom you or your spouse have assumed a legal obligation in anticipation of adoption.
  - Any other person for whom you or your spouse is a court-appointed guardian.

Students who suffer a severe illness or injury that causes them to lose full-time student status will continue to be considered full-time students for eligibility purposes, provided that within 31 days after the loss of full-time student status, we receive written certification from the child's treating physician that the child is suffering from a serious illness or injury and that the leave of absence or other change of enrollment is Medically Necessary. Eligibility as a full-time student under this provision may then continue for up to 12 months from the date that your child's medical leave of absence began, or until your child reaches the student dependent limiting age specified by your group, which ever comes first.

- An person of any age who is chiefly dependent upon you or your spouse for support and maintenance if the person is incapable of self-sustaining employment by reason of developmental disability or physical handicap which occurred prior to his or her reaching the general dependent limiting age specified by your group, if the person is any of the following:
  - Your or your spouse's child.
  - A child adopted by you or your spouse, or for whom you or your spouse have assumed a legal obligation for total or partial support in anticipation of adoption.
  - Any other person for whom you or your spouse is a court-appointed guardian and was a court-appointed guardian prior to the person's reaching the limiting age specified by your group.

You must give us proof of incapacity and dependency annually if we request it, but only after the two-year period following attainment of the general dependent limiting age specified by your group.

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.

Section 2.5 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 in

this section, enrollment is permitted and membership begins at the beginning (12 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 Section 2.5.

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 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 subscribers

When your group informs you that you are eligible to enroll as a subscriber, you may enroll yourself and any eligible dependents by submitting the applicable Health Plan–approved enrollment application or 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 subscribers and their eligible family dependents is determined by your group, 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 the applicable Health Plan–approved change of enrollment form or 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 determined by your group, 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 the applicable Health Plan–approved enrollment application or 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 next 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 the applicable Health Plan–approved enrollment or change of enrollment application or 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 31 days after marriage, establishment of domestic partnership, birth, adoption, or placement for adoption by submitting to your group the applicable Health Plan–approved enrollment application or 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 the applicable enrollment application or 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 (non group) 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 or Children's Health Insurance Program coverage, or Access for Infants or 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 the applicable Health Plan–approved enrollment or change of enrollment application or 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 or 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 30 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 eligibility requirements as a dependent, the subscriber may add the spouse or child as a dependent by submitting to your group the applicable Health Plan-approved enrollment or change of enrollment application or a Senior Advantage Election For each person.

Subject to confirmation by the Centers for Medicare & Medicaid Services, your group will determine the effective date of an enrollment resulting from a court or administrative order, except that subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date cannot be earlier than the date of the order and cannot be later than the first day of the month following the date of the order.

Special enrollment due to eligibility for premium subsidy under Medicaid or CHIP. You may enroll as a subscriber (along with any or all eligible dependents), and existing subscribers may add any or all eligible dependents, if the subscriber or at least one of the enrolling dependents becomes eligible to receive premium assistance under Medicaid or CHIP.

To request enrollment, the subscriber must submit the applicable Health Plan-approved enrollment or change of enrollment application or Senior Advantage Election Form for each person, to your group within 60 days after the subscriber or dependent is determined eligible for premium assistance. Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from eligibility for the premium assistance under Medicaid or CHIP is no later than the first day of the month following the date your group receives the applicable enrollment or change of enrollment application or Senior Advantage Election Form for each person, from the subscriber.

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.

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

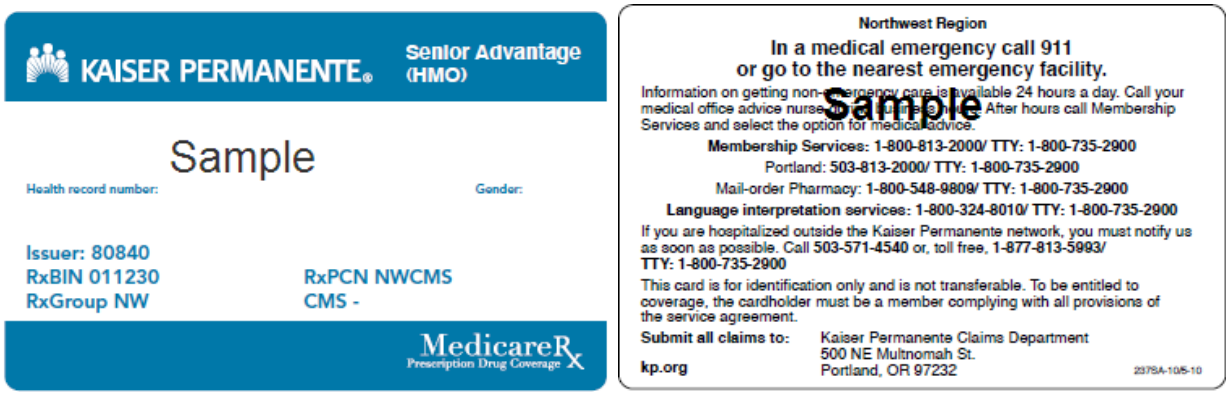
be reenrolled in your group's health plan if required by state or federal law. Please ask your group for more information.

Subject to confirmation by the Centers for Medicare & Medicaid Services, your group will determine the effective date of an enrollment resulting from a court or administrative order, except that subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date cannot be earlier than the date of the order and cannot be later than the first day of the month following the date of the order.

SECTION 3. What other materials will you get from us?

Section 3.1 Your plan membership card — Use it to get all covered care and prescription drugs

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



As long as you are a member of our plan, **you must not use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). Keep your red, white, and blue Medicare card in a safe place in case you need it later.

Here's why this is so important: If you get covered services using your red, white, and blue Medicare card instead of using your membership card while you are a plan member, you may have to pay the full cost yourself.

If your plan membership card is damaged, lost, or stolen, call Membership Services right away and we will send you a new card.

Section 3.2 The *Senior Advantage Directory*: Your guide to all providers and pharmacies in our network

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

If you don't have your copy of the *Senior Advantage Directory*, you can request a copy from Membership Services. You may ask Membership Services for more information about our network providers, including their qualifications. A complete list of network providers and pharmacies is available online at our website **kp.org**. Both Membership Services and the website can give you the most up-to-date information about our network providers and pharmacies.

What are "network providers"?

Network providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan.

Why do you need to know which providers are part of our network?

It is important to know which providers are part of our network because, with limited exceptions, while you are a member of our plan you must use network providers to get your medical care and services. The only exceptions are emergencies, urgently needed care when the network is not available (generally, when you are out of the area), out-of-area dialysis services, care covered under our travel benefit, and cases in which our plan authorizes use of out-of-network providers. See Chapter 3, "Using our plan's coverage for your medical services," for more specific information about emergency, out-of-network, and out-of-area coverage.

If you don't have your copy of the *Senior Advantage Directory,* you can request a copy from Membership Services. You may ask Membership Services for more information about our network providers, including their qualifications. You can view or download the *Senior Advantage Directory* at **kp.org.** Both Membership Services and our website can give you the most up-do-date information about our network providers.

What are "network pharmacies"?

Our *Senior Advantage Directory* gives you a complete list of our network pharmacies – that means all of the pharmacies that have agreed to fill covered prescriptions for our plan members.

Why do you need to know about network pharmacies?

You can use the *Senior Advantage Directory* to find the network pharmacy you want to use. This is important because, with few exceptions, you must get your prescriptions filled at one of our network pharmacies if you want our plan to cover (help you pay for) them.

Section 3.3 Our plan's *List of Covered Drugs* (Formulary)

Our plan has a *List of Covered Drugs* (Formulary). We call it the "*Drug List*" for short. It tells which Part D prescription drugs are covered by our plan. The drugs on this list are selected by our plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved our *Drug List*. The *Drug List* also tells you if there are any rules that restrict coverage for your drugs.

We will send you a copy of the *Drug List*. The *Drug List* we send to you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed *Drug List*. If one of your drugs is not listed in the *Drug List*, you should visit our website or contact Membership Services to find out if we cover it. To get the most complete and current information about which drugs are covered, you can visit our website (**kp.org/seniormedrx**) or call Membership Services (phone numbers are on the back cover of this booklet).

Section 3.4 The *Explanation of Benefits* (the "*EOB*"): Reports with a summary of payments made for your Part D prescription drugs

When you use your Part D prescription drug benefits, we will send you a summary report to help you understand and keep track of payments for your Part D prescription drugs. This summary report is called the *Explanation of Benefits* (or the "*EOB*").

The *EOB* tells you the total amount you have spent on your Part D prescription drugs and the total amount we have paid for each of your Part D prescription drugs during the month. Chapter 6 ("What you pay for your Part D prescription drugs") gives more information about the *EOB* and how it can help you keep track of your drug coverage.

An *EOB* summary is also available upon request. To get a copy, please contact Membership Services.

You can also choose to get your *EOB* online instead of by mail. Please visit **kp.org/gopaperless** and sign on to learn more about choosing to view your *EOB* securely online.

SECTION 4. Premiums

Section 4.1 Plan and Medicare premiums

Plan 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.

Medicare premiums

As explained in Section 2 above, in order to be eligible for our plan, you must be entitled to Medicare Part A and/or enrolled in Medicare Part B. Some members will be paying a premium for Medicare Part A and most members will be paying premium for Medicare Part B to Medicare directly. You must continue paying your Medicare premiums to remain a member of our plan.

Medicare late enrollment penalties. If you become eligible for Medicare Part B and do not enroll, Medicare may require you to pay a late enrollment penalty to get Medicare Part B coverage if you later enroll in Medicare Part B. However, if you delay enrollment in Part B because you or your husband or wife are still working and have coverage through an employer group health plan, you may not have to pay the penalty. Also, if you are (or become) eligible for Medicare and go without creditable prescription drug coverage (drug coverage that is at least as good as the standard Medicare Part D prescription drug coverage) for a continuous period of 63 days or more, you may have to pay a late enrollment penalty if you later sign up for Medicare prescription drug coverage. If you are (or become) eligible for Medicare, your Group is responsible for informing you about whether your drug coverage under this *Evidence of Coverage* is creditable prescription drug coverage at the time required by the Centers for Medicare & Medicaid Services and upon your request. If you are required to pay a late enrollment, your group will inform you the amount that you will be required to pay your group. See Chapter 6 for more information.

Part D premium due to income. Some people pay an extra amount for Medicare Part D drug coverage 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 Medicare an extra amount for your Medicare Part D coverage. If you have to pay an extra amount, the Social Security Administration, not our plan, will send you a letter telling you what that extra amount will be. For more information about Part D premiums based on income, go to Chapter 6, Section 10 of this booklet. You can also visit **http://www.medicare.gov** on the web or call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. Or, you may call the Social Security Administration at **1-800-772-1213**. TTY users should call **1-800-325-0778**.

- Your copy of *Medicare & You 2012* gives information about these premiums in the section called "2012 Medicare Costs." This explains how Medicare premiums differ for people with different incomes.
- Everyone with Medicare receives a copy of *Medicare & You* each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of *Medicare & You 2012* from the Medicare website **(http://www.medicare.gov)**. Or, you can order a printed copy by phone at **1-800-MEDICARE (1-800-633-4227),** 24 hours a day, 7 days a week. TTY users call **1-877-486-2048**.

SECTION 5. Please keep your plan membership record up-to-date

Section 5.1 How to help make sure that we have accurate information about you

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

The doctors, hospitals, pharmacists, and other providers in our network need to have correct information about you. **These network providers use your membership record to know what services and drugs are covered for you**. Because of this, it is very important that you help us keep your information up-to-date.

Let us know about these changes:

- Changes to your name, your address, or your phone number.
- Changes in any other health insurance coverage you have (such as from your employer, your spouse's employer, workers' compensation, or Medicaid).
- If you have any liability claims, such as claims from an automobile accident.
- If you have been admitted to a nursing home.
- If your designated responsible party (such as a caregiver) changes.
- If you are participating in a clinical research study.

If any of this information changes, please let us know by calling Membership Services (phone numbers are on the back cover of this booklet).

Read over the information we send you about any other insurance coverage you have

Medicare requires that we collect information from you about any other medical or drug insurance coverage that you have. That's because we must coordinate any other coverage you have with your benefits under our plan. (For more information about how our coverage works when you have other insurance, see Section 7 in this chapter.)

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Membership Services (phone numbers are on the back cover of this booklet).

SECTION 6. We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

For more information about how we protect your personal health information, please go to Chapter 8, Section 1.4, of this booklet.

SECTION 7. How other insurance works with our plan

Section 7.1 Which plan pays first when you have other insurance?

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

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

- If you have retiree coverage, Medicare pays first.
- If your group health plan coverage is based on your or a family member's current employment, who pays first depends upon your age, the size of the employer, and whether you have Medicare based on age, disability, or End-Stage Renal Disease (ESRD):
  - If you're under 65 and disabled and you or your family member is still working, your plan pays first if the employer has 100 or more employees or at least one employer in a multiple employer plan has more than 100 employees.
  - If you're over 65 and you or your spouse is still working, the plan pays first if the employer has 20 or more employees or at least one employer in a multiple employer plan has more than 20 employees.
  - If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

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

CHAPTER 2. Important phone numbers and resources

SECTION 1. Kaiser Permanente Senior Advantage contacts (how to contact us, including how to reach Membership Services at our plan)

How to contact our plan's Membership Services

For assistance with claims, billing, or membership card questions, please call or write to Senior Advantage Membership Services. We will be happy to help you.

Membership Services	
CALL	**1-877-221-8221** Calls to this number are free. Hours of operation are 8 a.m. to 8 p.m., seven days a week. Membership Services also has free language interpreter services available for non-English speakers by calling **1-800-324-8010**, 24 hours a day, seven days a week.
TTY	**1-800-735-2900** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation are 8 a.m. to 8 p.m., seven days a week.
FAX	**503-813-3985**
WRITE	Membership Services Kaiser Foundation Health Plan of the Northwest 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099
WEBSITE	**kp.org**

How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care or 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 medical services or Part D prescription drugs. 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 or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes.

For more information on asking for coverage decisions or making an appeal or complaint about your medical care or Part D prescription drugs, see Chapter 9, "What to do if you have a problem

or complaint (coverage decisions, appeals, and complaints)." You may call us if you have questions about our coverage decision process.

Coverage decisions, appeals, and complaints for medical care or Part D prescription drugs	
CALL	**1-877-221-8221** Calls to this number are free. Hours of operation are 8 a.m. to 8 p.m., seven days a week. (If you require a “fast” decision, “fast appeal," or "fast" complaint, described in Chapter 9, you may also call Member Relations directly at **503-813-4480**, 8 a.m. to 5 p.m., Monday – Friday.)
TTY	**1-800-735-2900** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation are 8 a.m. to 8 p.m., seven days a week.
FAX	**503-813-3985**
WRITE	Member Relations Kaiser Foundation Health Plan of the Northwest 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099

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

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 7, "Asking us to pay our share of a bill you have received for covered medical services or drugs."

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," for more information.

Payment requests	
CALL	**1-877-221-8221** Calls to this number are free. Hours of operation are 8 a.m. to 8 p.m., seven days a week.

Payment requests	
TTY	**1-800-735-2900** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Hours of operation are 8 a.m. to 8 p.m., seven days a week.
WRITE	Claims Administration Kaiser Foundation Health Plan of the Northwest 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099
WEBSITE	**kp.org**

SECTION 2. 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, 7 days a week.
TTY	**1-877-486-2048** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	**http://www.medicare.gov** This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state by selecting "Help and Support," and then clicking

Medicare	
	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.

