disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:

- as a result of the mental disorder the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and either (1) the child is at risk of removal from the home or has already been removed from the home, or (2) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
- the child displays psychotic features, or risk of suicide or violence due to a mental disorder
- the child meets special education eligibility requirements under Chapter 26.5 (commencing with Section 7570) of Division 7 of Title 1 of the California Government Code

Outpatient mental health Services

We cover at **no charge** the following Services when provided by Plan Physicians or other Plan Providers who are licensed health care professionals acting within the scope of their license:

- Individual and group visits for diagnostic evaluation and psychiatric treatment
- Psychological testing when necessary to evaluate a mental disorder
- Visits for the purpose of monitoring drug therapy

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

Inpatient psychiatric hospitalization and intensive psychiatric treatment programs

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

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

Services not covered under this "Mental Health Services" section

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

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

Ostomy and Urological Supplies

Inside our Service Area, we cover ostomy and urological supplies prescribed in accord with our soft goods formulary and Medicare guidelines at **no charge**. We select the vendor, and coverage is limited to the standard supply that adequately meets your medical needs.

About our soft goods formulary

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

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

Ostomy and urological supplies exclusion

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Special Procedures

We cover the following Services at the Cost Sharing indicated only when prescribed as part of care covered

under other parts of this "Benefits and Cost Sharing" section:

- Diagnostic and therapeutic imaging, such as X-rays, mammograms, and ultrasound: **no charge**
- MRI, CT, and PET: **no charge**
- Nuclear medicine: **no charge**
- Laboratory tests (including tests for specific genetic disorders for which genetic counseling is available):
  - laboratory tests to monitor the effectiveness of dialysis: **no charge**
  - fecal occult blood tests: **no charge**
  - cervical cancer screening–including screening for human papillomavirus (HPV), prostate specific antigen tests, cholesterol tests (lipid panel and profile), diabetes screening (fasting blood glucose tests), sexually transmitted disease (STD) tests, and HIV tests: **no charge**
  - all other laboratory tests: **no charge**
- Routine preventive retinal photography screenings: **no charge**
- All other diagnostic procedures provided by Plan Providers who are not physicians (such as EKGs and EEGs): **no charge**
- Radiation therapy: **no charge**
- Ultraviolet light treatments: **no charge**

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

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

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

Outpatient Prescription Drugs, Supplies, and Supplements

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

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

Obtaining refills by mail

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

Certain items from Non–Plan Pharmacies

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

- The drug is related to covered Emergency Care, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency, Post-Stabilization, and Urgent Care from Non–Plan Providers" section. Note: Prescription drugs prescribed and provided outside of

the United States and its territories as part of covered Emergency Care or Urgent Care are covered up to a 30-day supply in a 30-day period. These drugs are covered under Part C benefits, and are not covered under Medicare Part D. Therefore, payments for these drugs do not count toward reaching the Part D Catastrophic Coverage Stage

- For Medicare Part D covered drugs, the following are additional situations when a Part D drug may be covered:
  - If you are traveling within the United States and its territories, but outside our Service Area, and you become ill or run out of your covered Part D prescription drugs. We will cover prescriptions that are filled at a Non–Plan Pharmacy according to our Medicare Part D formulary guidelines
  - If you are unable to obtain a covered drug in a timely manner within our Service Area because there is no Plan Pharmacy within a reasonable driving distance that provides 24-hour service. We may not cover your prescription if a reasonable person could have purchased the drug at a Plan Pharmacy during normal business hours
  - If you are trying to fill a prescription for a drug that is not regularly stocked at an accessible Plan Pharmacy or available through our mail-order pharmacy (including high-cost drugs)

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

Medicare Part D drugs

Medicare Part D covers most outpatient prescription drugs if they are sold in the United States and approved for sale by the federal Food and Drug Administration. We cover Medicare Part D drugs in accord with our Medicare Part D formulary guidelines and certain insulin administration devices (needles, syringes, alcohol swabs, and gauze) at **no charge** for up to a 100-day supply. Please refer to "Medicare Part D formulary" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section for more information about this formulary.

Note: If you have coverage from a third party (e.g., insurance plans, government funded health programs, or workers' compensation) that pays a part of or all of your out-of-pocket costs, you must let us know.

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

Medicare Part D drug formulary

Our Medicare Part D drug formulary is a list of the drugs that we cover under your Part D drug coverage. We will generally cover the drugs listed in our formulary as long as the drug is Medically Necessary, the prescription is filled at a Plan Pharmacy, and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described under "Utilization management" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section

The drugs on the formulary are selected by our Plan with the help of a team of Plan Providers. Not all drugs are covered by our Plan. In some cases, the law prohibits Medicare coverage of certain types of drugs under Part D coverage.

Each year, we send you an updated Part D formulary so you can find out what drugs are on our Part D formulary. You can get updated information about the drugs our Plan covers by visiting our Web site at **kp.org/seniormedrx**. You may also call our Member Service Call Center to find out if your drug is on the formulary or to request an updated copy of our formulary.

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

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

If we remove drugs from the formulary, or add prior authorizations, quantity limits, or step therapy restrictions on a drug, or move a drug to a higher Cost

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

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

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

Transition policy. If you recently joined our Plan, you may be able to get, during the first 90 days of your membership, a temporary supply of a drug you were taking when you joined our Plan if it isn't on our formulary. Current members may also be affected by changes in our formulary from one year to the next. Members should talk to their Plan Physicians to decide if they should switch to a different drug that we cover or request a Part D formulary exception in order to get coverage for the drug. Please refer to our formulary or our Web site **kp.org/seniormedrx** for more information about our Part D transition coverage.

Medicare Part D exclusions (non–Part D drugs). By law, certain types of drugs are not covered by Medicare Part D. A Medicare Prescription Drug Plan can't cover a drug under Medicare Part D in the following situations:

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

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

- Nonprescription drugs (or over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the symptomatic relief of cough or colds
- 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
- Drugs such as Viagra, Cialis, Levitra, and Caverject when used for the treatment of sexual or erectile dysfunction
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Barbiturates and Benzodiazepines

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

Other prescription drug coverage. If you have additional health care or drug coverage from another plan besides your Group's non-Medicare plan, you must

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

Outpatient drugs covered by Medicare Part B

In addition to Medicare Part D drugs, we also cover the limited number of outpatient prescription drugs that are covered by Medicare Part B in accord with our other drug formulary applicable to non–Part D items at **no charge** for up to a 100-day supply (except that certain self-administered intravenous drugs are provided up to a 30-day supply). The following are the types of drugs that Medicare Part B covers:

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

Other outpatient drugs, supplies, and supplements

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

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

Outpatient drugs, supplies, and supplements

We cover the following outpatient drugs, supplies, and supplements:

- Drugs for which a prescription is required by law. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary. Note: Certain tobacco-cessation drugs are covered only if you participate in a behavioral intervention program approved by the Medical Group
- Diaphragms, cervical caps, and oral contraceptives
- Disposable needles and syringes needed for injecting covered drugs
- Inhaler spacers needed to inhale covered drugs

Cost Sharing for other outpatient drugs, supplies, and supplements. The Cost Sharing for these items is **no charge** for up to a 100-day supply, except that the following items require payment of a different Cost Sharing:

- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria) and elemental dietary enteral formula when used as a primary therapy for regional enteritis: **no charge** for up to a 30-day supply
- Continuity drugs: **50 percent Coinsurance** for up to a 30-day supply in a 30-day period

Non–Part D drug formulary. Our non–Part D drug formulary includes the list of drugs that have been approved by our Pharmacy and Therapeutics Committee for our Members. Our Pharmacy and Therapeutics

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

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

Certain intravenous drugs, supplies, and supplements

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

Drug utilization review

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

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

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

Medication therapy management programs

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

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

ID card at Plan Pharmacies

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

Notes:

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

Inpatient Care" and "Skilled Nursing Facility Care" in this "Benefits and Cost Sharing" section)

Outpatient prescription drugs, supplies, and supplements limitations

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

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

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

Outpatient prescription drugs, supplies, and supplements exclusions

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

Prosthetic and Orthotic Devices

We cover the devices specified in this "Prosthetic and Orthotic Devices" section if they are in general use, intended for repeated use, primarily and customarily used for medical purposes, and generally not useful to a person who is not ill or injured. Coverage is limited to the standard device that adequately meets your medical needs.

We select the provider or vendor that will furnish the covered device. Coverage includes fitting and adjustment of these devices, their repair or replacement (unless due to misuse), and Services to determine whether you need a prosthetic or orthotic device. If we do not cover the device, we will try to help you find facilities where you may obtain what you need at a reasonable price.