SECTION 3. State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. Here is a list of the State Health Insurance Programs in each state we serve.

- In Oregon, the SHIP is called Senior Health Insurance Benefits Assistance (SHIBA).
- In Washington, the SHIP is called Statewide Health Insurance Benefit Advisors (SHIBA).

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

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

Senior Health Insurance Benefits Assistance (Oregon's SHIP) **Statewide Health Insurance Benefit Advisors (Washington's SHIP)**		
CALL	Oregon: **1-800-722-4134**	Washington: **1-800-562-6900**

TTY	Oregon: **1-800-735-2900** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking	
WRITE	Oregon SHIBA 250 Church St. SE, Suite 200 Salem, OR 97301-3921	Washington SHIBA PO Box 40256 Olympia, WA 98504-0256
WEBSITE	Oregon: **www.oregon.gov/dcbs/shiba**	Washington: **www.insurance.wa.gov/shiba**

SECTION 4. Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare)

There is a Quality Improvement Organization (QIO) for each state. Here is a list of the Quality Improvement Organizations in each state we serve:

- For Oregon, the Quality Improvement Organization is called Acumentra Health.
- For Washington, the Quality Improvement Organization is called Qualis Health.

The Quality Improvement Organization 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 Quality Improvement Organization is an independent organization. It is not connected with our plan.

You should contact the Quality Improvement Organization 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 are ending too soon.

Acumentra Health (Oregon's QIO) and Qualis Health (Washington's QIO)		
CALL	Acumentra Health: **503-279-0100 or 1-800-344-4354**. FAX: **503-279-0190**	Qualis Health: **1-800-445-6941**
TTY	Qualis Health: **1-800-251-8890** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking	
WRITE	Acumentra Health: 2020 SW Fourth Ave. Suite 520,	Qualis Health: 10700 Meridian Ave North

Acumentra Health (Oregon's QIO) and Qualis Health (Washington's QIO)		
	Portland, OR 97201	Suite 100 Seattle, WA 98133
WEBSITE	**acumentra.org**	**qualishealthmedicare.org**

SECTION 5. 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 a.m. to 7 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 a.m. to 7 p.m., Monday through Friday.
WEBSITE	**http://www.ssa.gov**

SECTION 6. 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 (like deductibles, coinsurance, and copayments).
- **Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs in either Oregon or Washington, use the contact information provided below.

Division of Medical Assistance Programs (Oregon's Medicaid program) and Department of Social and Health Services (Washington's Medicaid program)		
CALL	Oregon: **503-945-4772** or **1-800-273-0557**	Washington: **1-800-562-3022**
TTY	Oregon: **1-800-375-2863** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.	Washington: **1-800-848-5429**
WRITE	Oregon: Division of Medical Assistance Programs 500 Summer St. NE Salem, OR 97301	Washington: Department of Social and Health Services 1115 Washington St. SE Olympia, WA 98504
WEBSITE	**www.oregon.gov/OHA/healthplan/**	**www.adsa.dshs.wa.gov/**

SECTION 7. Information about programs to help people pay for their prescription drugs

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, 7 days a week;
- The Social Security Office at **1-800-772-1213**, between 7 am to 7 pm, Monday through Friday. TTY users should call **1-800-325-0778**; or
- Your state Medicaid office (see Section 6 of this chapter for contact information).

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 pharmacy, our plan has established a process that allows you either to request assistance in obtaining evidence of your proper copayment 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 network pharmacy or Membership Services. 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 network pharmacy when obtaining covered Part D prescriptions so that we may charge you the appropriate cost-sharing amount until CMS (the Centers for Medicare & Medicaid Services) updates its records to reflect your current status. Once CMS updates its records, you will no longer need to present the evidence to the pharmacy. Please provide your evidence in one of the following ways so we can forward it to CMS 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 network pharmacy or your local Membership Service office at a plan facility.

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

Medicare Coverage Gap Discount Program

The 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 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 copay 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 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 Membership Services (phone numbers are on the back cover of this booklet).

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

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

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

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

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

If you think that you have reached the coverage gap and did not get a discount when you paid for your brand-name drug, you should review your next *Explanation of Benefits* (*EOB*) notice. If the discount doesn't appear on your *Explanation of Benefits*, you should contact us to make sure that your prescription records are correct and up-to-date. If we don't agree that you are owed a discount, you can appeal. You can get help filing an appeal from your State Health Insurance Assistance Program (SHIP) (telephone numbers are in Section 3 of this Chapter) or by calling **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

State Pharmaceutical Assistance Programs

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

These programs provide financial help for prescription drugs to limited income and medically needy seniors and individuals with disabilities. Here is a list of the State Pharmaceutical Assistance Programs in each state we serve:

- In Oregon, the State Pharmaceutical Assistance Program is the Oregon Prescription Drug Program.
- In Washington, the State Pharmaceutical Assistance Program is the Washington Prescription Drug Program.

Oregon Prescription Drug Program and Washington Prescription Drug Program		
CALL	Oregon: **503-373-1603** or **1-888-411-6737**	Washington: **206-521-2027**
WRITE	Oregon: General Services Building, 1225 Ferry St. SE	Washington: PO Box 91132

Oregon Prescription Drug Program and Washington Prescription Drug Program		
	Salem, OR 97301	Seattle, WA 98111-9232
WEBSITE	Oregon: **www.oregon.gov/OHA/pharmacy/OPDP**	Washington: **www.rx.wa.gov**

SECTION 8. How to contact the Railroad Retirement Board

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

Railroad Retirement Board	
CALL	**1-877-772-5772** Calls to this number are free. Available 9 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	**http://www.rrb.gov**

SECTION 9. "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 benefit administrator. You can ask about your employer or retiree health benefits, any contributions toward the group's premium, eligibility, and enrollment period.

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.

CHAPTER 3. Using our plan's coverage for your medical services

SECTION 1. Things to know about getting your medical care covered as a member of our plan

This chapter tells you things you need to know about using our plan to get your medical care covered. It gives definitions of terms and explains the rules you will need to follow to get the medical treatments, services, and other medical care that are covered by our plan.

For the details on what medical care is covered by our plan and how much you pay as your share of the cost when you get this care, use the Medical Benefits Chart found at the front of this *EOC.*

Section 1.1 What are "network providers" and "covered services"?

Here are some definitions that can help you understand how you get the care and services that are covered for you as a member of our plan:

- **"Providers"** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **"Network providers"** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan.
- **"Covered services"** include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart found at the front of this *EOC*.

Section 1.2 Basic rules for getting your medical care covered by our plan

As a Medicare health plan, our plan must cover all services covered by Original Medicare and must follow Original Medicare's coverage rules.

We will generally cover your medical care as long as:

- The care you receive is included in our plan's **Medical Benefits Chart** (found at the front of this *EOC*).
- The care you receive is considered **medically necessary**. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You have a **network primary care provider** (a PCP) who is providing and overseeing your care. As a member of our plan, you may choose a network PCP (for more information about this, see Section 2.1 in this chapter).
  - In most situations, your network PCP must give you approval in advance before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing

facilities, or home health care agencies. This is called giving you a "referral" (for more information about this, see Section 2.3 of this chapter).

- Referrals from your PCP are not required for emergency care or urgently needed care. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 of this chapter).

- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. Here are four exceptions:
  - The plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider if we authorize the services before you get the care. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.4 in this chapter.
  - We cover kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area.
  - If you travel outside our service area, in the United States or its territories, we will provide coverage for preventive services and for routine, follow-up, and continuing care obtained from out-of-network providers not to exceed $800 in covered charges per calendar year (see the Medical Benefits Chart found at the front of this *EOC*.

SECTION 2. Use providers in our network to get your medical care

Section 2.1 You may choose a Primary Care Provider (PCP) to provide and oversee your medical care

What is a "PCP" and what does the PCP do for you?

As a member, you may choose a network provider to be your primary care plan physician. Your primary care plan physician is a physician who meets state requirements and is trained to give you primary medical care. At some network facilities, if you prefer, you may choose a nurse practitioner or physician assistant to be your primary care plan provider. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the covered services you get as a member of our plan. For example, in order for you to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a network specialist).

Your PCP will provide most of your care and will help you arrange or coordinate the rest of the covered services you get as a member of our plan. This includes:

- X-rays.

- Laboratory tests.
- Therapies
- Care from doctors who are specialists.
- Hospital admissions.
- Follow-up care.

"Coordinating" your services includes checking or consulting with other network providers about your care and how it is going. If you need certain types of covered services or supplies, you must get approval in advance from your PCP (such as giving you a referral to see a specialist). In some cases, your PCP will need to get prior authorization (prior approval) from us. The services that require prior authorization from us are discussed in Chapter 4.

How do you choose your PCP?

Your relationship with your Primary Care Provider is an important one. That's why we strongly recommend you choose a PCP close to your home or place of employment as soon as you enroll. You choose who you want as your primary care provider. You can pick a doctor, nurse practitioner, or a physician assistant in family medicine, internal medicine, or obstetrics/gynecology. Also, women can select any available primary care plan provider from obstetrics/gynecology. Women's health services are available from the obstetrics/gynecology department without a referral from a PCP. You are not restricted to a particular PCP or plan facility. We encourage you to use the one facility that will be most convenient for you. The *Senior Advantage Directory* lists network providers by medical office.

You can always ask Membership Services for help in selecting your PCP. You can also request the name, title, professional, and educational qualifications of any Kaiser Permanente health care professional. Call Membership Services once you have selected a PCP at the numbers on the back of this booklet and also shown in Chapter 2, Section 1. They will ensure this information is updated in your membership file. If you are a new member, when you have chosen your PCP, we recommend that you have all of your medical records sent to Kaiser Permanente.

When you join our plan, you are selecting our medical care system to provide your medical care, including all Medicare covered services. You may use any Kaiser Permanente medical office when you need care. You aren't required to choose a primary care doctor. However, a primary care provider will generally be in the best position to see that you get the medical services you need. Your provider will become familiar with your history and unique health concerns. We hope you decide to choose a primary care provider.

Changing your PCP

You may change your PCP for any reason, at any time. Also, it's possible that your PCP might leave our network of providers and you would have to find a new PCP.

To change your PCP, call Membership Services. When you call, be sure to tell Membership Services if you are seeing specialists or getting other covered services that needed your PCP's approval (such as home health services and durable medical equipment). Membership Services will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Membership Services will change your membership record to show the name of your new PCP, and tell you when the change to your new PCP will take effect.

Section 2.2 What kinds of medical care can you get without getting approval in advance from your PCP?

You can get the services listed below without getting approval in advance from your PCP.

- Routine women's health care, which includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider.
- Flu shots and pneumonia vaccinations, as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed care from in-network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, for example, when you are temporarily outside of our service area.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area. (If possible, please call Membership Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.)
- If you visit the service area of another Kaiser Permanente region or Group Health Cooperative (GHC) for not more than 90 days, you can receive certain care from designated providers in that service area. Please call Membership Services for more information about getting care when visiting other Kaiser Permanente region's or the GHC service area, including coverage information and facility locations in the District of Columbia and in California, Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, and Virginia..
- Outpatient care for addiction or mental health at Kaiser Permanente's Addiction Medicine and Mental Health departments.
- Routine vision exams at a Kaiser Permanente Ophthalmology or Optometry department and hardware at Vision Essentials by Kaiser Permanente.
- Audiology.
- Cancer counseling.
- Cosmetic Center (cosmetic services are generally not considered medically necessary and are therefore not a covered benefit).
- Genetics.
- Obstetrics/gynecology.
- Occupational health.
- Social services.

Section 2.3 How to get care from specialists and other network providers

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:

- Oncologists, who care for patients with cancer.
- Cardiologists, who care for patients with heart conditions.
- Orthopedists, who care for patients with certain bone, joint, or muscle conditions.

Referrals from your PCP

You will usually see your PCP first for most of your routine health care needs. There are only a few types of covered services you may get on your own, without getting approval from your PCP first. When your PCP thinks that you need specialized treatment, he/she will give you a referral (approval in advance) to see a plan specialist or certain other providers.

For some types of referrals, your PCP may need to get approval in advance from our plan (this is called getting "prior authorization"). In these cases, if the specialist wants you to come back for more care, check first to be sure that the written referral (approval in advance) you got from us for the first visit covers more visits to the specialist.

Some preventive services, such as colonoscopies, may be performed by a physician assistant in accordance with the state practice act. However, you have the right to request that a medical doctor perform the service instead.

What if a specialist or another network provider leaves our plan?

Sometimes a specialist, clinic, hospital, or other network provider you are using might leave our plan. If this happens, you will have to switch to another provider who is part of our plan. Membership Services can assist you in finding and selecting another provider.

Section 2.4 How to get care from out-of-network providers

Care you receive from an out-of-network provider will not be covered except in the following situations:

- The plan covers emergency care or urgently needed care that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed care means, see Section 3 in this chapter.
- If your PCP decides that you require services not available from plan providers or plan facilities, he or she will recommend to us that you be referred to an out-of-network provider or facility inside or outside our service area. If it is determined that the services are medically necessary and are not available from a plan provider or plan facility and we determine that the services are covered services, we will authorize your referral to a out-of-network provider or facility for the covered services. The cost shares for these approved referral services are the same as those required for services provided by a plan provider or plan facility. You will need written authorization in advance in order for the services to be covered. If we authorize the

services, you will receive a written "Authorization for Outside Medical Care" approved referral to the out of-network provider or out-of-network facility, and only services that are listed on the written referral will be covered, subject to any benefit limitations and exclusions applicable to these services

- We cover kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area.
- We cover routine care outside the service area for If you travel outside our service area, in the United States or its territories, we will provide coverage for preventive services and for routine, follow-up, and continuing care obtained from out-of-network providers not to exceed $800 in covered charges per calendar year (see the Medical Benefits Chart found at the front of this *EOC*.

SECTION 3. How to get covered services when you have an emergency or an urgent need for care

Section 3.1 Getting care if you have a medical emergency

What is a "medical emergency" and what should you do if you have one?

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

If you have a medical emergency:

- **Get help as quickly as possible. Call 911** for help or go to the nearest emergency room, hospital, or urgent care center. Call for an ambulance if you need it. You do not need to get approval or a referral first from your PCP.
- As soon as possible, **make sure that our plan has been told about your emergency**. We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The phone number is listed on the back of your membership identification card.

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart found at the front of this *EOC*.

Also, you may get covered emergency medical care whenever you need it, anywhere in the world (see the Medical Benefits Chart found at the front of this *EOC* for more information).

If you have an emergency, we will talk with the doctors who are giving you emergency care to help manage and follow up on your care. The doctors who are giving you emergency care will decide when your condition is stable and the medical emergency is over.

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care may be covered by our plan. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow. Your follow-up post-stabilization care will be covered according to Medicare guidelines. It is very important that your provider call us to get authorization for post-stabilization care before you receive the care from the out-of-network provider. You will only be held financially liable if you are notified by the out-of-network provider or us about your potential liability.

What if it wasn't a medical emergency?

Sometimes it can be hard to know if you have a medical emergency. For example, you might go in for emergency care – thinking that your health is in serious danger – and the doctor may say that it wasn't a medical emergency after all. If it turns out that it was not an emergency, as long as you reasonably thought your health was in serious danger, we will cover your care.