Internally implanted devices

We cover at **no charge** internal devices implanted during covered surgery, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints in accord with Medicare guidelines. Note: You may request insertion of presbyopia-correcting intraocular lenses (IOLs) following cataract surgery. You may also request IOLs for correction of astigmatism. You are responsible for payment of that portion of the charge for the IOL and associated services that exceed Charges for insertion of a conventional IOL following cataract surgery.

External devices

We cover the following external prosthetic and orthotic devices (including repair or replacement of covered devices, unless due to misuse) at **no charge**:

- Prosthetics and orthotics in accord with Medicare guidelines. These include braces, prosthetic shoes, artificial limbs, and therapeutic footwear for severe diabetes-related foot disease in accord with Medicare guidelines
- Prosthetic devices and installation accessories to restore a method of speaking following the removal

of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)

- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect
- Other covered prosthetic and orthotic devices:
  - prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity
  - orthotic devices required to support or correct a defective body part in accord with Medicare guidelines
  - covered special footwear when custom made for foot disfigurement due to disease, injury, or developmental disability

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

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

- Eyeglasses and contact lenses (refer to "Vision Services")
- Hearing aids other than internally implanted devices described in this section (refer to "Hearing Services")

Prosthetic and orthotic devices exclusions

- Dental appliances
- Except as otherwise described above in this "Prosthetic and Orthotic Devices" section, nonrigid supplies not covered by Medicare, such as elastic stockings and wigs
- Comfort, convenience, or luxury equipment or features
- Shoes or arch supports, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications and foot disfigurement

Reconstructive Surgery

We cover reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Plan Physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible.

Also, following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas.

You pay the following for covered reconstructive surgery Services:

- Office visits: **no charge**
- Outpatient surgery: **no charge**
- Hospital inpatient care (including room and board, drugs, and Plan Physician Services): **no charge**

Services not covered under this "Reconstructive Surgery" section

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

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

Reconstructive surgery exclusions

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

Religious Nonmedical Health Care Institution Services

Care in a Medicare-certified Religious Nonmedical Health Care Institution (RNHCI) is covered by our Plan under certain conditions. Covered Services in an RNHCI are limited to nonreligious aspects of care. To be eligible

for covered Services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital or Skilled Nursing Facility care. You may get Services furnished in the home, but only items and Services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "nonexcepted" medical treatment. ("Excepted" medical treatment is a Service or treatment that you receive involuntarily or that is required under federal, state, or local law. "Nonexcepted" medical treatment is any other Service or treatment.) Your stay in the RNHCI is not covered by us unless you obtain authorization (approval) in advance from us.

Note: Covered Services are subject to the same limitations and Cost Sharing required for Services provided by Plan Providers as described in this "Benefits and Cost Sharing" section.

Skilled Nursing Facility Care

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

We cover the following Services:

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

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

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

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

Non–Plan Skilled Nursing Facility care

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

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

Transplant Services

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

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

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

For covered transplant Services that you receive, you will pay the **Cost Sharing you would pay if the Services were not related to a transplant**.

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

Services not covered under this "Transplant Services" section

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

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

Vision Services

We cover the Services listed below at Plan Medical Offices or Plan Optical Sales Offices when prescribed by a Plan Physician or by a Plan Provider who is an optometrist.

Optical Services

Eyeglasses and contact lenses. We provide a **$350 Allowance** toward the purchase price of any or all of the following every 24 months:

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

We will not provide the Allowance if we have provided an Allowance toward (or otherwise covered) lenses or frames within the previous 24 months This also means that if your Group's non-Medicare plan includes coverage for eyeglasses and contact lenses, the **$350** Allowance reflects the coordination of the two coverages, thus they cannot be combined.

The Allowance can only be used at the initial point of sale. If you do not use all of your Allowance at the initial point of sale, you cannot use it later.

If you have a change in prescription of at least .50 diopter in one or both eyes within 12 months of the initial point of sale, we will provide an Allowance toward the purchase price of a replacement eyeglass lens (or contact lens, fitting, and dispensing). The Allowance for these replacement lenses is **$60** for single vision eyeglass lenses or contact lenses, fitting, and dispensing and **$90** for multifocal eyeglass lenses.

Special contact lenses. We cover the following special contact lenses:

- Up to two Medically Necessary contact lenses, fitting, and dispensing per eye every 12 months (including lenses we covered under any other evidence of coverage offered by your Group) to treat aniridia (missing iris): **no charge**
- Up to six Medically Necessary aphakic contact lenses, fitting, and dispensing per eye per calendar year (including lenses we covered under any other evidence of coverage offered by your Group) to treat aphakia (absence of the crystalline lens of the eye): **no charge**
- If contact lenses will provide a significant improvement in your vision not obtainable with eyeglass lenses, we cover either one pair of contact lenses or an initial supply of disposable contact lenses every 24 months at **no charge**. When we cover these special contact lenses, you cannot use the Allowance mentioned under "Eyeglasses and contact lenses" for another 24 months. However, if the combination of special contact lenses and eyeglasses will provide a significant improvement in your vision not obtainable with special contact lenses alone, you can use that Allowance toward the purchase of the eyeglasses if we have not covered lenses or frames within the previous 24 months. If you have a change in prescription of at least .50 diopter in one or both eyes, we will cover special contact lens replacements, including fitting and dispensing for the eye(s) that have the .50 diopter change

Eyewear following cataract surgery. In accord with Medicare guidelines, we provide at **no charge** one pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. Also, we provide corrective lenses and frames (and replacements) needed after a cataract removal without a lens implant. If the eyewear you purchase costs more than what Original Medicare covers, you pay the difference.

Services not covered under this "Vision Services" section

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

- Eye refraction exams to determine the need for vision correction and to provide a prescription for eyeglass lenses and glaucoma screenings (refer to "Outpatient Care")
- Services related to the eye or vision other than those related to eyeglasses and contact lenses described in this section (refer to the applicable heading in this "Benefits and Cost Sharing" section)

Vision Services exclusions

- Industrial frames
- Lenses and sunglasses without refractive value, except that this exclusion does not apply to any of the following:
  - a clear balance lens if only one eye needs correction
  - tinted lenses when Medically Necessary to treat macular degeneration or retinitis pigmentosa
- Replacement of lost, broken, or damaged lenses or frames
- Lens adornment, such as engraving, faceting, or jeweling
- Low-vision devices
- Non-prescription products, such as eyeglass holders, eyeglass cases, and repair kits

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

The Services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this *Evidence of Coverage*. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in the "Benefits and Cost Sharing" section.

Certain exams and Services

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

Chiropractic Services

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

Conception by artificial means

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

Cosmetic Services

Services that are intended primarily to change or maintain your appearance, except for Services covered under "Reconstructive Surgery" and the following prosthetic devices covered under "Prosthetic and Orthotic Devices" in the "Benefits and Cost Sharing" section: prostheses needed after a mastectomy and prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect.

Custodial care

Custodial care means assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine), or care that can be performed safely and effectively by people who, in order to provide the care, do not require medical licenses or certificates or the presence of a supervising licensed nurse.

This exclusion does not apply to covered hospice Services.

Dental care

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

Disposable supplies

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

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

Experimental or investigational Services

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

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

Note: For information about clinical trials covered by Original Medicare, refer to "Special Note about Clinical Trials" in the "Benefits and Cost Sharing" section.

Eye surgery

Services related to eye surgery or orthokeratologic Services for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism.

Hair loss or growth treatment

Services for the promotion, prevention, or other treatment of hair loss or hair growth.

Intermediate care

Care in a licensed intermediate care facility. This exclusion does not apply to covered hospice Services.

Oral nutrition

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

This exclusion does not apply to any of the following:

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

Residential care

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

Routine foot care Services

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

Services not approved by the federal Food and Drug Administration

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

Services not covered by Medicare

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

Services related to a noncovered Service

When a Service is not covered, all Services related to the noncovered Service are excluded, except for Services we would otherwise cover to treat complications of the noncovered Service or if covered in accord with Medicare guidelines.

Surrogacy

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

Transgender surgery

Travel and lodging expenses

Travel and lodging expenses, except that in some situations if the Medical Group refers you to a Non–Plan

Provider as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines. Our travel and lodging guidelines are available from our Member Service Call Center.

This exclusion does not apply to reimbursement for travel and lodging expenses provided under "Bariatric Surgery" in the "Benefits and Cost Sharing" section.