However, after the doctor has said that it was not an emergency, we will cover additional care only if you get the additional care in one of these two ways:

- You go to a network provider to get the additional care.
- Or, the additional care you get is considered "urgently needed care" and you follow the rules for getting this urgent care (for more information about this, see Section 3.2 below).

Section 3.2 Getting care when you have an urgent need for care

What is "urgently needed care"?

"Urgently needed care" is a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care, but our plan's network of providers is temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have (for example, a flare-up of a chronic skin condition).

What if you are in our service area when you have an urgent need for care?

In most other situations, if you are in our service area, we will cover urgently needed care only if you get this care from a network provider and follow the other rules described earlier in this chapter. However, if the circumstances are unusual or extraordinary, and network providers are temporarily unavailable or inaccessible, we will cover urgently needed care that you get from an out-of-network provider.

What if you are <u>outside</u> our service area when you have an urgent need for care?

When you are outside the service area and cannot get care from a network provider, we will cover urgently needed care that you get from any provider. Our plan does cover emergency and urgently needed care outside of the United States.

SECTION 4. What if you are billed directly for the full cost of your covered services?

Section 4.1 You can ask our plan to pay its share of the cost of your covered services

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 7, "Asking us to pay our share of a bill you have received for covered medical services or drugs," for information about what to do.

Section 4.2 If services are not covered by our plan, you must pay the full cost

Our plan covers all medical services that are medically necessary, are listed in the Medical Benefits Chart (this chart is found at the front of this *EOC*), and are obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by our plan, either because they are not plan covered services or they were obtained out-of-network where not authorized.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. If we say we will not cover your services, you have the right to appeal our decision not to cover your care. Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Membership Services at the number on the back cover of this booklet to get more information about how to do this.

For covered services that have a benefit limitation, you pay the full cost of any services you get after you have used up your benefit for that type of covered service. Any amounts you pay after the benefit has been exhausted will not count toward the out-of-pocket maximum. You can call Membership Services when you want to know how much of your benefit limit you have already used.

SECTION 5. How are your medical services covered when you are in a "clinical research study"?

Section 5.1 What is a "clinical research study"?

A clinical research study is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. They test new medical care procedures or drugs by asking for volunteers to help with the study. This kind of study is one of the final stages of a research process that helps doctors and scientists see if a new approach works and if it is safe.

Not all clinical research studies are open to members of our plan. Medicare first needs to approve the research study. If you participate in a study that Medicare has not approved, you will be responsible for paying all costs for your participation in the study.

Once Medicare approves the study, someone who works on the study will contact you to explain more about the study and see if you meet the requirements set by the scientists who are running the study. You can participate in the study as long as you meet the requirements for the study and you have a full understanding and acceptance of what is involved if you participate in the study.

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

If you want to participate in a Medicare-approved clinical research study, you do not need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do not need to be part of our plan's network of providers.

Although you do not need to get our plan's permission to be in a clinical research study, **you do need to tell us before you start participating in a clinical research study.** Here is why you need to tell us:

- We can let you know whether the clinical research study is Medicare-approved.
- We can tell you what services you will get from clinical research study providers instead of from our plan.

If you plan on participating in a clinical research study, contact Membership Services (see Chapter 2, Section 1, of this *Evidence of Coverage*).

Section 5.2 When you participate in a clinical research study, who pays for what?

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:

- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

Original Medicare pays most of the cost of the covered services you receive as part of the study. After Medicare has paid its share of the cost for these services, our plan will also pay for part of the costs:

- We will pay the difference between the cost-sharing in Original Medicare and your cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.
  - Here's an example of how the cost-sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but would be only $10 under our plan's benefits.

In this case, Original Medicare would pay $80 for the test and we would pay another $10. This means that you would pay $10, which is the same amount you would pay under our plan's benefits.

- 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 study and how much you owe. Please see Chapter 7 for more information about submitting requests for payment.

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

- Generally, Medicare will not pay for 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 and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your condition would usually require only one CT scan.

Do you want to know more?

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website (http://www.**medicare.gov**). You can also call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

SECTION 6. Rules for getting care covered in a "religious non-medical health care institution"

Section 6.1 What is a religious non-medical health care institution?

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility care. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we will instead provide coverage for care in a religious non-medical health care institution. You may choose to pursue medical care at any time for any reason. This benefit is provided only for Part A inpatient services (non-medical health care services). Medicare will only pay for non-medical health care services provided by religious non-medical health care institutions.

Section 6.2 What care from a religious non-medical health care institution is covered by our plan?

To get care from a religious non-medical health care institution, you must sign a legal document that says you are conscientiously opposed to getting medical treatment that is "non-excepted."

- "Non-excepted" medical care or treatment is any medical care or treatment that is voluntary and not required by any federal, state, or local law.
- "Excepted" medical treatment is medical care or treatment that you get that is not voluntary or is required under federal, state, or local law.

To be covered by our plan, the care you get from a religious non-medical health care institution must meet the following conditions:

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to non-religious aspects of care.
- If you get services from this institution that are provided to you in your home, we will cover these services only if your condition would ordinarily meet the conditions for coverage of services given by home health agencies that are not religious non-medical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - *– and –* you must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.

Note: Covered services are subject to the same limitations and cost-sharing required for services provided by network providers as described in Chapters 4 and 12.

SECTION 7. Rules for ownership of durable medical equipment

Section 7.1 Will you own your durable medical equipment after making a certain number of payments under our plan?

Durable medical equipment includes items such as oxygen equipment and supplies, wheelchairs, walkers, and hospital beds ordered by a provider for use in the home. Certain items, such as prosthetics, are always owned by the enrollee. In this section, we discuss other types of durable medical equipment that must be rented.

In Original Medicare, people who rent certain types of durable medical equipment own the equipment after paying copayments for the item for 13 months. As a member of our plan, however, you usually will not acquire ownership of rented durable medical equipment items no matter how many copayments you make for the item while a member of our plan. Under certain limited circumstances we will transfer ownership of the durable medical equipment item. Call Membership Services (phone numbers are on the back cover of this booklet) to find out about the requirements you must meet and the documentation you need to provide.

What happens to payments you have made for durable medical equipment if you switch to Original Medicare?

If you switch to Original Medicare after being a member of our plan and you did not acquire ownership of the durable medical equipment item while in our plan, you will have to make 13 new consecutive payments for the item while in Original Medicare in order to acquire ownership of the item. Your previous payments while in our plan do not count toward these new 13 consecutive payments.

If you made payments for the durable medical equipment item under Original Medicare before you joined our plan, these previous Original Medicare payments also do not count toward the new 13 consecutive payments. You will have to make 13 new consecutive payments for the item under Original Medicare in order to acquire ownership. There are no exceptions to this case when you return to Original Medicare.

CHAPTER 4. Medical Benefits Chart (what is covered and what you pay)

SECTION 1. Understanding your out-of-pocket costs for covered services

This chapter focuses on your covered services and what you pay for your medical benefits. The Medical Benefits Chart that gives a list of your covered services and tells how much you will pay for each covered service as a member of our plan is found at the front of this *EOC*. Later in this chapter, you can find information about medical services that are not covered. It also tells about limitations on certain services. Please see Chapter 11 and Chapter 12 for additional coverage limitations (such as coordination of benefits, custodial care, home health care, skilled nursing facility care, and third-party liability).

Section 1.1 Types of out-of-pocket costs you may pay for your covered services

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services.

- A **"copayment"** is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service. (The Medical Benefits Chart found at front of this *EOC* tells you more about your copayments.)
- **"Coinsurance"** is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service. (The Medical Benefits Chart found at front of this *EOC* tells you more about your coinsurance.)

Some people qualify for state Medicaid programs to help them pay their out-of-pocket costs for Medicare. These "Medicare Savings Programs" include the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualifying Individual (QI), and Qualified Disabled & Working Individuals (QDWI) programs. If you are enrolled in one of these programs, you may still have to pay a copayment for the service, depending upon the rules in your state.

Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

Because you are enrolled in a Medicare Advantage Plan, there is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B (see the Medical Benefits Chart found at the front of this *EOC*). This limit is called the maximum out-of-pocket amount for medical services.

As a member of our plan, the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2012 is **$4,000**. The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for your Part D prescription drugs do not count toward your maximum out-–of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk in the Medical

Benefits Chart. If you reach the maximum out-of-pocket amount of **$4,000**, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third-party).

Section 1.3 Our plan does not allow providers to "balance bill" you

As a member of our plan, an important protection for you is that, after you meet any deductibles, you only have to pay our plan's cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges such as "balance billing." This protection (that you never pay more than our plan cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there is a dispute and we don't pay certain provider charges. Here is how this protection works:

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends upon which type of provider you see:
  - If you obtain covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).
  - If you obtain covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, our plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)
  - If you obtain covered services from an out-of-network provider who does not participate with Medicare, then you pay the coinsurance amount multiplied by the Medicare payment rate for non-participating providers. (Remember, our plan covers services from out-of-network providers only in certain situations, such as when you get a referral.)

SECTION 2. Use the Medical Benefits Chart at the front of this *EOC* to find out what is covered for you and how much you will pay

Section 2.1 Your medical benefits and costs as a member of our plan

The Medical Benefits Chart found at the front of this *EOC* lists the services our plan covers and what you pay out-of-pocket for each service. The services listed in the Medical Benefits Chart are covered only when the following coverage requirements are met:

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.

- Your services (including medical care, services, supplies, and equipment) must be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in our plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart found at the front of this *EOC* are covered only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart with a footnote (*f*). In addition, the following services not listed in the Medical Benefits Chart require prior authorization:
  - **Services not available from network providers.** If your network physician decides that you require covered services not available from network providers, he or she will recommend to the Medical Group that you be referred to an out-of-network provider. 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 network provider. Referrals to out-of-network physicians will be for a specific treatment plan. Please ask your network physician what services have been authorized
  - **Bariatric surgery.** If your network physician makes a written referral for bariatric surgery, the Medical Group's regional bariatric medical director or his or her designee will authorize the service if he or she determines that it is medically necessary.
  - **Breast reduction.**
  - **Cosmetic surgery.**
  - **Open MRI.**
  - **Orthognathic surgery.**
  - **Plastic and reconstructive surgery.**
  - **Routine foot care services.**
  - **Select provider referrals to a non-network provider or facility.**
  - **Transplant services.**

For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.

SECTION 3. What benefits are not covered by our plan?

Section 3.1 Benefits we do *not* cover (exclusions)

This section tells you what kinds of benefits are "excluded." Excluded means that our plan doesn't cover these benefits.

The list below describes some services and items that aren't covered under any conditions and some that are excluded only under specific conditions.

If you get benefits that are excluded, you must pay for them yourself. We won't pay for the excluded medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9, Section 5.3, in this booklet.)

In addition to any exclusions or limitations described in the Medical Benefits Chart found at the front of this *EOC*, or anywhere else in this *Evidence of Coverage* (see Chapter 11 and Chapter 12 for important coverage limitations), the following items and services aren't covered under Original Medicare or by our plan:.

- Acupuncture/
- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment, and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study. (See Chapter 3, Section 5, for more information on clinical research studies.) Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.

Any of the services listed below that aren't covered will remain not covered even if received at an emergency facility. For example, non-authorized, routine conditions that do not appear to a reasonable person to be based on a medical emergency are not covered if received at an emergency facility.

- Care in a licensed intermediate care facility, assisted living facility, or adult foster home.
- Chiropractic care is generally not covered under the plan, (with the exception of manual manipulation of the spine and is limited according to Medicare guidelines, or your employer purchased the optional Alternative Therapies coverage).

- Collection, processing, and storage of blood donated by donors whom you designate, and procurement and storage of cord blood, unless medically necessary for the imminent use at the time of collection for a designated recipient.
- Comfort, convenience, or luxury equipment or features.
- Conception by artificial means, such as in vitro fertilization, zygote intrafallopian transfers and gamete intrafallopian transfers (artificial insemination is a covered service); and nonprescription contraceptive supplies and devices. However, medically necessary services to treat infertility are covered. Infertility drugs are only covered if your employer purchased such coverage.
- Corrective lenses, eyeglasses, contact lens(es), and other eye care Services except for routine eye exams, unless such coverage is purchased by your employer. This exclusion does not apply to eyewear following cataract surgery covered by Medicare.
- Cosmetic surgery or procedures, unless needed because of accidental injury or to improve the function of a malformed part of the body. However, all stages of reconstruction are covered for the breast after a mastectomy as well as the unaffected breast to produce a symmetrical appearance.
- Custodial care unless it is provided with covered skilled nursing care and/or skilled rehabilitation services. “Custodial care” or non-skilled care is care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
- Educational and clinical programs for weight control.
- Elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: Weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance unless medically necessary.
- Electronic monitors of bodily functions.
- Exercise or hygiene equipment.
- Experimental medical and surgical procedures, equipment, and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study. (See Chapter 3, Section 5, for more information on clinical research studies.) Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Fees charged by immediate relatives or members of your household.
- Full-time nursing care in your home.
- Genetic testing, except counseling and medically necessary testing for diagnosis and treatment planning are covered subject to copayments and coinsurance.
- Hearing aids, unless such coverage is purchased by your employer. This exclusion does not apply to cochlear implants and osseointegrated external hearing devices covered by Medicare.
- Homemaker services, including basic household assistance such as light housekeeping or light meal preparation.
- Hypnotherapy.

- Internally implanted insulin pumps.
- Interrupted pregnancy except when the pregnancy is the result of rape or incest or in the case of physical injury, illness, or life-endangering physical condition caused by or arising from the pregnancy that would, as certified by a physician, place the woman in danger of death.
- Massage therapy is generally not covered by our plan with the exception of (a) referred services incident to treatment by a licensed physical therapist that are part of a physician's treatment plan, and are limited according to Medicare guideline; or (b) if your employer has purchased the optional Alternative therapies coverage.
- Meals delivered to your home.
- Mental health services, including evaluations and psychological testing, on court order or as a condition of parole or probation.
- Modifications to your home or car.
- More than one corrective appliance or artificial aid or item of durable medical equipment, serving the same function or the same part of the body, except for necessary repairs, adjustments, and replacements.
- Naturopath services unless such coverage is purchased by your employer.
- Non-human and artificial organs and their implantation.
- Non-medical items, such as sauna baths or elevators.
- Nursing care on a full-time basis in your home.
- Orthopedic shoes unless they are part of a leg brace and are included in the cost of the leg brace, shoes for people with diabetic foot disease.
- Personal items, such as a telephone or television in your room at a hospital or skilled nursing facility.
- Physical examinations and other services (a) required for obtaining or maintaining employment or participation in employee programs, (b) required for insurance or governmental licensing, or (c) on a court order or required for parole or probation, or (d) received while incarcerated.
- Private duty nurses.
- Private room in a hospital, unless medically necessary.
- Psychological testing for ability, aptitude, intelligence, or interest.
- Replacement of eyewear and accessories due to loss, damage, or carelessness. Exceptions may apply under optional warranty plans.
- Replacement of lost durable medical equipment, prosthetics and orthotics items.
- Reversal of sterilization procedures, sex change operations, and non-prescription contraceptive supplies and devices. (Medically necessary services for infertility are covered according to Original Medicare guidelines.)
- Routine dental care, such as cleanings, fillings or dentures. However, non-routine dental care received at a hospital may be covered.
- Routine foot care is generally not covered under the plan and is limited according to Medicare guidelines.

- Services and benefits under an individual Senior Advantage plan are excluded when a member is enrolled under an employer group Senior Advantage plan. Members enrolled in a Kaiser Foundation Health Plan of the Northwest employer group Senior Advantage plan cannot be enrolled on individual Senior Advantage Basic or Senior Advantage at the same time.
- Services and supplies for patients who, in the judgment of a plan provider or other plan mental health professional, are seeking services and supplies for other than therapeutic purposes.
- Services provided or arranged by criminal justice officials or institutions for detained or confined members, unless the services meet the requirements for care that would be covered as emergency care.
- Services provided to veterans in Veterans Affairs (VA) facilities. However, in the case of emergency services received at a VA hospital, if the VA cost-sharing is more than the cost-sharing required under our plan, we will reimburse veterans for the difference. Members are still responsible for our plan cost-sharing amount.
- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services.
- Services related to eye surgery or orthokeratologic services for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism (for example, radial keratotomy and LASIK surgery), and vision therapy and other low vision aids and services.
- Services that you get from non-plan providers, except for care for a medical emergency and urgently needed care, renal (kidney) dialysis services that you get when you are temporarily outside the plan's service area, care from non-plan providers that is arranged or approved by a plan provider, care provided or authorized by another Kaiser Foundation Health Plan, routine, preventive, covered care provided by Group Health Cooperative, and care covered under the travel benefit. See other parts of this booklet (especially Chapter 3) for information about using plan providers and the exceptions that apply.
- Services that you get without prior authorization, when prior authorization is required for getting that service. (Chapter 12 gives a definition of prior authorization and tells which services require prior authorization.)
- Supportive care primarily to maintain the level of correction already achieved; care primarily for the convenience of the member; and care on a non-acute, symptomatic basis are excluded.
- Supportive devices for the feet. There is an exception: Orthopedic or therapeutic shoes are covered for people with diabetic foot disease.
- Surgical treatment for morbid obesity, except when it is considered medically necessary and covered under Original Medicare.
- Tobacco cessation drugs unless prescribed as part of an approved tobacco cessation program.
- Transportation: We do not cover transportation (by car, taxi, bus, gurney-van, wheelchair van, mini-van, and any other type of transportation other than a licensed ambulance) or living expenses for any person, including the patient, except for medically necessary ambulance service, and we may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines under transplants. Your transplant coordinator can provide information about covered expenses.

- When a service is not covered, all services related to the non-covered service are excluded, except that this exclusion does not apply to services we would otherwise cover to treat complications arising after the non-covered service.

Our plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.

CHAPTER 5. Using our plan's coverage for your Part D prescription drugs

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

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, **some information in this *Evidence of Coverage* about the costs for Part D prescription drugs does not apply to you.** We will mail you a document, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider), which tells you about your drug coverage. If you don't receive this rider on or before September 30, 2011, please call Membership Services and ask for the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider). Phone numbers for Membership Services are on the back cover of this booklet.

SECTION 1. Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

This chapter explains rules for using your coverage for Part D drugs. The Medical Benefits Chart found at the front of this *EOC* tells what you pay for Part D drugs.

In addition to your coverage for Part D drugs, we also cover some drugs under our plan's medical benefits:

- We cover drugs you are given during covered stays in the hospital or in a skilled nursing facility. The Medical Benefits Chart found at the front of this *EOC* tells about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay.
- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. The Medical Benefits Chart found at the front of this *EOC* (tells about the benefits and costs for Part B drugs.

The two examples of drugs described above are covered by our plan's medical benefits. The rest of your prescription drugs are covered under our plan's Part D benefits. **This chapter explains rules for using your coverage for Part D drugs.** The Medical Benefits Chart found at the front of this *EOC* tells what you pay for Part D drugs.

Section 1.2 Basic rules for our plan's Part D drug coverage

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

- You must have a network provider (a doctor or other prescriber) write your prescription. (For more information, see Section 2, "Your prescriptions should be written by a network provider.")
- You must use a network pharmacy to fill your prescription. (See Section 3, "Fill your prescriptions at a network pharmacy or through our mail-order service.")
- Your drug must be on our *List of Covered Drugs* (Formulary) (we call it the "*Drug List*" for short). (See Section 4, "Your drugs need to be on our *Drug List*.")
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 4 for more information about a medically accepted indication.)

SECTION 2. Your prescriptions should be written by a network provider

Section 2.1 In most cases, your prescription must be from a network provider

You need to get your prescription (as well as your other care) from a provider in our provider network. This person would often be your primary care provider (your PCP). He or she could also be another professional in our provider network if your PCP has referred you for care. To find network providers, look in the *Senior Advantage Directory*.

Our plan will cover prescriptions from providers who are not in our plan's network only in a few special circumstances. These include:

- Prescriptions you get in connection with covered emergency care.
- Prescriptions you get in connection with covered urgently needed care when network providers are not available.

Other than these circumstances, you must have approval in advance ("prior authorization") from our plan to get coverage of a prescription from an out-of-network provider.

If you pay "out-of-pocket" for a prescription written by an out-of-network provider and you think we should cover this expense, please contact Membership Services or send the bill to us for payment. Chapter 7, Section 2.1, tells how to ask us to pay our share of the cost.

SECTION 3. Fill your prescription at a network pharmacy or through our mail-order service

Section 3.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered *only* if they are filled at our network pharmacies. (See Section 3.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with our plan to provide your covered prescription drugs. The term "covered drugs" means all of the Part D prescription drugs that are covered on our plan's *Drug List*.

Section 3.2 Finding network pharmacies

How do you find a network pharmacy in your area?

To find a network pharmacy, you can look in your *Senior Advantage Directory*, visit our website (**kp.org/seniormedrx**), or call Membership Services (phone numbers are on the back cover of this booklet). Choose whatever is easiest for you. You may go to any of our network pharmacies.

What if the pharmacy you have been using leaves the network?

If the pharmacy you have been using leaves our plan's network, you will have to find a new pharmacy that is in the network. To find another network pharmacy in your area, you can get help from Membership Services (phone numbers are on the back cover of this booklet) or use the *Senior Advantage Directory*. You can also find information on our website at **kp.org/seniormedrx**.

What if you need a specialized pharmacy?

Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact Membership Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. Note: This scenario should happen rarely.

To locate a specialized pharmacy, look in your *Senior Advantage Directory* or call Membership Services.

Section 3.3 Using our mail-order services

For certain kinds of drugs, you can use our plan's network mail-order services. Generally, the drugs available through mail-order are drugs that you take on a regular basis, for a chronic or long-term medical condition. The drugs available through our mail-order service are marked as "mail-order" drugs on our *Drug List*.

Our mail-order service requires you to order **at least a 30-day supply of the drug and no more than a 90-day supply**.

To get information about filling your prescriptions by mail, visit you local Kaiser Permanente pharmacy or call the Mail Delivery Pharmacy at **503-778-2678** from Portland, **1-800-548-9809** from other areas (TTY **1-800-735-2900**), Monday through Friday, 8 a.m. to 4:30 p.m. You can conveniently order your prescription refills in the following ways:

- Order online at kp.org. To register to use our secure online mail-order service, please go to kp.org/register and follow the on-screen instructions.
- Call the Mail Delivery Pharmacy at **503-778-2678** from Portland, or toll free from other areas at **1-800-548-9809** (TTY **1-800-735-2900**), Monday through Friday, 8 a.m. to 4:30 p.m.

When you order refills for home delivery or by phone, you must pay your cost-sharing when you place your order (there are no shipping charges for regular mail-order service). If you prefer, you may designate a network pharmacy where you want to pick up and pay for your prescription. Please contact a network pharmacy if you have a question about whether your prescription can be mailed, or see our *Drug List* for information about the types of drugs that can be mailed.

Usually a mail-order pharmacy order will get to you in no more than 10 days. If your mail-order prescription is delayed, please call our Mail Delivery Pharmacy for assistance at **503-778-2678** or **1-800-548-9809**, (TTY **1-800-735-2900**), Monday through Friday 8 a.m. to 4:30 p.m.

Section 3.4 How can you get a long-term supply of drugs?

When you get a long-term supply of drugs, your cost-sharing **may** be lower. Our plan offers two ways to get a long-term supply of "mail-order" drugs on our plan's *Drug List*. Mail-order drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.

- Some retail pharmacies in our network allow you to get a long-term supply of mail-order drugs. Your *Senior Advantage Directory* tells you which pharmacies in our network can give you a long-term supply of mail-order drugs. You can also call Membership Services for more information.
- For certain kinds of drugs, you can use our plan's network mail-order services. The drugs available through our mail-order service are marked as "mail-order" drugs on our *Drug List*. Our mail-order service requires you to order at least a 30-day supply of the drug and no more than a 90-day supply. See Section 3.3 for more information about using our mail-order services.

Section 3.5 When can you use a pharmacy that is not in our network?

Your prescription may be covered in certain situations

Generally, we cover drugs filled at an out-of-network pharmacy only when you are not able to use a network pharmacy. Here are the circumstances when we would cover prescriptions filled at an out-of-network pharmacy:

- If you are traveling within the United States and its territories but outside the service area and you become ill or run out of your covered Part D prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy in limited, nonroutine circumstances according to our Medicare Part D formulary guidelines.
- We will cover Medicare Part D prescriptions that are filled at an out-of-network pharmacy if the prescriptions are related to covered care for a medical emergency or urgent care. Note: Prescription drugs prescribed and provided outside of the United States and its territories as part of covered emergency or urgent care are covered up to a 30-day supply in a 30-day period. These drugs are not covered under Medicare Part D; therefore, payments for these drugs do not count toward reaching the catastrophic coverage stage.
- If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24-hour service. We may not cover your prescription if a reasonable person could have purchased the drug at a network pharmacy during normal business hours.
- If you are trying to fill a prescription for a drug that is not regularly stocked at an accessible network pharmacy or available through our mail-order pharmacy (including high-cost drugs).

In these situations, please check first with Membership Services to see if there is a network pharmacy nearby.

How do you ask for reimbursement from our plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) when you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1, explains how to ask our plan to pay you back.)

SECTION 4. Your drugs need to be on our *Drug List*

Section 4.1 The "*Drug List*" tells which Part D drugs are covered

Our plan has a *List of Covered Drugs* (Formulary). In this *Evidence of Coverage*, **we call it the "*Drug List*" for short.**

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

The drugs on the *Drug List* are only those covered under Medicare Part D (earlier in this chapter, Section 1.1 explains about Part D drugs).

We will generally cover a drug on our plan's *Drug List* as long as you follow the other coverage rules explained in this chapter 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. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- Or, supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

Our *Drug List* includes both brand-name and generic drugs

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

What is *not* on our *Drug List*?

Our plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 8.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our *Drug List*.

Section 4.2 There are three "cost-sharing tiers" for drugs on our *Drug List*

Every drug on our plan's *Drug List* is in one of three cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug. Preferred and nonpreferred generic drugs listed in the formulary will be subject to the generic drug cost-sharing and preferred and nonpreferred brand-name drugs listed in the formulary will be subject to the brand-name cost-sharing. You will pay the applicable cost-sharing depending upon the tier the drug is in:

- Cost-sharing **Tier 1** for generic drugs (lowest cost-sharing tier).
- Cost-sharing **Tier 2** for brand-name drugs.
- Cost-sharing **Tier 3** for specialty drugs (highest cost-sharing tier).

To find out which cost-sharing tier your drug is in, look it up on our *Drug List*. The amount you pay for drugs in each cost-sharing tier is shown in the Medical Benefits Chart found at the front of this *EOC*.

Section 4.3 How can you find out if a specific drug is on our *Drug List*?

You have three ways to find out:

1. Check the most recent *Drug List* that we sent you in the mail. (Please note: The *Drug List* we sent you includes information for the covered drugs that are most commonly used

by our members. However, we cover additional drugs that are not included in the printed *Drug List*. If one of your drugs is not listed in the *Drug List*, you should visit our website or contact Membership Services to find out if we cover it.)

2. Visit our website (**kp.org/seniormedrx**). Our *Drug List* on the website is always the most current.
3. Call Membership Services to find out if a particular drug is on our plan's *Drug List* or to ask for a copy of the list. Phone numbers for Membership Services are on the back cover of this booklet.

SECTION 5. There are restrictions on coverage for some drugs

Section 5.1 Why do some drugs have restrictions?

For certain prescription drugs, special rules restrict how and when our plan covers them. A team of doctors and pharmacists developed these rules to help our members use drugs in the most effective ways. These special rules also help control overall drug costs, which keeps your drug coverage more affordable.

In general, our rules encourage you to get a drug that works for your medical condition and is safe and effective. Whenever a safe, lower-cost drug will work medically just as well as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option. We also need to comply with Medicare's rules and regulations for drug coverage and cost-sharing.

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2, for information about asking for exceptions.)

Section 5.2 What kinds of restrictions?

Our plan uses different types of restrictions to help our members use drugs in the most effective ways. The sections below tell you more about the types of restrictions we use for certain drugs.

Restricting brand-name drugs when a generic version is available

Generally, a "generic" drug works the same as a brand-name drug and usually costs less. In most cases, when a generic version of a brand-name drug is available, our network pharmacies will provide you the generic version. We usually will not cover the brand-name drug when a generic version is available. However, if your provider has told us the medical reason that the generic drug will not work for you, then we will cover the brand-name drug. (Your share of the cost may be greater for the brand-name drug than for the generic drug.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan before we will agree to cover the drug for you. This is called **"prior authorization."** Sometimes the requirement for getting approval in advance helps guide appropriate use of certain drugs. If you do not get this approval, your drug might not be covered by our plan.

Quantity limits

For certain drugs, we limit the amount of the drug that you can have. For example, we might limit how many refills you can get, or how much of a drug you can get each time you fill your prescription. For example, if it is normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 5.3 Do any of these restrictions apply to your drugs?

Our plan's *Drug List* includes information about the restrictions described above. To find out if any of these restrictions apply to a drug you take or want to take, check our *Drug List*. For the most up-to-date information, call Membership Services (phone numbers are on the back cover of this booklet) or check our website (**kp.org/seniormedrx**).

If there is a restriction for your drug, it usually means that you or your provider will have to take extra steps in order for us to cover the drug. If there is a restriction on the drug you want to take, you should contact Membership Services to learn what you or your provider would need to do to get coverage for the drug. If you want us to waive the restriction for you, you will need to use the formal appeals process and ask us to make an exception. We may or may not agree to waive the restriction for you. (See Chapter 9, Section 6.2, for information about asking for exceptions.)

SECTION 6. What if one of your drugs is not covered in the way you'd like it to be covered?

Section 6.1 There are things you can do if your drug is not covered in the way you'd like it to be covered

Suppose there is a prescription drug you are currently taking, or one that you and your provider think you should be taking. We hope that your drug coverage will work well for you, but it's possible that you might have a problem. For example:

- What if the drug you want to take is not covered by our plan? For example, the drug might not be covered at all. Or, maybe a generic version of the drug is covered but the brand-name version you want to take is not covered.
- What if the drug is covered, but there are extra rules or restrictions on coverage for that drug? As explained in Section 5, some of the drugs covered by our plan have extra rules to restrict their use. In some cases, you may want us to waive the restriction for you.