Limitations

We will do our best to provide or arrange for our Members' health care needs in the event of unusual circumstances that delay or render impractical the provision of Services under this *Evidence of Coverage*, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor disputes. Under these extreme circumstances, if you have an Emergency Medical Condition, go to the nearest hospital as described under "Emergency Care" in the "Emergency, Post-Stabilization, and Urgent Care from Non-Plan Providers" section, and we will provide coverage and reimbursement as described in that section.

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

Coordination of Benefits

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

You must tell us if you have other health care coverage, in addition to your Group's non-Medicare plan, and let us know whenever there are any changes in your additional coverage. The types of additional coverage that you might have include the following:

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

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

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

If you have additional health coverage besides your Group's non-Medicare plan, please call our Member Service Call Center to find out which rules apply to your situation, and how payment will be handled.

Reductions

Employer responsibility

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

Government agency responsibility

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

Injuries or illnesses alleged to be caused by third parties

If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered Services, you must pay us Charges for those Services, except that the amount you must pay will not exceed the maximum amount allowed under California Civil Code Section 3040. Note: This "Injuries or illnesses alleged to be caused by third parties" section does not affect your obligation to pay Cost Sharing for these Services, but we will credit any such payments toward the amount you must pay us under this paragraph.

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

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

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

Northern California Third Party Liability Supervisor
Kaiser Foundation Health Plan, Inc.
Special Recovery Unit
Parsons East, Second Floor
393 E. Walnut St.
Pasadena, CA 91188

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.

Medicare law may apply with respect to Services covered by Medicare.

Surrogacy arrangements

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

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

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

Surrogacy Third Party Liability Supervisor
Kaiser Foundation Health Plan, Inc.
Special Recovery Unit
Parsons East, Second Floor
393 E. Walnut St.
Pasadena, CA 91188

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

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

U.S. Department of Veterans Affairs

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

Workers' compensation or employer's liability benefits

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

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

Requests for Payment

Requests for Payment of Covered Services or Part D drugs

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

Sometimes when you get a Service or a Part D drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of our Plan. In either case, you can ask 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 Services or Part D drugs that are covered by our Plan.

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

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

- **When you've received emergency, urgent, or dialysis care from a Non–Plan Provider.** You can receive emergency services from any provider, whether or not the provider is a Plan Provider. When you receive emergency, urgent, or dialysis care from a Non–Plan Provider, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill our Plan for our share of the cost
  - If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made
  - At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made. If the provider is owed anything, we will pay the provider directly. If you have already paid more than your share of the cost of the service, we will determine

how much you owed and pay you back for our share of the cost

- **When a Plan Provider sends you a bill you think you should not pay.** Plan Providers should always bill us directly, and ask you only for your share of the cost.
  - Whenever you get a bill from a Plan Provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
  - If you have already paid a bill to a Plan Provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under our Plan.
- **When you use a Non–Plan Pharmacy to get a prescription filled.** If you go to a Non–Plan Pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription
  - Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost
- **When you pay the full cost for a prescription because you don't have your Plan membership card with you.** If you do not have your Plan membership card with you, you can ask the pharmacy to call us or to look up your Plan enrollment information. However, if the pharmacy cannot get the enrollment information they need, you may need to pay the full cost of the prescription yourself
  - Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost
- When you pay the full cost for a prescription in other situations. You may pay the full cost of the prescription because you find that the drug is not covered for some reason
  - For example, the drug may not be on our Plan's *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

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

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

How and where to send us your request for payment

EOC 2

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

- As soon as possible, request our claim form by calling our Member Service Call Center toll free at 1-800-443-0815 or 1-800-390-3510 (TTY users call 1-800-777-1370). One of our representatives will be happy to assist you if you need help completing our claim form
- If you have paid for Services, you must send us your request for reimbursement. Please attach any bills and receipts from the Non–Plan Provider
- You must complete and return to us any information that we request to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled. For example, we may require documents such as travel documents or original travel tickets to validate your claim
- The completed claim form must be mailed to the following address as soon as possible, but no later than 15 months after receiving the care (or up to 27 months according to Medicare rules, in some cases). Please do not send any bills or claims to Medicare. Any additional information we request should also be mailed to this address:
  Kaiser Foundation Health Plan, Inc.
  Claims Department
  P.O. Box 24010
  Oakland, CA 94623-1010

Note: If you are requesting payment of a Part D drug that was prescribed by a Plan Provider and obtained from a Plan Pharmacy, write to:
Kaiser Foundation Health Plan, Inc.
Part D Unit
P.O. Box 23170
Oakland, CA 94623-0170

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

We Will Consider Your Request For Payment and Say Yes or No

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

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and decide whether to pay it and how much we owe.

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

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

If you think we have made a mistake in turning down your request for payment, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

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

- If you want to make an appeal about getting paid back for a Service, go to "Step-by-step: How to make a Level 2 appeal" under "Your medical care: How to ask for a coverage decision or make an appeal" in the "Coverage Decisions, Appeals, and Complaints" section
- If you want to make an appeal about getting paid back for a Part D drug, go to "Step-by-step: How to make a Level 2 appeal" under "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal" in the "Coverage Decisions, Appeals, and Complaints" section

Other Situations in Which You Should Save Your Receipts and Send Them to Our Plan

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

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

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

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

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

Coverage Decisions, Appeals, and Complaints

Introduction

What to do if you have a problem or concern

Please call us first

Your health and satisfaction are important to us. When you have a problem or concern, we hope you'll try an informal approach first. Please call our Member Service Call Center (phone numbers are on the cover of this booklet). We will work with you to try to find a satisfactory solution to your problem.

You have rights as a member of our Plan and as someone who is getting Medicare. We pledge to honor your rights, to take your problems and concerns seriously, and to treat you with respect.

Two formal processes for dealing with problems

Sometimes you might need a formal process for dealing with a problem you are having as a member of our Plan. This chapter explains two types of formal processes for handling problems:

- 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 on the type of problem you are having. The guide under "To deal with your problem, which process should you use?" in this "Coverage Decisions, Appeals, and Complaints" section will help you identify the right process to use.

What about the legal terms?

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

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

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

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You Can Get Help From Government Organizations That Are Not Connected With Us

Where to get more information and personalized assistance

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

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your State Health Insurance Assistance Program. This government program has trained counselors in every state. The program is not connected with our Plan 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.

Their services are free. You will find phone numbers in the "Important Phone Numbers and Resources" section.

You can also get help and information from Medicare

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

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

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

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

If you have a problem or concern and you want to do something about it, you don't need to read this whole section. You just need to find and read the parts of this section that apply to your situation. The guide that follows will help.

To figure out which part of this section tells what to do for your problem or concern, START HERE:

- **Is your problem or concern about your benefits and coverage?** (This includes problems about whether particular Services or Part D drugs are covered or not, the way in which they are covered, and problems related to payment for Services or Part D drugs)
  - **Yes:** Go on to "A Guide to the Basics of Coverage Decisions and Appeals"
  - **No:** Skip ahead to "Making complaints about quality of care, waiting times, customer service, or other concerns"

Special note about other dispute resolution procedures

Your Group's non-Medicare plan. Please keep in mind that this section describes the procedures under this Senior Advantage *Evidence of Coverage* when Medicare is secondary. You must refer to your non-Medicare plan document which provides your primary Group coverage for the dispute resolution procedures applicable to your non-Medicare plan.

Hospice care. If Original Medicare covers your hospice care, you must submit any complaint or appeal directly to Medicare and not through any Health Plan grievance or appeal procedure. Medicare complaint and appeal procedures are described in the Medicare handbook *Medicare & You,* which is available from your local Social Security office, at www.medicare.gov, or by calling toll free 1-800-MEDICARE/1-800-633-4227 (TTY users call 1-877-486-2048) 24 hours a day, seven days a week. You must be simultaneously enrolled in your Group's non-Medicare plan as your primary coverage.

A Guide to the Basics of Coverage Decisions and Appeals

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

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

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Services or Part D drugs. We make a coverage decision for you whenever you go to a doctor for Services. You can also contact us and ask for a coverage decision. For example, 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:

- Usually, there is no problem. We decide the service or Part D drug is covered and pay our share of the cost
- But in some cases we might decide the service or Part D drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal

Making an appeal

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

When you make an appeal, we review the coverage decision we have made to check to see if we were being fair and following all of the rules properly. 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 our Plan. If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through several more levels of appeal.