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

- If your drug is not on our *Drug List* or if your drug is restricted, go to Section 6.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 6.3 to learn what you can do.

Section 6.2 What can you do if your drug is not on our *Drug List* or if the drug is restricted in some way?

If your drug is not on our *Drug List* or is restricted, here are things you can do:

- You may be able to get a temporary supply of the drug (only members in certain situations can get a temporary supply). This will give you and your provider time to change to another drug or to file a request to have the drug covered.
- You can change to another drug.
- You can request an exception and ask us to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

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

To be eligible for a temporary supply, **you must meet the two requirements** below:

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

- The drug you have been taking is no longer on our plan's *Drug List*.
- Or, the drug you have been taking is now restricted in some way (Section 5 in this chapter tells about restrictions).

2. You must be in one of the situations described below:

- **For those members who were in our plan last year and aren't in a long-term care facility:** We will cover a temporary supply of your drug one time only during the first 90 days of the calendar year. This temporary supply will be for a maximum of a 30-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.
- **For those members who are new to our plan and aren't in a long-term care facility:** We will cover a temporary supply of your drug one time only during the first 90 days of your membership in our plan. This temporary supply will be for a maximum of a 30-day supply, or less if your prescription is written for fewer days. The prescription must be filled at a network pharmacy.
- **For those members who are new to our plan and reside in a long-term care facility:** We will cover a temporary supply of your drug during the first 90 days of your membership in our plan. The first supply will be for a maximum of a 31-day supply, or less if your

prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in our plan.

- **For those members who have been in our plan for more than 90 days and reside in a long-term care facility and need a supply right away:** We will cover one 31-day supply or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.
- As a current member of our plan, **if you have a covered inpatient stay in the hospital or in a skilled nursing facility**, the drugs you obtain during your stay will be covered under your medical benefit rather than your Medicare Part D prescription drug coverage. When you are discharged home or to a custodial level of care at a long-term care facility, any outpatient prescription drugs you obtain at a pharmacy will be covered under your Medicare Part D coverage. Since your drug coverage is different depending upon the setting where you obtain the drug, it is possible that a drug you were taking that was covered under your medical benefit might not be covered by Medicare Part D (for example, over-the-counter drugs, cough medicine, or barbiturates). When this transition occurs, you will have to pay full price for that drug unless you have other coverage (for example, employer group or union coverage).

To ask for a temporary supply, call Membership Services (phone numbers are on the back cover of this booklet).

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

You can change to another drug

Start by talking with your provider. Perhaps there is a different drug covered by our plan that might work just as well for you. You can call Membership Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

You and your provider can ask us to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask us to cover a drug even though it is not on our plan's *Drug List*. Or, you can ask us to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4, tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

Section 6.3 What can you do if your drug is in a cost-sharing tier you think is too high?

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, start by talking with your provider. Perhaps there is a different drug in a lower cost-sharing tier that might work just as well for you. You can call Membership Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can file an exception

You and your provider can ask us to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule.

If you and your provider want to ask for an exception, Chapter 9, Section 6.4, tells what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

SECTION 7. What if your coverage changes for one of your drugs?

Section 7.1 The *Drug List* can change during the year

Most of the changes in drug coverage happen at the beginning of each year (January 1). However, during the year, our plan might make many kinds of changes to the *Drug List*. For example, our plan might:

- Add or remove drugs from the *Drug List*. New drugs become available, including new generic drugs. Perhaps the government has given approval to a new use for an existing drug. Sometimes, a drug gets recalled and we decide not to cover it. Or, we might remove a drug from the list because it has been found to be ineffective.
- Move a drug to a higher or lower cost-sharing tier.
- Add or remove a restriction on coverage for a drug (for more information about restrictions to coverage, see Section 5 in this chapter).
- Replace a brand-name drug with a generic drug.

In almost all cases, we must get approval from Medicare for changes we make to our *Drug List*.

Section 7.2 What happens if coverage changes for a drug you are taking?

How will you find out if your drug's coverage has been changed?

If there is a change to coverage for a drug you are taking, we will send you a notice to tell you. Normally, **we will let you know at least 60 days ahead of time**.

Once in a while, a drug is suddenly recalled because it's been found to be unsafe or for other reasons. If this happens, we will immediately remove the drug from the *Drug List*. We will let you know of this change right away. Your provider will also know about this change, and can work with you to find another drug for your condition.

Do changes to your drug coverage affect you right away?

If any of the following types of changes affect a drug you are taking, the change will not affect you until January 1 of the next year if you stay in our plan:

- If we move your drug into a higher cost-sharing tier.
- If we put a new restriction on your use of the drug.
- If we remove your drug from the *Drug List*, but not because of a sudden recall or because a new generic drug has replaced it.

If any of these changes happens for a drug you are taking, then the change won't affect your use or what you pay as your share of the cost until January 1 of the next year. Until that date, you probably won't see any increase in your payments or any added restriction to your use of the drug. However, on January 1 of the next year, the changes will affect you.

In some cases, you will be affected by the coverage change before January 1:

- If a brand-name drug you are taking is replaced by a new generic drug, we must give you at least 60 days' notice or give you a 60-day refill of your brand-name drug at a network pharmacy.
  - During this 60-day period, you should be working with your provider to switch to the generic or to a different drug that we cover.
  - Or, you and your provider can ask us to make an exception and continue to cover the brand-name drug for you. For information on how to ask for an exception, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)."
- Again, if a drug is suddenly recalled because it's been found to be unsafe or for other reasons, we will immediately remove the drug from the *Drug List*. We will let you know of this change right away.
  - Your provider will also know about this change, and can work with you to find another drug for your condition.

SECTION 8. What types of drugs are *not* covered by our plan?

Section 8.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.

If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section, except for certain excluded drugs covered under our enhanced drug coverage and if the requested drug is found upon appeal to be a drug that is not excluded under

Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 6.5, in this booklet.)

Here are three general rules about drugs that Medicare drug plans will not cover under Part D:

- Our plan's Part D drug coverage cannot cover a drug that would be covered under Medicare Part A or Part B.
- Our plan cannot cover a drug purchased outside the United States and its territories.
- Our plan usually cannot cover off-label use. "Off-label use" is any use of the drug other than those indicated on a drug's label as approved by the Food and Drug Administration.
  - Generally, coverage for "off-label use" is allowed only when the use is supported by certain reference books. These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor. If the use is not supported by any of these reference books, then our plan cannot cover its "off-label use."

Also, by law, these categories of drugs are not covered by Medicare drug plans unless we offer drugs listed below through our enhanced drug coverage: More information is provided below:

- Non-prescription 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.

We offer additional coverage of some prescription drugs not normally covered in a Medicare prescription drug plan (enhanced drug coverage). The amount you pay when you fill a prescription for these drugs does not count toward qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 7, of this booklet.)

In addition, if you are **receiving Extra Help from Medicare** to pay for your prescriptions, the Extra Help program will not pay for the drugs not normally covered. (Please refer to your formulary or call Membership Services for more information.) However, if you have drug coverage through Medicaid, you state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 9. Show your plan membership card when you fill a prescription

Section 9.1 Show your membership card

To fill your prescription, show your plan membership card at the network pharmacy you choose. When you show your plan membership card, the network pharmacy will automatically bill our plan for our share of your covered prescription drug cost. You will need to pay the pharmacy your share of the cost when you pick up your prescription.

Section 9.2 What if you don't have your membership card with you?

If you don't have your plan membership card with you when you fill your prescription, ask the pharmacy to call our plan to get the necessary information.

If the pharmacy is not able to get the necessary information, you may have to pay the full cost of the prescription when you pick it up. (You can then ask us to reimburse you for our share. See Chapter 7, Section 2.1, for information about how to ask us for reimbursement.)

SECTION 10. Part D drug coverage in special situations

Section 10.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by our plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by our plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, we will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell about the rules for getting drug coverage. The Medical Benefits Chart found at the front of this *EOC* gives more information about drug coverage and what you pay.

Please note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage at any time. (Chapter 10, "Ending your membership in our plan," tells when you can leave our plan and join a different Medicare plan.)

Section 10.2 What if you're a resident in a long-term care facility?

Usually, a long-term care facility (such as a nursing home) has its own pharmacy, or a pharmacy that supplies drugs for all of its residents. If you are a resident of a long-term care facility, you may get your prescription drugs through the facility's pharmacy as long as it is part of our network.

Check your *Senior Advantage Directory* to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Membership Services.

What if you're a resident in a long-term care facility and become a new member of our plan?

If you need a drug that is not on our *Drug List* or is restricted in some way, we will cover a **temporary supply** of your drug during the first 90 days of your membership. The first supply will be for a maximum of a 31-day supply, or less if your prescription is written for fewer days. If needed, we will cover additional refills during your first 90 days in our plan.

If you have been a member of our plan for more than 90 days and need a drug that is not on our *Drug List* or if our plan has any restriction on the drug's coverage, we will cover one 31-day supply, or less if your prescription is written for fewer days.

During the time when you are getting a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. Perhaps there is a different drug covered by our plan that might work just as well for you. Or, you and your provider can ask us to make an exception for you and cover the drug in the way you would like it to be covered. If you and your provider want to ask for an exception, Chapter 9, Section 6.4, tells what to do.

SECTION 11. Programs on drug safety and managing medications

Section 11.1 Programs to help members use drugs safely

We conduct drug use reviews for our members to help make sure that they are getting safe and appropriate care. These reviews are especially important for members who have more than one provider who prescribes their drugs.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems such as:

- Possible medication errors.
- Drugs that may not be necessary because you are taking another drug to treat the same medical condition.
- Drugs that may not be safe or appropriate because of your age or gender.
- Certain combinations of drugs that could harm you if taken at the same time.
- Prescriptions written for drugs that have ingredients you are allergic to.
- Possible errors in the amount (dosage) of a drug you are taking.

If we see a possible problem in your use of medications, we will work with your provider to correct the problem.

Section 11.2 Programs to help members manage their medications

We have programs that can help our members with special situations. For example, some members have several complex medical conditions or they may need to take many drugs at the same time, or they could have very high drug costs.

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

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

CHAPTER 6. What you pay for your Part D prescription drugs

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

There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, some information in this *Evidence of Coverage* about the costs for Part D prescription drugs does not apply to you. We will mail you a document, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider), which tells you about your drug coverage. If you don't receive this rider on or before September 30, 2011, please call Membership Services and ask for the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (LIS Rider). Phone numbers for Membership Services are on the back cover of this booklet.

SECTION 1. Introduction

Section 1.1 Use this chapter together with other materials that explain your drug coverage

This chapter focuses on what you pay for your Part D prescription drugs. To keep things simple, we use "drug" in this chapter to mean a Part D prescription drug. As explained in Chapter 5, not all drugs are Part D drugs. Some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law. Some excluded drugs may be covered under your group's plan.

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

- **Our *List of Covered Drugs* (Formulary).** To keep things simple, we call this the "*Drug List*."
  - This *Drug List* tells which drugs are covered for you.
  - It also tells which of the three "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the *Drug List*, call Membership Services (phone numbers are on the back cover of this booklet). You can also find the *Drug List* on our website at **kp.org/seniormedrx**. The *Drug List* on the website is always the most current.
- **Chapter 5 of this booklet**. Chapter 5 gives the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells which types of prescription drugs are not covered by our plan.

- **Our plan's *Senior Advantage Directory*.** In most situations you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The *Senior Advantage Directory* has a list of pharmacies in our plan's network. It also explains how you can get a long-term supply of a drug (such as filling a prescription for a three-month supply).

SECTION 2. What you pay for a drug depends upon which "drug payment stage" you are in when you get the drug

Section 2.1 What are the drug payment stages for Senior Advantage members?

As shown in the table below, there are "drug payment stages" for your prescription drug coverage under our plan. How much you pay for a drug depends upon which of these stages you are in at the time you get a prescription filled or refilled.

Stage 1	Stage 2	Stage 3	Stage 4
Yearly Deductible Stage Because there is no deductible for our plan, this payment stage **does not apply** to you.	**Initial Coverage Stage** You begin in this stage when you fill your first prescription of the year. During this stage, our plan pays its share of the cost of your drugs and **you pay your share of the cost.** You stay in this stage until your year-to-date "**total drug costs**" (your payments plus any Part D plan's payments) total **$4,700.** (Details are in Section 5 of this chapter.)	**Coverage Gap Stage** Because there is no coverage gap for our plan, this payment stage does not apply to you.	**Catastrophic Coverage Stage** During this stage, **we will pay most of the cost** of your drugs for the rest of the calendar year (through December 31, 2012). (Details are in Section 7 of this chapter.)

SECTION 3. We send you reports that explain payments for your drugs and which payment stage you are in

Section 3.1 We send you a monthly report called the "*Explanation of Benefits*" (the "*EOB*")

Our plan keeps track of the costs of your prescription drugs and the payments you have made when you get your prescriptions filled or refilled at the pharmacy. This way, we can tell you when you have moved from one drug payment stage to the next. In particular, there are two types of costs we keep track of:

- We keep track of how much you have paid. This is called your **"out-of-pocket"** cost.
- We keep track of your **"total drug costs."** This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.

Our plan will prepare a written report called the *Explanation of Benefits* (it is sometimes called the "*EOB*") when you have had one or more prescriptions filled through our plan during the previous month. It includes:

- **Information for that month.** This report gives the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.
- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

Section 3.2 Help us keep our information about your drug payments up-to-date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here is how you can help us keep your information correct and up-to-date:

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.
- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2, of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.

- When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
- Anytime you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you receive an *Explanation of Benefits* (an *EOB*) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call Membership Services (phone numbers are on the back cover of this booklet). You can also choose to view your *EOB* online instead of by mail. Please visit kp.org/gopaperless and sign on to learn more about choosing to view your *EOB* securely online. Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4. There is no deductible for Senior Advantage

Section 4.1 You do not pay a deductible for your Part D drugs

There is no deductible for Senior Advantage. You begin in the Initial Coverage Stage when you fill your first prescription of the year. See Section 5 for information about your coverage in the Initial Coverage Stage.

SECTION 5. During the Initial Coverage Stage, our plan pays its share of your drug costs and you pay your share

Section 5.1 What you pay for a drug depends upon the drug and where you fill your prescription

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

Our plan has three cost-sharing tiers

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

- Cost-sharing **Tier 1** for generic drugs.
- Cost-sharing **Tier 2** for brand-name drugs.

- Cost-sharing **Tier 3** for specialty drugs.

To find out which cost-sharing tier your drug is in, look it up in our plan's *Drug List*.

Your pharmacy choices

How much you pay for a drug depends upon whether you get the drug from:

- A retail pharmacy that is in our plan's network.
- A pharmacy that is not in our plan's network.
- Our plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, see Chapter 5 in this booklet and our plan's *Senior Advantage Directory*.

Section 5.2 A table that shows your costs for a one-month supply of a drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

- **"Copayment"** means that you pay a fixed amount each time you fill a prescription.
- **"Coinsurance"** means that you pay a percent of the total cost of the drug each time you fill a prescription.

As shown in the table below, the amount of the copayment or coinsurance depends upon which cost-sharing tier your drug is in. **Please note:**

- If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay either the full price of the drug or the copayment amount, whichever is lower.
- We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 3.5, for information about when we will cover a prescription filled at an out-of-network pharmacy.
- Refer to the Medical Benefits Chart found at the front of this *EOC* for your cost-sharing amounts in the Initial Coverage Stage.

Section 5.3 A table that shows your costs for a long-term (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5.)

Refer to the Medical Benefits Chart found at the front of this *EOC* for your cost-sharing amounts when you get a long-term 90-day supply of a drug.

Section 5.4 You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,700

You stay in the Initial Coverage Stage until the total amount for the prescription drugs you have filled and refilled reaches the **$4,700 limit for the Initial Coverage Stage**.

Your total drug cost is based on adding together what you have paid and what any Part D plan has paid:

- What you have paid for all the covered drugs you have gotten since you started with your first drug purchase of the year. (See Section 5.5 for more information about how Medicare calculates your out-of-pocket costs.) This includes:
  - The total you paid as your share of the cost for your drugs during the Initial Coverage Stage.
- What our plan has paid as its share of the cost for your drugs during the Initial Coverage Stage. (If you were enrolled in a different Part D plan at any time during 2012, the amount that plan paid during the Initial Coverage Stage also counts toward your total drug costs.)

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach **$4,700**. Medicare has rules about what counts and what does not count as your out-of-pocket costs. (See Section 5.5 for information about how Medicare counts your out-of-pocket costs.) When you reach an out-of-pocket limit of $4,700, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

We offer additional coverage on some prescription drugs that are not normally covered in a Medicare prescription drug plan. Payments made for these drugs will not count toward your initial coverage limit or total out-of-pocket costs. To find out which drugs our plan covers, refer to your formulary.

The *Explanation of Benefits* (*EOB*) that we send to you will help you keep track of how much you and our plan have spent for your drugs during the year. Many people do not reach the **$4,700** limit in a year.

We will let you know if you reach this **$4,700** amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Coverage Gap Stage.

Section 5.5 How Medicare calculates your out-of-pocket costs for prescription drugs

Medicare has rules about what counts and what does *not* count as your out-of-pocket costs. When you reach an out-of-pocket limit of **$4,700**, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

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

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

When you add up your out-of-pocket costs, you can include the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in Chapter 5 of this booklet):

- The amount you contribute for drugs when you are in any of the following drug payment stages:
  - 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, by a State Pharmaceutical Assistance Program that is qualified by Medicare, 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 also included. The amount the manufacturer pays for your brand-name drugs is included. But the amount our plan pays for your generic drugs, if any, is not included.

Moving on to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of **$4,700** in out-of-pocket costs within the calendar year, you will move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments are not included in your out-of-pocket costs

When you add up your out-of-pocket costs, you are **not** allowed to include any of these types of payments for prescription drugs:

- The amount you 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 drugs under our additional coverage but not normally covered in a Medicare prescription drug plan.
- Payments you make toward prescription drugs not normally covered in a Medicare prescription drug plan.
- Payments made by our plan for your generic drugs while in the Coverage Gap.
- Payments for your drugs that are made by group health plans, including employer health plans.

- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the 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 drugs, you are required to tell our plan. Call Membership Services to let us know (phone numbers are on the back cover of this booklet).

How can you keep track of your out-of-pocket total?

- **We will help you.** The *Explanation of Benefits* (*EOB*) report we send to you includes the current amount of your out-of-pocket costs (Section 3 in this chapter above tells about this report). When you reach a total of $4,700 in out-of-pocket costs for the year, this report will tell you that you have left the Initial Coverage Stage and have moved on to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Section 3.2 above tells what you can do to help make sure that our records of what you have spent are complete and up-to-date.

SECTION 6. There is no coverage gap for our plan

Section 6.1 You do not have a coverage gap for your Part D drugs

There is no coverage gap for our plan. Once you leave the Initial Coverage Stage, you move on to the Catastrophic Coverage Stage. See Section 7 for information about your coverage in the Catastrophic Coverage Stage.

SECTION 7. What you pay for vaccinations covered by Part D depends upon how and where you get them

Section 7.1 Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot

Our plan provides coverage of a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Medical Benefits Chart found at front of this *EOC*.

There are two parts to our coverage of Part D vaccinations:

- The first part of coverage is the cost of the vaccine medication itself. The vaccine is a prescription medication.
- The second part of coverage is for the cost of giving you the vaccination shot. (This is sometimes called the "administration" of the vaccine.)

What do you pay for a Part D vaccination?

What you pay for a Part D vaccination depends upon three things:

1. **The type of vaccine** (what you are being vaccinated for).
   - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to the "Medical Benefits Chart found at the front of this *EOC* (what is covered and what you pay)."
   - Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's *List of Covered Drugs* (Formulary).
2. **Where you get the vaccine medication.**
3. **Who gives you the vaccination shot.**

What you pay at the time you get the Part D vaccination can vary depending upon the circumstances. For example:

- Sometimes when you get your vaccination shot, you will have to pay the entire cost for both the vaccine medication and for getting the vaccination shot. You can ask our plan to pay you back for our share of the cost.
- Other times, when you get the vaccine medication or the vaccination shot, you will pay only your share of the cost.

To show how this works, here are three common ways you might get a Part D vaccination shot.

Situation 1:

- You buy the Part D vaccine at the pharmacy and you get your vaccination shot at the network pharmacy. (Whether you have this choice depends upon where you live. Some states do not allow pharmacies to administer a vaccination.)
  - You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
  - Our plan will pay for the cost of giving you the vaccination shot.

Situation 2:

- You get the Part D vaccination at your doctor's office.
  - When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
  - You can then ask our plan to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet ("Asking us to pay our share of a bill you have received for covered medical services or drugs").
  - You will be reimbursed the amount you paid less your normal copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

Situation 3:

- You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccination shot.
  - You will have to pay the pharmacy the amount of your copayment for the vaccine itself.

- When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7 of this booklet.
- You will be reimbursed the amount charged by the doctor for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you get Extra Help, we will reimburse you for this difference.)

IMPORTANT NOTE: When you receive a covered injectable Part D vaccine at a Kaiser Permanente network medical office or injection clinic, **you will not be charged at the time of your visit.** Instead, we will send you a bill for the applicable cost-sharing for the vaccine administration.

Section 7.2 You may want to call Membership Services before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you call us first at Membership Services whenever you are planning to get a vaccination (phone numbers are on the back cover of this booklet).

- We can tell you about how your vaccination is covered by our plan and explain your share of the cost.
- We can tell you how to keep your own cost down by using providers and pharmacies in our network.
- If you are not able to use a network provider and pharmacy, we can tell you what you need to do to get payment from us for our share of the cost.

SECTION 8. Do you have to pay the Part D "late enrollment penalty"?

Section 8.1 What is the Part D "late enrollment penalty"?

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

You may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage or you experienced a continuous period of 63 days or more when you didn't 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 upon how long you waited to enroll in a creditable prescription drug coverage plan anytime after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage.

Your group will inform you if you are required to pay a late enrollment penalty.

Section 8.2 How much is the Part D late enrollment penalty?

Medicare determines the amount of the penalty. Here is how it works:

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or, count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.
- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2011, this average premium amount was $32.34. This amount may change for 2012.
- To get your monthly penalty, you multiply the penalty percentage and the average monthly premium and then round it to the nearest 10 cents. In the example here it would be 14% times $32.34. This equals $4.53, which rounds to $4.50. This amount would be added to the monthly premium for someone with a late enrollment penalty.

There are three important things to note about this monthly premium penalty:

- First, the penalty may change each year, because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.
- Second, you will continue to pay a penalty every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.
- Third, if you are under 65 and currently receiving Medicare benefits, the late enrollment penalty will reset when you turn 65. After age 65, your late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

Section 8.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the late enrollment penalty.

You will not have to pay a premium penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "creditable drug coverage." Please note:
  - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from our plan. Keep this information, because you may need it if you join a Medicare drug plan later. Please

note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.

- The following are not creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
- For additional information about creditable coverage, please look in your *Medicare & You 2012* Handbook or call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.

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

Section 8.4 What can you do if you disagree about your late enrollment penalty?

If you disagree about your late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Call Membership Services at the number on the back cover of this booklet to find out more about how to do this.

SECTION 9. Do you have to pay an extra Part D amount because of your income?

Section 9.1 Who pays an extra Part D amount because of income?

Some people pay an extra amount for Part D 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 our 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, 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.

Section 9.2 How much is the extra Part D amount?

If your modified adjusted gross income as reported on your IRS tax return is above a certain amount, you will pay an extra amount in addition to your other Medicare premium(s). The chart below shows the extra amount you will pay to Medicare based on your income.

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

Section 10.3 What can you do if you disagree about paying an extra Part D amount?

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

CHAPTER 7. Asking us to pay our share of a bill you have received for covered medical services or drugs

SECTION 1. Situations in which you should ask us to pay our share of the cost of your covered services or drugs

Section 1.1 If you pay our plan's share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of our plan. In either case, you can ask our plan 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 medical services or 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 medical care 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 our plan to pay you back or to pay a bill you have received:

1. When you've received emergency or urgently needed medical care from a provider who is not in our network

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed care from a provider who is not part of our network, 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.

2. When a network provider sends you a bill you think you should not pay

Network providers should always bill us directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share.

- Whenever you get a bill from a network 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 network 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.

3. 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 Membership Services for additional information about how to ask us to pay you back and deadlines for making your request.

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

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section 3.5, 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.

5. 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.

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

7. 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. Chapter 9 of this booklet, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," has information about how to make an appeal.

SECTION 2. How to ask us to pay you back or to pay a bill you have received

Section 2.1 How and where to send us your request for payment

Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

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

- You don't have to use the form, but it will help us process the information faster.
- Either download a copy of the form from our website (kp.org) or call Membership Services and ask for the form. The phone numbers for Membership Services are on the back cover of this booklet.

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

Claims Administration
Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099

You must submit your claim to us within 90 days of the date you received the service, item, or drug. If it is not reasonably possible to submit a claim within 90 days, then you must submit a claim as soon as reasonably possible, but in no case more than 15 months after receiving the Service, except in the absence of legal capacity.

Please be sure to contact Membership Services 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.

SECTION 3. We will consider your request for payment and say yes or no

Section 3.1 We check to see whether we should cover the service or 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 medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is not covered, or you did not follow all 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.

Section 3.2 If we tell you that we will not pay for all or part of the medical care or 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 Chapter 9 of this booklet, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)." 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 Section 4 of Chapter 9. Section 4 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 Section 4, you can go to the section in Chapter 9 that tells what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to Section 5.3 in Chapter 9.
- If you want to make an appeal about getting paid back for a drug, go to Section 6.5 of Chapter 9.

SECTION 4. Other situations in which you should save your receipts and send copies to us

Section 4.1 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 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:

1. 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.
- Please 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 coverage decision. Therefore, you cannot make an appeal if you disagree with our decision.

CHAPTER 8. Your rights and responsibilities

SECTION 1. We must honor your rights as a member of our plan

Section 1.1 We must provide information in a way that works for you (in languages other than English, large print, or audio tapes)

To get information from us in a way that works for you, please call Membership Services (phone numbers are on the back cover of this booklet).

Our plan has people and free language interpreter services available to answer questions from non-English speaking members. We can also give you information in large print or audio tapes, if you need it. If you are eligible for Medicare because of a disability, we are required to give you information about our plan's benefits that is accessible and appropriate for you.

If you have any trouble getting information from our plan because of problems related to language or a disability, please call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week, and tell them that you want to file a complaint. TTY users call **1-877-486-2048**.

Section 1.2 We must treat you with fairness and respect at all times

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

If you want more information or have concerns about discrimination or unfair treatment, please call the Department of Health and Human Services' Office for Civil Rights at **1-800-368-1019 (TTY 1-800-537-7697)** or your local Office for Civil Rights.

If you have a disability and need help with access to care, please call Membership Services (phone numbers are on the back cover of this booklet). If you have a complaint, such as a problem with wheelchair access, Membership Services can help.

Section 1.3 We must ensure that you get timely access to your covered services and drugs

As a member of our plan, you have the right to choose a primary care provider in our network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Membership Services to learn which doctors are accepting new patients (phone numbers are on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral.

As a plan member, you have the right to get appointments and covered services from our network of providers within a reasonable amount of time. This includes the right to get

timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9, Section 10, of this booklet tells what you can do. (If we have denied coverage for your medical care or drugs and you don't agree with our decision, Chapter 9, Section 4, tells what you can do.)

Section 1.4 We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practice," that tells about these rights and explains how we protect the privacy of your health information.

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records.
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you.
- Your health information is shared with your Group only with your authorization or as otherwise permitted by law.
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - For example, we are required to release health information to government agencies that are checking on quality of care.
  - Because you are a member of our plan through Medicare, we are required to give Medicare your health information, including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations.

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held by our plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call Membership Services (phone numbers are on the back cover of this booklet).

Section 1.5 We must give you information about our plan, our network of providers, and your covered services

As a member of our plan, you have the right to get several kinds of information from us. (As explained above in Section 1.1, you have the right to get information from us in a way that works for you. This includes getting the information in large print or audio tapes.)

If you want any of the following kinds of information, please call Membership Services (phone numbers are on the back cover of this booklet):

- Information about our plan. This includes, for example, information about our plan's financial condition. It also includes information about the number of appeals made by members and our plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- Information about our network providers including our network pharmacies.
  - For example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
  - For a list of the providers in our network, see the *Senior Advantage Directory*.
  - For a list of the pharmacies in our network, see the *Senior Advantage Directory*.
  - For more detailed information about our providers or pharmacies, you can call Membership Services (phone numbers are on the back cover of this booklet) or visit our website at **kp.org**.
- Information about your coverage and rules you must follow in using your coverage.
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus our plan's *List of Covered Drugs* (Formulary). These chapters, together with the *List of Covered Drugs* (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
  - If you have questions about the rules or restrictions, please call Membership Services (phone numbers are on the back cover of this booklet).
- Information about why something is not covered and what you can do about it.
  - If a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or drug from an out-of-network provider or pharmacy.

- If you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 9 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 9 also tells about how to make a complaint about quality of care, waiting times, and other concerns.)
- If you want to ask our plan to pay our share of a bill you have received for medical care or a Part D prescription drug, see Chapter 7 of this booklet.

Section 1.6 We must support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- To know about all of your choices. This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- To know about the risks. You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- The right to say "no." You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.
- To receive an explanation if you are denied coverage for care. You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells how to ask us for a coverage decision.

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself.
- Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself.

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them. Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- Get the form. If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact Membership Services to ask for the forms (phone numbers are on the back cover of this booklet).
- Fill it out and sign it. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it.
- Give copies to appropriate people. You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home.

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you.
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one.

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital hasn't followed the instructions in it, you may file a complaint with (in Oregon) the Oregon Insurance Division, Consumer Advocacy Unit, **503-947-798**4 or **1-888-877-4894**; or (in Washington) the Washington Office of the Insurance Commissioner Consumer Protection Division, **1-800-562-6900**.

Section 1.7 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 9 of this booklet tells what you can do. It gives the details about how to deal with all types of problems and complaints.

As explained in Chapter 9, what you need to do to follow up on a problem or concern depends upon the situation. You might need to ask our plan to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do – ask for a coverage decision, make an appeal, or make a complaint – we are required to treat you fairly.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call Membership Services (phone numbers are on the back cover of this booklet).

Section 1.8 What can you do if you think you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights

If you think you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' Office for Civil Rights at **1-800-368-1019** or TTY **1-800-537-7697**, or call your local Office for Civil Rights.