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

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

- You can call our Member Service Call Center (phone numbers are on the cover)
- To get free help from an independent organization that is not connected with our Plan, contact your State Health Insurance Assistance Program (see the "Important Phone Numbers and Resources" section)
- You should consider getting your doctor or other provider involved if possible, especially if you want a "fast" or "expedited" decision. In most situations involving a coverage decision or appeal, your doctor or other provider must explain the medical reasons that support your request. Your doctor or other prescriber can't request every appeal. He/she can request a coverage decision and a Level 1 Appeal with our Plan. To request any appeal after Level 1, your doctor or other prescriber must be appointed as your "representative" (see below about "representatives")
- You can ask someone to act on your behalf. If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal
  - There may be someone who is already legally authorized to act as your representative under State law
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call our Member Service Call Center and ask for the form to give that person permission to act on your behalf. The form must be signed by you and by the person who you would like to act on your behalf. You must give our Plan a copy of the signed form
- You also have the right to hire a lawyer to act for you. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision

Which section gives the details for your situation?

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

- "Your medical care: How to ask for a coverage decision or make an appeal"
- "Your Part D prescription drugs? How to ask for a coverage decision or make an appeal"
- "How to ask us to cover a longer hospital stay if you think the doctor is discharging you too soon"
- "How to ask us to keep covering certain medical Services if you think your coverage is ending too soon" (Applies to these Services only: home health care, Skilled Nursing Facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) Services)

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

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

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

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

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

1) You are not getting certain Services you want, and you believe that this care is covered by our Plan.
2) Our Plan will not approve the Services your doctor or other medical provider wants to give you, and you believe that this care is covered by our Plan.
3) You have received Services that you believe should be covered by us, but we have said we will not pay for this care.
4) You have received and paid for Services that you believe should be covered by our Plan, and you want to ask our Plan to reimburse you for this care.
5) You are being told that coverage for certain Services you have been getting will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

- Note: If the coverage that will be stopped is for hospital care, home health care, Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) Services, you need to read a separate section because special rules apply to these types of care. Here's what to read in those situations:
  - Go to "How to ask for a longer hospital stay if you think you are being asked to leave the hospital too soon"
  - Go to "How to ask our Plan to keep covering certain medical Services if you think your coverage is ending too soon." This section is about three Services only: home health care, Skilled Nursing Facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) Services

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

Which of these situations are you in?

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

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

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

How to request coverage for the Services you want

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

Generally we use the standard deadlines for giving you our decision

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

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

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

- **A fast decision means we will answer within 72 hours**
  - However, we can take up to 14 more days if we find that some information is missing that may benefit you, or if you need to get information to us

for the review. If we decide to take extra days, we will tell you in writing

- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section.) We will call you as soon as we make the decision

- **To get a fast decision, you must meet two requirements:**
  - You can get a fast decision only if you are asking for coverage for Services you have not yet received. (You cannot get a fast decision if your request is about payment for Services you have already received)
  - You can get a fast decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function
- **If your doctor tells us that your health requires a "fast decision,"** we will automatically agree to give you a fast decision
- **If you ask for a fast decision on your own, without your doctor's support,** our Plan will decide whether your health requires that we give you a fast decision
  - If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead)
  - This letter will tell you that if your doctor asks for the fast decision, we will automatically give a fast decision
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard decision instead of the fast decision you requested. (For more information about the process for making complaints, including fast complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section)

Step 2: Our Plan considers your request for Services and we 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 days under certain circumstances. If we take extra days, it is called "an extended time period"
  - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. "Step-by-step: How to make a Level 1 Appeal" below tells how to make an appeal
- If our answer is yes to part or all of what you requested, we must authorize or provide the Services we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no

*Deadlines for a **"standard"** coverage decision*

- Generally, for a standard decision, we will give you our answer within 14 days of receiving your request
  - We can take up to 14 more days ("an extended time period") under certain circumstances
  - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. "Step-by-step: How to make a Level 1 Appeal" below tells how to make an appeal
- If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no

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

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

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

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

When you start the appeals process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal."

What to do

- **To start an appeal, you, your representative, or in some cases your doctor must contact us.** For details on how to reach us for any purpose related to your appeal, go to "How to contact us when you are asking for a coverage decision or making an appeal or a complaint about your Services" in the "Important Phone Numbers and Resources" section
- **Make your standard appeal in writing by submitting a signed request.** Go to "How to contact us when you are asking for a coverage decision or making an appeal or a complaint about your Services" in the "Important Phone Numbers and Resources" section
- **You must make your appeal request within 60 calendar days from the date on the written notice** we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal
- **You can ask for a copy of the information in your appeal and add more information if you like**
  - 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 an oral request)*

- If you are appealing a decision our Plan 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 automatically agree to give you a fast appeal

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 request for coverage of Services. We check to see if we were being fair and 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 days
  - 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 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
- 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 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 days
  - 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 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 sent your appeal to the Independent Review Organization for a Level 2 Appeal

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

- To make sure we were being fair when we said no to your appeal, our Plan is required to send your appeal to the "Independent Review Organization." When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2

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

If our Plan says 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 our Plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Step 1: The Independent Review Organization reviews your appeal

- The Independent Review Organization is an outside, 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
- 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, 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 days

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

- If you made a standard appeal to our Plan at Level 1, 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 days

Step 2: The Independent Review Organization gives you their answer

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

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal)
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process,

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you must decide whether you want to go on to Level 3 and make a third appeal. The details on how to do this are in the written notice you got after your Level 2 Appeal

- The Level 3 Appeal is handled by an administrative law judge. "Taking Your Appeal to Level 3 and Beyond" in this "Coverage Decisions, Appeals, and Complaints" section tells more about Levels 3, 4, and 5 of the appeals process

What If You are Asking our Plan to Pay You for our Share of a Bill You Have Received for Services?

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

Asking for reimbursement is asking for a coverage decision from our Plan

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

We will say yes or no to your request

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

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

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

To make this appeal, follow the process for appeals that we describe under "Step-by-step: How to make a Level 1 Appeal." Go to this 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 Services you have already received and paid for yourself, you are not allowed to ask for a fast appeal)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days

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

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

Your benefits as a member of our Plan include coverage for many outpatient prescription drugs. Medicare calls these outpatient prescription drugs "Part D drugs." You can get these drugs as long as they are included in our Plan's *List of Covered Drugs (Formulary)* and they are medically necessary for you, as determined by your primary care doctor or other provider.

- **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*, rules and restrictions on coverage, and cost information, see "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section

Part D coverage decisions and appeals

As discussed under "A Guide to the Basics of Coverage Decisions and Appeals" in this "Coverage Decisions,

Appeals, and Complaints" section, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

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

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

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

Which of these situations are you in?

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

- **Request a Coverage Decision:**
  - Do you want to ask us to make an exception to the rules or restrictions on our Plan coverage of a drug? You can ask us to make an exception (This type of a coverage decision.) **Start with "What is a Part D exception"**
  - Do you want to ask us to cover a drug for you? (For example, if we cover the drug but we require you to get an approval from us first? You can us for a coverage decision. **Skip ahead to "Step-by-step: How to ask for a coverage decision, including a Part D exception"**
  - Do you want to ask us to pay you back for a drug you have already received and paid for? You can ask us to pay you back. (This is a type of coverage decision.) **Skip ahead to "Step-by-step: How to make a Level 1 Appeal"**
- **Make an Appeal:**
  - Has our Plan already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for? You can make an appeal. (This means you are asking us to reconsider.) **Skip ahead to "Step-by-step: How to make a Level 1 Appeal"**

What is a Part D exception?