Is it about something else?

If you think you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can call Membership Services (phone numbers are on the back cover of this booklet).
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.9 How to get more information about your rights

There are several places where you can get more information about your rights:

- You can call Membership Services (phone numbers are on the back cover of this booklet).
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact Medicare:

- You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at **http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf.**)
- Or, you can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

SECTION 2. You have some responsibilities as a member of our plan

Section 2.1 What are your responsibilities?

Things you need to do as a member of our plan are listed below. If you have any questions, please call Membership Services (phone numbers are on the back cover of this booklet). We're here to help.

- Get familiar with your covered services and the rules you must follow to get these covered services. Use this *Evidence of Coverage* booklet to learn what is covered for you and the rules you need to follow to get your covered services.
  - Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.
  - Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.
- If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us. **Please call Membership Services to let us know.**
  - We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "coordination of benefits" because it involves coordinating the health and drug benefits you get from us with any other health and drug benefits available to you. We'll help you with it. (For more information about coordination of benefits, go to Chapter 1, Section 7.)
- Tell your doctor and other health care providers that you are enrolled in our plan. Show your plan membership card whenever you get your medical care or Part D prescription drugs.
- Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.
  - To help your doctors and other health providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

- Be considerate. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- Pay what you owe. As a plan member, you are responsible for these payments:
  - Paying your Medicare premiums. In order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of our plan.
  - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). The Medical Benefits Chart found at the front of this EOC tells what you must pay for your medical services. The Medical Benefits Chart found at the front of this *EOC* tells what you must pay for your Part D prescription drugs.
  - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
  - If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.
  - If you are required to pay a late enrollment penalty, you must pay the penalty to remain a member of our plan.
- Tell us if you move. If you are going to move, it's important to tell us right away. Call Membership Services (phone numbers are on the back cover of this booklet).
  - If you move outside of our plan service area, you cannot remain a member of our plan. (Chapter 1 tells about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, we can let you know if we have a plan in your new area.
  - If you move within our service area, we still need to know so we can keep your membership record up-to-date and know how to contact you.
- Call Membership Services for help if you have questions or concerns. We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Membership Services are on the back cover of this booklet.
  - For more information on how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 9. What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)

Background

Coverage decisions and appeals

Making complaints

Background

SECTION 1. Introduction

Section 1.1 What to do if you have a problem or concern

This chapter 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 in Section 3 will help you identify the right process to use.

Other dispute resolution options

Your group may have chosen to cover benefits 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 Membership Services for information about our non-Medicare appeal process for non-Medicare coverage issues.

Section 1.2 What about the legal terms?

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

To keep things simple, this chapter explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this chapter 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. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

SECTION 2. You can get help from government organizations that are not connected with us

Section 2.1 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 (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You will find phone numbers in Chapter 2, Section 3, of this booklet.

You can also get help and information from Medicare

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

- You can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.
- You can visit the Medicare website (http://www.medicare.gov).

SECTION 3. To deal with your problem, which process should you use?

Section 3.1 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 chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter 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 medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

Yes, my problem is about benefits or coverage.	**No, my problem is not about benefits or coverage.**
▼	▼
Go to the next section of this chapter, Section 4: "A guide to the basics of coverage decisions and making appeals."	**Skip ahead to Section 10 at the end of this chapter:** "How to make a complaint about quality of care, waiting times, customer service, or other concerns."

Coverage decisions and appeals

SECTION 4. A guide to the basics of coverage decisions and appeals

Section 4.1 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 medical services and prescription 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 medical services or drugs. For example, your network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor 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 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 to 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.

Section 4.2 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 Membership Services (phone numbers are on the back cover of this booklet).
- To get free help from an independent organization that is not connected with our plan, contact your State Health Insurance Assistance Program (see Section 2 of this chapter).
- 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 Membership Services and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at **http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf**.) 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.

Section 4.3 Which section of this chapter 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:

- **Section 5** of this chapter: "Your medical care: How to ask for a coverage decision or make an appeal."
- **Section 6** of this chapter: "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal."
- **Section 7** of this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon."
- **Section 8** of this chapter: "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 Membership Services (phone numbers are on the back cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

SECTION 5. Your medical care: How to ask for a coverage decision or make an appeal

? Have you read Section 4 of this chapter ("A guide to the basics of coverage decisions and appeals")? If not, you may want to read it before you start this section.

Section 5.1 This section tells what to do if you have problems getting coverage for medical care 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 medical care and services. These benefits are described in the Medical Benefits Chart found at the front of this *EOC*. To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time.

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

1. You are not getting certain medical care you want, and you believe that this care is covered by our plan.

2. Our plan will not approve the medical care 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 medical care or 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 medical care or services that you believe should be covered by us, and you want to ask our plan to reimburse you for this care.
5. You are being told that coverage for certain medical care 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 of this chapter because special rules apply to these types of care. Here's what to read in those situations:

- Chapter 9, Section 7: "How to ask us for a longer hospital stay if you think you are being asked to leave the hospital too soon."
- Chapter 9, Section 8: "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 medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?	
If you are in this situation:	**This is what you can do:**
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section of this chapter, **Section 5.2**.
Have we already told you that we will not cover or pay for a medical 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 **Section 5.3** of this chapter.
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to **Section 5.5** of this chapter.

Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask us to authorize or provide the medical care coverage you want)

Legal Terms When a coverage decision involves your medical care, it is called an **"organization determination."**

Step 1: You ask our plan to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a "fast decision."

Legal Terms A "fast decision" is called an "**expedited determination**."

How to request coverage for the medical care you want

- Start by calling, writing, or faxing our plan to make your request for us to provide coverage for the medical care you want. You, your doctor, or your representative can do this.
- For the details on how to contact us, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care or Part D prescription drugs."

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 Section 10 of this chapter.)

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 Section 10 of this chapter.) 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 medical care you have not yet received. (You cannot get a fast decision if your request is about payment for medical care 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 Section 10 of this chapter.)

Step 2: We consider your request for medical care coverage 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 Section 10 of this chapter.)
  - 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. Section 5.3 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 medical care coverage 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 Section 10 of this chapter.)
  - 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. Section 5.3 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 medical care, 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 medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3 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)

Legal Terms

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

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

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 Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care or Part D prescription drugs."

- **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 Membership 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 at the phone number shown in Chapter 2, Section 1, "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care or Part D prescription drugs."
- **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)

Legal Terms A "fast appeal" is also called an "**expedited reconsideration**."

- 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 medical care. We check to see if we were following all 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***

- 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 Section 10 of this chapter.)
  - 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 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.

Section 5.4 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.

Legal Terms

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.
- 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 had 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 had 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 medical care coverage 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 medical care 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 medical care coverage 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. Section **9** in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: "Asking us to pay our share of a bill you have received for covered medical services or drugs." Chapter 7 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 Section 4.1 of this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service; see the Medical Benefits Chart found at the front of this *EOC*. We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: "Using our plan's coverage for your medical services").

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

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care 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 medical care is not covered, or you did not follow all 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 in Section 5.3 of this chapter. Go to this part 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 medical care 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.

SECTION 6. Your Part D prescription drugs: How to ask for a coverage decision or make an appeal

? Have you read Section 4 of this chapter ("A guide to the basics of coverage decisions and appeals")? If not, you may want to read it before you start this section.

Section 6.1 This section tells 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 *List of Covered Drugs* (Formulary) and the use of the drug is a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 4, for more information about a medically accepted indication.).

- 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 *List of Covered Drugs* (Formulary), rules and restrictions on coverage, and cost information, see Chapter 5 ("Using our plan's coverage for your Part D prescription drugs") and Chapter 6 ("What you pay for your Part D prescription drugs").

Part D coverage decisions and appeals

As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms

An initial coverage decision about your Part D drugs is 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 *List of Covered Drugs* (Formulary).
  - 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).
  - Asking to pay a lower cost-sharing amount for a covered nonpreferred drug.
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. For example, when your drug is on our plan's *List of Covered Drugs* (Formulary), but we require you to get approval from us before we will cover it for you.
  - **Please note:** If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

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

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

Which of these situations are you in?			
Request a Coverage Decision:			**Make an Appeal**
Do you need a drug that isn't on our *Drug List* or need us to waive a rule or restriction on a drug we cover?	Do you want us to cover a drug on our *Drug List* and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?	Do you want to ask us to pay you back for a drug you have already received and paid for?	Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?
▼	▼	▼	▼
You can ask us to make an exception. (This is a type of coverage decision.) **Start with Section 6.2 of this chapter.**	You can ask us for a coverage decision. **Skip ahead to Section 6.4 of this chapter.**	You can ask us to pay you back. (This is a type of coverage decision.) **Skip ahead to Section 6.4 of this chapter.**	You can make an appeal. (This means you are asking us to reconsider.) **Skip ahead to Section 6.5 of this chapter.**

Section 6.2 What is an exception?

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

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

2. **Covering a Part D drug for you that is not on our List of Covered Drugs (Formulary).** (We call it the "Drug List" for short.)

Legal Terms Asking for coverage of a drug that is not on the *Drug List* is sometimes called asking for a "**formulary exception.**"

- If we agree to make an exception and cover a drug that is not on the *Drug List*, you will need to pay the cost-sharing amount that applies to drugs in the generic or 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 Chapter 5.)

3. **Removing a restriction on our coverage for a covered drug.** There are extra rules or restrictions that apply to certain drugs on our List of Covered Drugs (Formulary) (for more information, go to Chapter 5 and look for Section 5).

Legal Terms Asking for removal of a restriction on coverage for a drug is sometimes called asking for a "**formulary exception.**"

- The extra rules and restrictions on coverage for certain drugs include:
  - Being **required to use the generic version** of a drug instead of a brand-name drug.
- 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 drug.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

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

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

- If we approve your request for an exception, our approval usually is valid until the end of the 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 an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells how to make an appeal if we say no.

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

Section 6.4 Step-by-step: How to ask for a coverage decision, including an 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 Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care or Part D prescription drugs." Or, if you are asking us to pay you back for a drug, go to the section called "Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received."
- You or your doctor or someone else who is acting on your behalf can ask for a coverage decision. Section 4 of this chapter 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 Chapter 7 of this booklet: "Asking us to pay our share of a bill you have received for covered medical services or drugs." Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.
- If you are requesting an exception, provide the "doctor's statement." Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "doctor's statement.") Your doctor or other prescriber can fax or mail the statement to us. Or, your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.

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

Legal Terms A "fast decision" is called an "**expedited coverage determination.**"

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast decision means we will answer within 24 hours.
- To get a fast decision, you must meet two requirements:
  - **You can get a fast decision only if you are asking for a** drug you have not yet received. (You cannot get a fast decision if you are asking us to pay you back for a drug you 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 Section 10 of this chapter.)

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

*Deadlines for a "**fast**" coverage decision*

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

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

- If we are using the standard deadlines, we must give you our answer within 72 hours.
  - Generally, this means within 72 hours after we receive your request. If you are requesting an exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to.
  - If we do not meet this deadline, 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.

Section 6.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)

Legal Terms An appeal to our plan about a Part D drug coverage decision is 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 Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care or Part D prescription drugs."
- 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 in Chapter 2, Section 1, (How to contact us when you are asking for

a coverage decision or making an appeal or complaint about your medical care or Part D prescription drugs).

- You must make your appeal request within 60 calendar days from the date on the written notice **we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal.** Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- You can ask for a copy of the information in your appeal and add more information.
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor or other prescriber may give us additional information to support your appeal.

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

Legal Terms A "fast appeal" is also called an "**expedited redetermination**."

- If you are appealing a decision 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 Section 6.4 of this chapter.

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 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).

Section 6.6 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.

Legal Terms

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

Step 1: To make a Level 2 Appeal, 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. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 7. 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 coverage for your hospital care, including any limitations on this coverage, see the Medical Benefits Chart found at the front of this *EOC*.

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.

Section 7.1 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 Membership Services. You can also call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

1. **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.**

Legal Terms

The written notice from Medicare tells you 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. (Section 7.2 below tells you how you can request an immediate review.)

2. **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. (Section 4 of this chapter 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.**
3. **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 Membership Services or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.**

Section 7.2 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 Membership Services (phone numbers are on the back cover of this booklet). Or, call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

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.

Legal Terms 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 Chapter 2, Section 4, of this booklet.)

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 Section 7.4.

Ask for a "fast 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.

Legal Terms

A "fast review" is also called an "**immediate review**" or an "**expedited review**."

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 informed 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.

Legal Terms

This written explanation is called the "**Detailed Notice of Discharge**." You can get a sample of this notice by calling Membership Services or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. (TTY users should call **1-877-486-2048**.) Or, you can see a sample notice online at **http://www.cms.hhs.gov/BNI/**.

Step 3: Within one full day after it has all 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 deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See the Medical Benefits Chart found at the front of this *EOC*.)

*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.

Section 7.3 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 we 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.
- Section **9** in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.2, 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.

Legal Terms 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 Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care or Part D prescription drugs."
- **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 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 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.

Legal Terms 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. Section **10** of this chapter 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 our plan 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.
- 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.
- Section **9** in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 8. How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 8.1 *This section is about three services only:* 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 Chapter **12**, "Definitions of important words.")
- **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 Chapter **12**, "Definitions of important words.")

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 on your covered services, including your share of the cost and any limitations to coverage that may apply, see the Medical Benefits Chart found at the front of this *EOC*.

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.

Section 8.2 We will tell you in advance when your coverage will be ending

1. **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 our plan to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms

In telling you what you can do, the written notice is telling 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. (Section 8.3 below tells how you can request a fast-track appeal.)

Legal Terms

The written notice is called the "**Notice of Medicare Non-Coverage**." To get a sample copy, call Membership Services or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. (TTY users should call **1-877-486-2048**.) Or, see a copy online at **http://www.cms.hhs.gov/BNI/**.

2. **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. (Section 4 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 our plan that it's time to stop getting the care.**

Section 8.3 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. Section **10** of this chapter 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 Membership Services (phone numbers are on the back cover of this booklet). Or, call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 of this chapter).

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 medical care.

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 Chapter 2, Section 4, of this booklet.)

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 Section 8.5.

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.

Legal Terms This notice explanation is called the "**Detailed Explanation of Non-Coverage**."

Step 3: Within one full day after they have all 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 deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see the Medical Benefits Chart found at the front of this *EOC*).

*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 its 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 this 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.

Section 8.4 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 we 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.
- Section **9** in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 8.3, 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.

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms 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 Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care or Part D prescription drugs."
- **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 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 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.

Legal Terms

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. Section **10** of this chapter 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 our plan 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.
- 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 our plan 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.
- Section **9** in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

SECTION 9. Taking your appeal to Level 3 and beyond

Section 9.1 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.

Section 9.2 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 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.

Making complaints

SECTION 10. 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 Section 4 of this chapter.

Section 10.1 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 medical care
  - 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 Membership Services 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 Membership Services 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 Sections 4–9 of this chapter. 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 our plan is 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 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.

Section 10.2 The formal name for "making a complaint" is "filing a grievance"

Legal Terms

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

Section 10.3 Step-by-step: Making a complaint

Step 1: Contact us promptly—either by phone or in writing.

- **Usually calling Membership Services is the first step.** If there is anything else you need to do, Membership Services will let you know or by calling us at 1-877-221-8221 (TTY users, 1-800-735-2900) between the hours of 8 a.m. and 8 p.m., seven days a week
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing.