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

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

1. **Covering a Part D drug for you that is not on our Plan's *List of Covered Drugs (Formulary).*** (We call it the "Drug List" for short.)
   - 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 brand-name drugs. 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 which Medicare does not cover. (For more information about excluded drugs, see "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section)
2. **Removing a restriction on our Plan's coverage for a covered Part D drug**. There are extra rules or restrictions that apply to certain drugs on our Plan's *List of Covered Drugs* (for more information, go to "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section).
   - The extra rules and restrictions on coverage for certain drugs include:
     - Being **required to use the generic version** of a drug instead of the brand-name drug
     - Getting **Plan approval in advance** before we will agree to cover the drug for you. (This is sometimes called "prior authorization")
     - **Quantity limits.** For some drugs, there are restrictions on the amount of the drug you can have
   - If our Plan agrees to make an exception and waive a restriction for you, you can ask for an

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

Important things to know about asking for a Part D exception

Your doctor must tell us the medical reasons

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

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

Our Plan can say yes or no to your request

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

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

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

Step 1: You ask our Plan 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 our Plan to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to "How to contact us when you are asking for a coverage decision or making an appeal or a complaint about your Part D prescription drugs" in the "Important Phone Numbers and Resources" section. Or if you are asking us to pay you back for a drug, go to the section called, go to "Where to send a request that asks us to pay for our share of the cost for a Service or a Part D drug you have received" in the "Important Phone Numbers and Resources" section
- You or your doctor or someone else who is acting on your behalf can ask for a coverage decision. The "A Guide to the Basics of Coverage Decisions and Appeals" section tells how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf
- If you want to ask us to pay you back for a drug, start by reading the "Requests for Payment" section, which describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for
- If you are requesting a Part D exception, provide the "doctor's statement." Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "doctor's statement.") Your doctor or other prescriber can fax or mail the statement to our Plan. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing the signed statement. See "What is a Part D exception?" and "Important things to know about asking for a Part D exception" for more information about exception requests

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

- 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 are 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), our Plan

will decide whether your health requires that we give you a fast decision

- If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead)
- This letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision
- The letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section

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

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

- If we are using the fast deadlines, we must give you our answer within 24 hours
  - Generally, this means within 24 hours after we receive your request. If you are requesting a Part D exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Level 2 Appeal
- 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*

- If we are using the standard deadlines, we must give you our answer within 72 hours
  - Generally, this means within 72 hours after we receive your request. If you are requesting a Part D exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this section, we tell about this review organization and explain what happens at Level 2 Appeal
- 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 we approve your request to pay you back for a drug you already bought, we are also required to send payment to you within 30 calendar days 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

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

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

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

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

When you start the appeals process by making an appeal, it is called the "first level of appeal" or a "Level 1 Appeal."

What to do

- To start your appeal, you (or your representative or your doctor or other prescriber) must contact our Plan
  - For details on how to reach us by phone, fax, mail, or in person for any purpose related to your appeal, go to "How to contact us when you are asking for a coverage decision or making an appeal or a complaint about your Part D

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prescription drugs" in the "Important Phone Numbers and Resources" section

- Make your appeal in writing by submitting a signed request. You may also ask for an appeal by calling us at the phone number shown under "How to contact us when you are asking for a coverage decision or making an appeal or a complaint about your Part D prescription drugs" in the "Important Phone Numbers and Resources" section
- You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal
- 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"

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

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

- When our Plan is reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were being fair and 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
- 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 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 our Plan says no to your appeal, you then choose whether to accept this decision or continue by making another appeal

If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below)

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

If our Plan says 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 our Plan made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

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

- If our Plan says 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 outside, 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 review our decisions about your Part D benefits with our Plan
- 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

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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 if the dollar value of the coverage you are requesting is high enough to continue with the appeals process.

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

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

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

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

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

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

During your 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 is supposed to give it to you within two days after you are admitted.

- **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
  - What to do if you think you are being discharged from the hospital too soon
- **You must sign the written notice to show that you received it and understand your rights**
  - You or someone who is acting on your behalf must sign the notice. ("A Guide to the Basics of Coverage Decisions and Appeals" in this "Coverage Decisions, Appeals, and Complaints" section tells how you can give written permission to someone else to act as your representative)
  - Signing the notice shows only that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice does not mean you are agreeing on a discharge date
- **Keep your copy of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it**
  - If you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged
  - To look at a copy of this notice in advance, you can call our Member Service Call Center or 1-800 MEDICARE/1-800-633-4227 (TTY 1-877-486-2048). You can also see it online at www.cms.hhs.gov

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 our Plan for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

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

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. 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

What is the Quality Improvement Organization?

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

How can you contact this organization?

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

Act quickly:

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

Ask for a "fast review":

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

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the Services should continue. You don't have to prepare anything in writing, but you may do so if you wish
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and our Plan has given to them
- During this review process, you will also get a written notice that gives your planned discharge date and explains the reasons why your doctor, the hospital, and our Plan think it is right (medically appropriate) for you to be discharged on that date
- This written explanation is called the *Detailed Notice of Discharge*

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

What happens if the answer is no?

- If the review organization says no to your appeal, they are saying that your planned discharge date is medically appropriate. (Saying no to your appeal is also called turning down your appeal.) If this happens, our Plan's 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 you decide to stay in the hospital, then you may have to pay the full cost of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal

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

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

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

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

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

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

- You must ask for this review within 60 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 days, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision

If the review organization says yes:

- Our Plan 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. Our Plan 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 to your Level 1 Appeal and will not change it. This is called "upholding the decision." It is also called "turning down your appeal"
- 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
- "Taking Your Appeal to Level 3 and Beyond" section tells more about Levels 3, 4, and 5 of the appeals process

What If You Miss the Deadline for Making Your Level 1 Appeal?

You can appeal to our Plan instead

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

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

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

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our Plan, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines.

Step 1: Contact our Plan and ask for a "fast review"

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

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

- During this review, our Plan takes 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: Our Plan gives you our decision within 72 hours after you ask for a "fast review" ("fast appeal")

- If our Plan says 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 our Plan says 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 our Plan says 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 being fair when we said no to your fast appeal, our Plan is 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 our Plan says 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 our Plan made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

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 appeals process. "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section tells how to make a complaint)

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

- The Independent Review Organization is an outside, 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 our Plan 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 our Plan that your planned hospital discharge date was medically appropriate. (This is called "upholding the decision." It is also called "turning down your appeal")
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say no to your Level 2 Appeal,

you decide whether to accept their decision or go on to Level 3 and make a third appeal

- "Taking Your Appeal to Level 3 and Beyond" in this "Coverage Decisions, Appeals, and Complaints" section tells more about Levels 3, 4, and 5 of the appeals process

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

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

This section is about the following three types of care only:

- Home health care Services you are getting
- Skilled nursing care you are getting as a patient in a Skilled Nursing Facility. (To learn about requirements for being considered a "Skilled Nursing Facility," see the "Definitions" section)
- Rehabilitation care you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see the "Definitions" section)

When you are getting any of these types of care, you have the right to keep getting your covered Services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information on your covered Services, including your share of the cost and any limitations to coverage that may apply, see the "Benefits and Cost Sharing" section.

When our Plan decides 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, our Plan will stop paying its 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.

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

- **You receive a notice in writing.** At least two days before our Plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice
  - The written notice tells you the date when our Plan 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
- **You must sign the written notice to show that you received it**
  - You or someone who is acting on your behalf must sign the notice. ("A Guide to the Basics of Coverage Decisions and Appeals" in this "Coverage Decisions, Appeals, and Complaints" section tells how you can give written permission to someone else to act as your representative.)
  - Signing the notice shows only that you have received the information about when your coverage will stop. Signing it does not mean you agree with our Plan that it's time to stop getting the care

Step-by-step: How to make a Level 1 Appeal to have our Plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our Plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section tells you how to file a complaint)
- **Ask for help if you need it**. If you have questions or need help at any time, please call our Member Service Call Center (phone numbers are on the front cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see the "Important Phone Numbers and Resources" section)

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our Plan

Step 1: Make your Level 1 Appeal: Contact the Quality Improvement Organization in your state and ask for a review. You must act quickly

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the federal government. These experts are not part of our Plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of Services

How can you contact this organization?

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

What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for our Plan 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 our Plan instead. For details about this other way to make your appeal, see "Step-by-step: How to make a Level 2 Appeal to have our Plan cover your care for a longer time"

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the Services should continue. You don't have to prepare anything in writing, but you may do so if you wish
- The review organization will also look at your medical information, talk with your doctor, and review information that our Plan has given to them
- During this review process, you will also get a written notice from us that gives our reasons for wanting to end our Plan's coverage for your Services

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 our Plan must keep providing your covered Services for as long as it is medically necessary
- You will have to keep paying your share of the costs (such as Cost Sharing, if applicable). In addition, there may be limitations on your covered Services (see the "Benefits and Cost Sharing" section)

What happens if the reviewers say no to your appeal?

- If the reviewers say no to your appeal, then your coverage will end on the date we have told you. Our Plan 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

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.

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

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

- You must ask for this review within 60 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 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?

- Our Plan must reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. Our plan 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 they made to your Level 1 Appeal and will not change it. (This is called "upholding the decision." It is also called "turning down your appeal")
- 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 whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge
- "Taking Your Appeal to Level 3 and Beyond" in this "Coverage Decisions, Appeals, and Complaints" section tells more about Levels 3, 4, and 5 of the appeals process

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

You can appeal to our Plan instead

As explained above, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.

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

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to our Plan, 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:

Step 1: Contact our Plan and ask for a "fast review"

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

Step 2: Our Plan does a "fast" review of the decision we made about when to stop coverage for your Services

- During this review, our Plan takes another look at all of the information about your case. We check to see if we were being fair and 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: Our Plan gives you our decision within 72 hours after you ask for a "fast review" ("fast appeal")

- If our Plan says 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 our Plan says no to your fast appeal, then your coverage will end on the date we have told you and our Plan will not pay after this date. Our Plan will stop paying its 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 our Plan says no to your fast appeal, your case will automatically go on to the next level of the appeals process

- To make sure we were being fair when we said no to your fast appeal, our Plan is 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 our Plan says 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 our Plan made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

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 appeals process. "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section tells how to make a complaint.)

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

- The Independent Review Organization is an outside, 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 our Plan 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. (This is called "upholding the decision." It is also called "turning down your appeal")
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge
- "Taking Your Appeal to Level 3 and Beyond" in this "Coverage Decisions, Appeals, and Complaints" section tells more about Levels 3, 4, and 5 of the appeals process

Taking Your Appeal to Level 3 and Beyond

Levels of Appeal 3, 4, and 5 for Medical Service Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot

appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who 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 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 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 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, 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 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. It depends on your situation. If the Medicare Appeals Council says no to your 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 who 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 stage of the appeals process

- This is the last step of the administrative appeals process

Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the Part D drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain who 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
- 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 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
- 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. It depends on your situation. Whenever the reviewer says no to your appeal, the notice you get will tell you whether the rules allow you to go on to another level of appeal. If the rules allow you to go on, the written notice will also tell you who 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 stage of the appeals process.

- This is the last step of the administrative appeals process

How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns

If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to "A Guide to the Basics of Coverage Decisions and Appeals" in this "Coverage Decisions, Appeals, and Complaints" section.

What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. Here are examples of the kinds of problems handled by the complaint process.

If you have any of these kinds of problems, you can "make a complaint"

- **Quality of your Services**
  - Are you unhappy with the quality of care you have received (including care in the hospital)?
- **Respecting your privacy**
  - Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
- **Disrespect, poor customer service, or other negative behaviors**
  - Has someone been rude or disrespectful to you?
  - Are you unhappy with how our Member Service Call Center has dealt with you?
  - Do you feel you are being encouraged to leave our Plan?
- **Waiting times**
  - Are you having trouble getting an appointment, or waiting too long to get it?
  - Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Service Call Center or other staff at our Plan?
  - Examples include waiting too long on the phone, in the waiting room , in the exam room, or when getting a prescription
- **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 compliant

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 earlier part of this "Coverage Decisions, Appeals, and Complaints" section. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that our Plan is 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 Part D drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint
- When our Plan does 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

The formal name for "making a complaint" is "filing a grievance."

Step-by-step: Making a complaint

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

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

- Usually calling our Member Service Call Center is the first step. If there is anything else you need to do, our Member Service Call Center will let you know. Call 1-800-443-0815 (TTY users call 1-800-777-1370), seven days a week from 8:00 a.m. to 8:00 p.m.
- If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you do this, it means that we will use our formal procedure for answering grievances. Here's how it works:
  - If you have a complaint, we will try to resolve your complaint over the phone. If you ask for a written response, file a written grievance, or your complaint is related to quality of care, we will respond in writing to you. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. Your grievance must explain your concern, such as why you are dissatisfied with the services you received. Please see the "Important Phone Numbers and Resources" section for who you should contact if you have a complaint
  - The grievance must be submitted to us (orally or in writing) within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame to make our decision by up to 14 days if you ask for an extension, or if we justify a need for additional information and the delay is in your best interest. If our decision is not completely in your favor, we will send you our decision with an explanation and tell you about any dispute resolution options you may have.
  - You may make an oral or written request that we expedite your grievance if we:
    1. Deny your request to expedite a decision related to a service that you have not yet received
    2. Deny your request to expedite your Medicare appeal
    3. Decide to extend the time we need to make a standard or expedited decision.

    If you request an expedited grievance, we will respond to your request within 24 hours.
- Whether you call or write, you should contact our Member Service Call Center right away. The complaint must be made within 60 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

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 days, but we may take up to 44 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 days (44 days total) to answer your complaint
- If we do not agree with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We

must respond whether we agree with the complaint or not

You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to our Plan 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 our Plan). To find the name, address, and phone number of the Quality Improvement Organization in your state, look in the "Important Phone Numbers and Resources" section. If you make a complaint to this organization, we will work together 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 our Plan and also to the Quality Improvement Organization

Binding Arbitration

For all claims subject to this "Binding Arbitration" section, both Claimants and Respondents give up the right to a jury or court trial and accept the use of binding arbitration. Insofar as this "Binding Arbitration" section applies to claims asserted by Kaiser Permanente Parties, it shall apply retroactively to all unresolved claims that accrued before the effective date of this *Evidence of Coverage*. Such retroactive application shall be binding only on the Kaiser Permanente Parties.

Scope of arbitration

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *Evidence of Coverage* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc. (Health Plan), including any claim for medical or hospital malpractice (a claim that medical services were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, Services, irrespective of the legal theories upon which the claim is asserted
- The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
- The claim is *not* within the jurisdiction of the Small Claims Court
- If your Group must comply with the Employee Retirement Income Security Act (ERISA) requirements, the claim is *not* a benefit-related request that constitutes a "benefit claim" in Section 502(a)(1)(B) of ERISA. Note: Benefit claims under this section of ERISA are excluded from this binding arbitration requirement only until such time as the United States Department of Labor regulation prohibiting mandatory binding arbitration of this category of claim (29 CFR 2560.503-1(c)(4)) is modified, amended, repealed, superseded, or otherwise found to be invalid. If this occurs, these claims will automatically become subject to mandatory binding arbitration without further notice
- The claim is *not* subject to a Medicare appeal procedure

As referred to in this "Binding Arbitration" section, "Member Parties" include:

- A Member
- A Member's heir, relative, or personal representative
- Any person claiming that a duty to him or her arises from a Member's relationship to one or more Kaiser Permanente Parties

"Kaiser Permanente Parties" include:

- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals
- KP Cal, LLC
- The Permanente Medical Group, Inc.
- Southern California Permanente Medical Group
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., or Southern California Permanente Medical Group physician
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties
- Any employee or agent of any of the foregoing

"Claimant" refers to a Member Party or a Kaiser Permanente Party who asserts a claim as described above. "Respondent" refers to a Member Party or a

Kaiser Permanente Party against whom a claim is asserted.

Initiating arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and telephone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include all claims against Respondents that are based on the same incident, transaction, or related circumstances in the Demand for Arbitration.

Serving Demand for Arbitration

Health Plan, Kaiser Foundation Hospitals, KP Cal, LLC, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of:

Kaiser Foundation Health Plan, Inc.
Legal Department
1950 Franklin St., 17th Floor
Oakland, CA 94612

Service on that Respondent shall be deemed completed when received. All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

Filing fee

The Claimants shall pay a single, nonrefundable filing fee of $150 per arbitration payable to "Arbitration Account" regardless of the number of claims asserted in the Demand for Arbitration or the number of Claimants or Respondents named in the Demand for Arbitration.

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling our Member Service Call Center.

Number of arbitrators

The number of arbitrators may affect the Claimant's responsibility for paying the neutral arbitrator's fees and expenses.

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing that the arbitration shall be heard by two party arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than $200,000.

If the Demand for Arbitration seeks total damages of more than $200,000, the dispute shall be heard and determined by one neutral arbitrator and two party arbitrators, one jointly appointed by all Claimants and one jointly appointed by all Respondents. Parties who are entitled to select a party arbitrator may agree to waive this right. If all parties agree, these arbitrations will be heard by a single neutral arbitrator.

Payment of arbitrators' fees and expenses

Health Plan will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* ("Rules of Procedure"). In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

If the parties select party arbitrators, Claimants shall be responsible for paying the fees and expenses of their party arbitrator and Respondents shall be responsible for paying the fees and expenses of their party arbitrator.

Costs

Except for the aforementioned fees and expenses of the neutral arbitrator, and except as otherwise mandated by laws that apply to arbitrations under this "Binding Arbitration" section, each party shall bear the party's own attorneys' fees, witness fees, and other expenses incurred in prosecuting or defending against a claim regardless of the nature of the claim or outcome of the arbitration.

Rules of Procedure

Arbitrations shall be conducted according to the Rules of Procedure developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from our Member Service Call Center.

General provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondents served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with

reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

The California Medical Injury Compensation Reform Act of 1975 (including any amendments thereto), including sections establishing the right to introduce evidence of any insurance or disability benefit payment to the patient, the limitation on recovery for noneconomic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted or required by law.