- 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 Chapter 2 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 Membership Services right away.** The complaint must be made within 60 calendar days after you had the problem you want to complain about.
- **If you are making a complaint because we denied your request for a "fast response"** to a coverage decision or appeal, we will automatically give you a "fast" complaint. If you have a "fast" complaint, it means we will give you an answer **within 24 hours**.

Legal Terms What this 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.

Section 10.4 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 Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or, you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

CHAPTER 10. Ending your membership in our plan

SECTION 1. Introduction

Section 1.1 This chapter focuses on ending your membership in our plan

Ending your membership in our plan may be **voluntary** (your own choice) or **involuntary** (not your own choice):

- You might leave our plan because you have decided that you want to leave.
- There are also limited situations where you do not choose to leave, but we are required to end your membership. Section 5 tells you about situations when we must end your membership.

If you are leaving our plan, you must continue to get your medical care and prescription drugs through our plan until your membership ends.

SECTION 2. When can you end your membership in our plan?

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.

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.

Section 2.1 Where can you get more information about when you can end your group membership?

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

- Contact your group's benefits administrator.
- You can call Membership Services (phone numbers are on the back cover of this booklet).
- You can find the information in the *Medicare & You 2012* Handbook.
  - **Everyone with Medicare receives a copy of** *Medicare & You* each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (http://www.**medicare.gov**). Or, you can order a printed copy by calling Medicare at the number below.
- You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3. How do you end your Senior Advantage membership?

Section 3.1 There are several ways to end your Senior Advantage membership

You may request disenrollment by:

- Requesting disenrollment with your group's benefits administrator. You should always consult them before taking any action because it can affect your eligibility for group benefits.
- Calling toll free 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048, or
- Sending written notice to the following address:

  Kaiser Permanente
  Medicare Department
  PO Box 232407
  San Diego, CA 92193-9914

SECTION 4. Until your membership ends, you must keep getting your medical services and drugs through our plan

Section 4.1 Until your membership ends, you are still a member of our plan

If you leave our plan, it may take time before your membership ends and your new Medicare coverage goes into effect. (See Section 2 for information on when your new coverage begins.) During this time, you must continue to get your medical care and prescription drugs through our plan.

- You should continue to use our network pharmacies to get your prescriptions filled until your membership in our plan ends. Usually, your prescription drugs are only covered if they are filled at a network pharmacy, including through our mail-order pharmacy services.
- If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins).

SECTION 5. We must end your membership in our plan in certain situations

Section 5.1 When must we end your membership in our plan?

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

- If you do not stay continuously enrolled in Medicare Part A and/or Part B.
- If you move out of our service area for more than six months.
  - If you move or take a long trip, you need to call Membership Services to find out if the place you are moving or traveling to is in our plan's area.
  - If you have been a member of our plan continuously since before January 1999, and you were living outside of our service area before January 1999, you may continue your membership. However, if you move and your move is to another location that is outside of our service area, you will be disenrolled from our plan.
- If you become incarcerated (go to prison).
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan.
  - We cannot make you leave our plan for this reason unless we get permission from Medicare first.

- If you let someone else use your membership card to get medical care.
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

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

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

Section 5.2 We cannot ask you to leave our plan for any reason related to your health

What should you do if this happens?

If you feel that you are being asked to leave our plan because of a health-related reason, you should call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**. You may call 24 hours a day, 7 days a week.

Section 5.3 You have the right to make a complaint if we end your membership in our plan

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 10, for information about how to make a complaint.

Section 5.4 What happens if you are no longer eligible for group coverage?

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.

- If you are no longer eligible for group membership, you can request enrollment in our Senior Advantage Individual Plan if you still meet the eligibility requirements for Senior Advantage. The premiums and coverage under our individual plan will differ from those under this *Evidence of Coverage* and will include Medicare Part D prescription drug coverage.
- You may not be eligible to enroll in our Senior Advantage individual plan if your membership ends for the reasons stated under Section 5.1. For more information or information about other individual plans, call Membership Services.

CHAPTER 11. Legal notices

SECTION 1. Notice about governing law

Many laws apply to this *Evidence of Coverage* and some additional provisions may apply because they are required by law. This may affect your rights and responsibilities even if the laws are not included or explained in this document. The principal law that applies to this document is Title XVIII of the Social Security Act and the regulations created under the Social Security Act by the Centers for Medicare & Medicaid Services, or CMS. In addition, other federal laws may apply and, under certain circumstances, the laws of the state you live in.

SECTION 2. Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare health plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

SECTION 3. Administration of this *Evidence of Coverage*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of this *Evidence of Coverage*.

SECTION 4. 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*.

SECTION 5. 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*.

SECTION 6. 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.

SECTION 7. Attorneys' 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 attorneys' fees and other expenses.

SECTION 8. Litigation venue

Venue for all litigation between you and Kaiser Foundation Health Plan of the Northwest shall lie in Multnomah County, Oregon.

SECTION 9. Coordination of benefits

As described in Chapter 1 (Section 7) "How other insurance works with our plan," if you have other insurance, you are required 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. You will get your covered care as usual from network providers, and the other coverage you have will simply help pay for the care you receive.

If your other coverage is the primary payer, it will often settle its share of payment directly with us, and you will not have to be involved. However, if payment owed to us by a primary payer is sent directly to you, you are required by Medicare law to give this primary payment to us. For more information about primary payments in third-party liability situations, see Section 17, and for primary payments in workers' compensation cases, see Section 19.

You must tell us if you have other health care coverage, and let us know whenever there are any changes in your additional coverage.

SECTION 10. 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.

SECTION 11. *Evidence of Coverage* 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*.

SECTION 12. 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.

SECTION 13. Member nonliability

Our contracts with network providers provide that you are not liable for any amounts we owe. However, you are liable for the cost of noncovered services you obtain from network providers or out-of-network providers.

SECTION 14. 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.

SECTION 15. Notices

Our notices to you will be sent to the most recent address we have. You are responsible for notifying us of any change in your address. If you move, please call Membership Services and Social Security toll free at **1-800-772-1213 (TTY 1-800-325-0778)** as soon as possible to report your address change.

SECTION 16. 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.

SECTION 17. Third-party liability

As stated in Chapter 1, Section 7, 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 "Plan Charges" for those services. **Note:** This Section 17 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. Please refer to Chapter 12 for the definition of "Plan Charges."

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 Plan 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:

Patient Business Services—TPL
Kaiser Foundation Health Plan of the Northwest
7201 N Interstate Avenue
Portland, OR 97217

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.

SECTION 18. 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.

SECTION 19. Workers' compensation or employer's liability benefits

As stated in Chapter 1, Section 7, 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.

CHAPTER 12. Definitions of important words

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, which does not apply to the annual out-of-pocket maximum.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

Balance Billing – A situation in which a provider (such as a doctor or hospital) bills a patient more than the plan's cost-sharing amount for services. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" you. See Chapter 4, Section 1.3, for more information about balance billing.

Benefit Period – The way that both our plan and Original Medicare measure your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

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

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

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

Coinsurance – An amount you may be required to pay as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20%).

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Coordination of Benefits (COB) – Coordination of Benefits is a provision used to establish the order in which claims are paid when you have other insurance. If you have Medicare and other health insurance or coverage, each type of coverage is called a "payer." When there is more than one payer, there are "coordination of benefits" rules that decide which one pays first. The "primary payer" pays what it owes on your bills first, and then sends the rest to the "secondary payer" to pay. If payment owed to us is sent directly to you, you are required under Medicare law to give the payment to us. In some cases, there may also be a third payer. See Chapter 1 (Section 7) and Chapter 11 (Section 8) for more information.

Copayment – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

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

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

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you are required to pay for the prescription. In general, if you take your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called “coverage decisions” in this booklet. Chapter 9 explains how to ask us for a coverage decision.

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

Covered Services – The general term we use to mean all of the health care services and items that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

Dependent – A member who meets the eligibility requirements as a dependent (for dependent eligibility requirements, see Chapter 1, Section 2).

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

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

Durable Medical Equipment – Certain medical equipment that is ordered by your doctor for use at home. Examples are walkers, wheelchairs, or hospital beds.

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

Emergency Care – Covered services that are (1) rendered by a provider qualified to furnish emergency services; and (2) needed to evaluate or stabilize an emergency medical condition.

Emergency Medical Condition – Either: (1) a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs, or (2) active labor when there isn't enough time for safe transfer to a plan hospital (or designated hospital) before delivery or if transfer poses a threat to your (or your unborn child's) health and safety.

***Evidence of Coverage* (*EOC*) and Disclosure Information** – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a nonpreferred drug at the preferred cost-sharing level (a tiering exception).

Excluded Drug – A drug that is not a "covered Part D drug," as defined under 42 U.S.C. Section 1395w-102(e).

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.

Formulary – A list of Medicare Part D drugs covered by our plan.

Generic Drug – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, a "generic" drug works the same as a brand-name drug and usually costs less.

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

Group – The entity with which we have entered into the *Agreement* that includes this *Evidence of Coverage.*

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (for example, bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Medical Benefits Chart in the front of this *EOC*. We cover home health care in accord with Medicare guidelines. Home health care can include services from a home health aide if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services do not include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice Care – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending upon the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care, 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)**. TTY users should call **1-877-486-2048**.

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

Initial Coverage Stage – This is the stage before your total drug expenses have reached **$4,700**, including amounts you've paid and what our plan has paid on your behalf.

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

Inpatient Hospital Care – Health care that you get during an inpatient stay in an acute care general hospital.

Kaiser Foundation Health Plan (Health Plan) – Kaiser Foundation Health Plan of the Northwest, is a Northwest nonprofit corporation and a Medicare Advantage organization. This *Evidence of Coverage* sometimes refers to Health Plan as "we" or "us" and it applies to Senior Advantage members enrolled in our Northwest Region’s service area, which is described in Chapter 1, Section 2.3.

Kaiser Permanente – Kaiser Foundation Hospitals, Health Plan, and the Medical Group.

Late Enrollment Penalty – An amount added to the premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive Extra Help from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive Extra Help, you do not pay a penalty, even if you go without "creditable" prescription drug coverage.

List of Covered Drugs **(Formulary or "*Drug List*")** – A list of prescription drugs covered by our plan. The drugs on this list are selected by us with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Low Income Subsidy – See "Extra Help."

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for your, Medicare Part A and Part B premiums, and Part D prescription drugs do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.2, for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6, for information about how to contact Medicaid in your state.

Medical Care or Services – Health care services or items. Some examples of health care items include durable medical equipment, eyeglasses, and drugs covered by Medicare Part A or Part B, but not drugs covered under Medicare Part D.

Medical Group – It is the network of plan providers that our plan contracts with to provide covered services to you. The name of our medical group is Northwest Permanente, P.C. Physicians and Surgeons, a for-profit professional corporation.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 4, for more information about a medically accepted indication.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan, a PACE Plan, or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, a PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer

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

Medicare Cost Plan – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

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

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

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

Member (Member of our plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Membership Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Membership Services.

Network Pharmacy – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Physician – Any licensed and Kaiser Foundation Health Plan of the Northwest credentialed (KFHPNW) physician who is a partner or employee of the Medical Group, or any licensed and KFHPNW credentialed physician who contracts to provide services to our members.

Network Provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them "**network providers**" when they have an agreement with our plan to accept our payment as payment in full, and in some cases to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Organization Determination – The Medicare Advantage organization has made an organization determination when it, or one of its providers, makes a decision about whether services are covered or how much you have to pay for covered services. Organization determinations are

called "coverage decisions" in this booklet. Chapter 9 explains how to ask for a coverage decision.

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

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

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

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

PACE Plan. A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term c are services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – See **"Medicare Advantage (MA) Plan."**

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

Plan Charges – Plan 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.

Post-Stabilization Care – Medically necessary services related to your emergency medical condition that you receive after your treating physician determines that this condition is clinically stable. You are considered clinically stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (nonpreferred) providers.

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

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1, for information about Primary Care Provider.

Prior Authorization – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets “prior authorization” from our plan. Covered services that need prior authorization are marked in the Medical Benefits Chart found at the front of this *EOC*. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4, for information about how to contact the QIO for your state.

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

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's

also generally the area where you can get routine (nonemergency) services. Our plan may disenroll you if you move out of our plan's service area.

Services – Health care services or items.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Specialty-Tier Drugs – Very high-cost drugs approved by the FDA that are on our formulary.

Subscriber – A member who is eligible for membership on his or her own behalf and not by virtue of dependent status (for subscriber eligibility requirements, see Chapter 1, Section 2).

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Care – Urgently needed care is care provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care, if our plan's network of providers is temporarily unavailable or inaccessible.

Kaiser Permanente Senior Advantage Membership Services

CALL **1-877-221-8221**

Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.

Membership Services also has free language interpreter services available for non-English speakers.

TTY **1-800-735-2900**

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.

FAX **503-813-3985**

WRITE Membership Services
Kaiser Foundation Health Plan of the Northwest
500 NE Multnomah St., Suite 100
Portland, OR 97232-2099

WEBSITE **kp.org**

State Health Insurance Assistance Program

A State Health Insurance Assistance Program (SHIP) is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. Contact information for both the Oregon and Washington SHIPs can be found in Chapter 2, Section 3 of the *Evidence of Coverage*.

KAISER PERMANENTE®

Vision Hardware Optical Services Rider
Kaiser Permanente Senior Advantage (HMO) Plan

This rider is part of the Kaiser Permanente Senior Advantage (HMO) Evidence of Coverage (*EOC*) to which it is attached. All provisions of this rider become part of the *EOC* "Medical Benefits (what is covered and what you pay)" chapter. This entire benefit rider is therefore subject to all the terms and provisions of the *EOC*.

Eyeglasses and contact lenses

Every 24 months we provide an allowance toward the price of eyeglass lenses and a frame, or contact lenses. The allowance is listed in the Medical Benefits Chart. We will not provide the allowance if we have covered a lens, frame, or contact lens (but not counting any covered eyeglasses and contact lenses after cataract surgery) within the previous 24 months under this or any other evidence of coverage (including riders) with the same group number printed on this *EOC*. The date we cover any of these items is the date on which you order the item.

If a plan provider determines that one or both of your eyes has had a change in prescription of at least .50 diopters within 12 months after the date of your last exam where the "Vision Hardware Optical Services Rider" benefit was used, we will provide an allowance toward the price of a replacement eyeglass lens or contact lens for each qualifying eye at the following maximum values:

- $60 for single vision eyeglass lenses
- $60 for single vision cosmetic contact lenses
- $90 for multifocal eyeglass lenses
- $90 for multifocal cosmetic contact lenses

This replacement lens allowance is the same total amount whether you replace one lens or two. The replacement lenses must be the same type as the lenses you are replacing (eyeglass lenses or contact lenses).

An allowance can be used only when you order the item. If you do not use all of your allowance when you order the item, you cannot use it later.

Vision hardware optical services exclusions

- Low vision aids.
- Non-prescription products (other than eyeglass frames), such as eyeglass holders, eyeglass cases, repair kits, contact lens cases, contact lens cleaning and wetting solution, and lens protection plans.
- Professional services for fitting and follow-up care for contact lenses.
- Replacement of lost, broken, or damaged lenses or frames.
- Vision therapy (orthoptics or eye exercises).