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding Arbitration" section.

Termination of Membership

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered. (For example, if your termination date is January 1, 2010, your last minute of coverage was at 11:59 p.m. on December 31, 2009). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *Evidence of Coverage* after your membership terminates, except:

- As provided under "Payments after Termination" in this "Termination of Membership" section
- If you are receiving covered Services as an acute care hospital inpatient on the termination date, we will continue to cover those hospital Services (but not physician Services or any other Services) until you are discharged

Until your membership terminates, you remain a Senior Advantage Member and must continue to receive your medical care from us, except as described in the "Emergency, Urgent, and Routine Care" section about Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care and the "Benefits and Cost Sharing" section about out-of-area dialysis care.

Note: If you enroll in another Medicare health plan or a Prescription Drug Plan, your Senior Advantage membership will terminate as described under "Disenrolling from Senior Advantage" in this "Termination of Membership" section. Such a termination will not affect your enrollment in your Group's non-Medicare plan.

E O C 2

Termination Due to Loss of Eligibility

If you meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership will end at 11:59 p.m. on the last day of that month. For example, if you become ineligible on December 5, 2009, your termination date is January 1, 2010, and your last minute of coverage is at 11:59 p.m. on December 31, 2009.

Also, we will terminate your Senior Advantage membership under this *Evidence of Coverage* on the last day of the month if you:

- Are temporarily absent from our Service Area for more than six months in a row
- Permanently move outside our Service Area
- No longer are entitled to Medicare Part B
- Medicare becomes primary, for example, when you retire
- Enroll in another Medicare health plan (for example, a Medicare Advantage Plan or a Medicare Prescription Drug Plan). The Centers for Medicare & Medicaid Services will automatically terminate your Senior Advantage membership when your enrollment in the other plan becomes effective

Note: If you lose eligibility for Senior Advantage due to any of these circumstances, you will be able to continue membership under your Group's non-Medicare plan, or if you retire, you may be able to enroll in a different Senior Advantage plan either through your Group (if available) or as discussed under "Conversion to an Individual Plan" below. Please contact your Group for information.

Termination of *Agreement*

If your Group's *Agreement* with us terminates for any reason, your membership ends on the same date. Your Group is required to notify Subscribers in writing if its *Agreement* with us terminates.

Disenrolling from Senior Advantage

You may terminate (disenroll from) your Senior Advantage membership and remain a Member through your Group's non-Medicare plan at any time. Your disenrollment effective date will be the first day of the month following our receipt of your disenrollment request.

You may request disenrollment by calling toll free 1-800-MEDICARE/1-800-633-4227 (TTY users call 1-877-486-2048) or sending written notice to the following address:

Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 232400
San Diego, CA 92193-2400

Other Medicare health plans. If you want to enroll in another Medicare health plan or a Medicare Prescription Drug Plan, you should first confirm with the other plan and your Group that you are able to enroll in their plan. Your new plan will tell you the date when your membership in that plan begins and your Senior Advantage membership will end on that same day (your disenrollment date).

The Centers for Medicare & Medicaid Services will let us know if you enroll in another Medicare health plan, so you will not need to send us a disenrollment request.

Original Medicare. If you request disenrollment from Senior Advantage and you do not enroll in another Medicare health plan, you will automatically be enrolled in Original Medicare when your Senior Advantage membership terminates (your disenrollment date). On your disenrollment date, you can start using your red, white, and blue Medicare card to get services under Original Medicare. You will not get anything in writing that tells you that you have Original Medicare after you disenroll. If you choose Original Medicare and you want to continue to get Medicare Part D prescription drug coverage, you will need to enroll in a Prescription Drug Plan.

Termination of Contract with the Centers for Medicare & Medicaid Services

If our contract with the Centers for Medicare & Medicaid Services to offer Senior Advantage terminates, your Senior Advantage membership will terminate on the same date. We will send you advance written notice and advise you of your health care options. However, you will still be enrolled under your Group's non-Medicare plan.

Termination for Cause

We may terminate your membership by sending you advance written notice if you commit one of the following acts:

- You behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for our other members. We cannot make you leave our Senior Advantage Plan for this reason unless we get permission first from Medicare
- If you let someone else use your Plan membership card to get medical care. If you are disenrolled for this reason, the Centers for Medicare & Medicaid Services may refer your case to the Inspector General for additional investigation
- You commit theft from Health Plan, from a Plan Provider, or at a Plan Facility
- You intentionally misrepresent membership status or commit fraud in connection with your obtaining membership
- You knowingly falsify or withhold information about other parties that provide reimbursement for your prescription drug coverage

If we terminate your membership for cause, you will not be allowed to enroll in Health Plan in the future until you have completed a Member Orientation and have signed a statement promising future compliance. We may report fraud and other illegal acts to the authorities for prosecution.

Termination for Nonpayment of Premiums

If your Group fails to pay us Premiums for your Family, we may terminate the memberships of everyone in your Family.

Termination of a Product or all Products

We may terminate a particular product or all products offered in a small or large group market as permitted or required by law. If we discontinue offering a particular product in a market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products to groups in a small or large group market, as applicable, we may terminate your Group's *Agreement* by sending you written notice at least 180 days before the *Agreement* terminates.

Payments after Termination

If we terminate your membership for cause or for nonpayment, we will:

- Refund any amounts we owe your Group for Premiums paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Requests for Payment" section. We will deduct any amounts you owe Health Plan or Plan Providers from any payment we make to you

Review of Membership Termination

If you believe that we terminated your Senior Advantage membership because of your ill health or your need for care, you may file a complaint as described in the "Coverage Decisions, Appeals, and Complaints" section.

Continuation of Membership

If your membership under your Group's non-Medicare plan ends, you may be eligible to maintain Health Plan membership without a break in coverage (group coverage) or you may be eligible to convert to an individual (nongroup) plan.

Continuation of Group Coverage

COBRA

You may be able to continue your coverage under this Senior Advantage *Evidence of Coverage* for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law (the Consolidated Omnibus Budget Reconciliation Act). COBRA applies to most employees (and most of their covered family Dependents) of most employers with 20 or more employees.

If your Group is subject to COBRA and you are eligible for COBRA coverage, in order to enroll, you must submit a COBRA election form to your Group within the COBRA election period. Please ask your Group for details about COBRA coverage, such as how to elect coverage, how much you must pay for coverage, when coverage and Premiums may change, and where to send your Premium payments.

As described in "Conversion from Group Membership to an Individual Plan" in this "Continuation of Membership" section, you may be able to convert to an individual (nongroup) plan if you don't apply for COBRA coverage, or if you enroll in COBRA and your COBRA coverage ends.

Coverage for a disabling condition

If you became totally disabled after December 31, 1977, while you were a Member under your Group's *Agreement* with us and while the Subscriber was employed by your Group, and your Group's *Agreement* with us terminates, coverage for your disabling condition will continue until any one of the following events occurs:

- 12 months have elapsed
- You are no longer disabled
- Your Group's *Agreement* with us is replaced by another group health plan without limitation as to the disabling condition

Your coverage will be subject to the terms of this *Evidence of Coverage* including Cost Sharing.

For Subscribers and adult Dependents, "totally disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months, and makes the person unable to engage in any employment or occupation, even with training, education, and experience.

For Dependent children, "totally disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months and the illness or injury makes the child unable to substantially engage in any of the normal activities of children in good health of like age.

To request continuation of coverage for your disabling condition, you must call our Member Service Call Center, within 30 days of the date your Group's *Agreement* with us terminates.

Conversion from Group Membership to an Individual Plan

After your Group notifies us to terminate your Group membership, we will send a termination letter to the Subscriber's address of record. The letter will include information about options that may be available to you to remain a Health Plan member through one of our Individual Plans. Individual–Conversion Plan coverage begins when your Group coverage ends. The premiums and coverage under our Individual–Conversion Plans are different from those under your Group's plan.

How to convert

If you are no longer eligible for Group membership, we will automatically convert your Group membership to our Senior Advantage Individual Plan if you still meet the eligibility requirements for Senior Advantage and have not disenrolled from 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.

However, if you are no longer eligible for Senior Advantage and Group coverage, you may be eligible to convert to our non-Medicare individual plan, called "Kaiser Permanente Individual–Conversion Plan." You may be eligible to enroll in our Individual–Conversion Plan if we receive your enrollment application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later).

You may not be eligible to convert if your membership ends for the reasons stated under "Termination for Cause" or "Termination of *Agreement*" in the "Termination of Membership" section.

For information about converting your membership or about other individual plans, call our Member Service Call Center.

Miscellaneous Provisions

Administration of *Agreement*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of your Group's *Agreement*, including this *Evidence of Coverage*.

Advance directives

The California Health Care Decision Law offers several ways for you to control the kind of health care you will receive if you become very ill or unconscious, including the following:

- A *Power of Attorney for Health Care* lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your own views on life support and other treatments
- *Individual health care instructions* let you express your wishes about receiving life support and other treatment. You can express these wishes to your doctor and have them documented in your medical chart, or you can put them in writing and have that included in your medical chart

To learn more about advance directives, including how to obtain forms, contact your local Member Services Department at a Plan Facility. You can also refer to *Your Guidebook* for more information about advance directives.

Agreement binding on Members

By electing coverage or accepting benefits under this *Evidence of Coverage*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *Evidence of Coverage*.

Amendment of *Agreement*

Your Group's *Agreement* with us will change periodically. If these changes affect this *Evidence of Coverage*, your Group is required to inform you in accord with applicable law and your Group's *Agreement*.

Applications and statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this *Evidence of Coverage*.

Assignment

You may not assign this *Evidence of Coverage* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

Attorney and advocate fees and expenses

In any dispute between a Member and Health Plan, the Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses.

Claims review authority

We are responsible for determining whether you are entitled to benefits under this *Evidence of Coverage* and we have the discretionary authority to review and evaluate claims that arise under this *Evidence of*

Coverage. We conduct this evaluation independently by interpreting the provisions of this *Evidence of Coverage*. If this *Evidence of Coverage* is part of a health benefit plan that is subject to the Employee Retirement Income Security Act (ERISA), then we are a "named fiduciary" to review claims under this *Evidence of Coverage*.

ERISA notices

This "ERISA notices" section applies only if your Group must comply with the Employee Retirement Income Security Act (ERISA). We provide these notices to assist ERISA groups in complying with ERISA. Coverage for Services described in these notices is subject to all provisions of this *Evidence of Coverage*.

Newborns' and Mother's Health Protection Act. Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act. If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same Cost Sharing applicable to other medical and surgical benefits provided under this plan.

Governing law

Except as preempted by federal law, this *Evidence of Coverage* will be governed in accord with California law and any provision that is required to be in this *Evidence of Coverage* by state or federal law shall bind Members and Health Plan whether or not set forth in this *Evidence of Coverage*.

Group and Members not our agents

Neither your Group nor any Member is the agent or representative of Health Plan.

No waiver

Our failure to enforce any provision of this *Evidence of Coverage* will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

Nondiscrimination

We do not discriminate in our employment practices or in the delivery of Services on the basis of age, race, color, national origin, cultural background, religion, sex, sexual orientation, physical or mental disability, or genetic information.

Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call our Member Service Call Center, and the Social Security Administration toll free at 1-800-772-1213 (TTY users call 1-800-325-0778) as soon as possible to report the address change. If a Member does not reside with the Subscriber, he or she should contact our Member Service Call Center to discuss alternate delivery options.

Note: When we tell your Group about changes to this *Evidence of Coverage* or provide your Group other information that affects you, your Group is required to notify the Subscriber within 30 days (or five days if we terminate your Group's *Agreement*) after receiving the information from us.

Other *Evidence of Coverage* formats

You can request a copy of this *Evidence of Coverage* in an alternate format (Braille, audio, electronic text file, or large print) by calling our Member Service Call Center.

Overpayment recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment or from any person or organization obligated to pay for the Services.

Privacy practices

Kaiser Permanente will protect the privacy of your protected health information. We also require contracting providers to protect your protected health information. Protected health information is health information that includes your name, Social Security number, or other information that reveals who you are. You may generally see and receive copies of your protected health

information, correct or update your protected health information, and ask us for an accounting of certain disclosures of your protected health information.

We may use or disclose your protected health information for treatment, payment, and health care operations purposes, including health research and measuring the quality of care and Services. We are sometimes required by law to give protected health information to government agencies or in judicial actions. In addition, Member-identifiable medical information is shared with your Group only with your authorization or as otherwise permitted by law. We will not use or disclose your protected health information for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy Practices* describing our policies and procedures for preserving the confidentiality of medical records and other protected health information is available and will be furnished to you upon request. To request a copy, please call our Member Service Call Center. You can also find the notice at your local Plan Facility or on our Web site at kp.org.

Public policy participation

The Kaiser Foundation Health Plan, Inc., Board of Directors establishes public policy for Health Plan. A list of the Board of Directors is available on our Web site at **kp.org** or from our Member Service Call Center. If you would like to provide input about Health Plan public policy for consideration by the Board, please send written comments to:

Kaiser Foundation Health Plan, Inc.
Office of Board and Corporate Governance Services
One Kaiser Plaza, 19th Floor
Oakland, CA 94612

Telephone access (TTY)

If you are hearing or speech impaired and use a text telephone device (TTY, also known as TDD) to communicate by phone, you can use the California Relay Service by calling 711 if a dedicated TTY number is not available for the telephone number that you want to call.

Important Phone Numbers and Resources

Kaiser Permanente Senior Advantage Contacts (how to contact us, including how to reach our Member Services at our Plan)

How to contact Member Services

For assistance, please call or write to our Senior Advantage Member Services. We will be happy to help you.

Member Services	
Call	**1-800-443-0815** Calls to this number are free. 8 a.m. to 8 p.m., seven days a week.
TTY	**1-800-777-1370** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
Write	Member Services office located at a Plan facility listed in the *Provider Directory*.
Website	**kp.org**

How to contact us when you are asking for a coverage decision or making an appeal or a complaint about your Services

You may call us if you have questions about our coverage decision, appeal, or complaint processes.

Coverage decisions, appeals, or complaints for Services	
Call	**1-800-443-0815** Calls to this number are free. 8 a.m. to 8 p.m., seven days a week. If your coverage decision, appeal, or complaint **qualifies for a fast decision**, call the Expedited Review Unit, 8:30 a.m. to 5 p.m., Monday through Saturday, at **1-888-987-7247**. After hours, you may leave a message and we will return your call the next business day.
TTY	**1-800-777-1370** This number requires special telephone equipment and is only for people who

	have difficulties with hearing or speaking. Calls to this number are free.
Fax	If your coverage decision, appeal, or complaint **qualifies for a fast decision**, fax your request to our Expedited Review Unit at **1-888-987-2252**.
Write	Member Services office located at a Plan Facility, unless you are requesting an appeal, a fast complaint, or a fast coverage decision, in which case, you would write to one of the following locations: • For a **standard appeal**, write to the address shown on the denial notice we send you (a standard appeal is one that does not involve a request for a fast decision). • If your coverage decision, appeal, or complaint **qualifies for a fast decision**, write to: Kaiser Foundation Health Plan, Inc. Expedited Review Unit P.O. Box 23170 Oakland, CA 94623-0170

For more information on asking for coverage decisions and making appeals or complaints about your Services, see the "Coverage Decisions, Appeals, and Complaints" section.

How to contact us when you are asking for a coverage decision or making an appeal or a complaint about your Part D prescription drugs

You may call us if you have questions about our coverage decisions or appeals processes.

Coverage decisions or appeals for Part D prescription drugs	
Call	**1-866-206-2973** Calls to this number are free. 8:30 a.m. to 5 p.m., seven days a week. After hours, you may leave a message and we will return your call the next day.
TTY	**1-800-777-1370** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
Fax	**1-866-206-2974**
Write	Kaiser Foundation Health Plan, Inc. Part D Unit P.O. Box 23170 Oakland, CA 94623-0170

For more information on asking for coverage decisions or making appeals about your Part D prescription drugs, see the "Coverage Decisions, Appeals, and Complaints" section.

How to contact us when you are making a complaint about your Part D prescription drugs

You may call us if you have questions about complaint process.

Complaints for Part D prescription drugs	
Call	**1-800-443-0815** Calls to this number are free. 8 a.m. to 8 p.m., seven days a week. If your complaint **qualifies for a fast decision**, call the Part D Unit, 8:30 a.m. to 5 p.m., seven days a week, at **1-866-206-2973.** After hours, you may leave a message and we will return your call the next day.
TTY	**1-800-777-1370** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
Fax	If your complaint qualifies for a fast review, fax your request to our Part D Unit at **1-866-206-2974.**
Write	Member Services office located at a Plan Facility, unless you are requesting a fast complaint, in which case, you should write to: Kaiser Foundation Health Plan, Inc. Part D Unit P.O. Box 23170 Oakland, CA 94623-0170

For more information on making a complaint about your Part D prescription drugs, see the "Coverage Decisions, Appeals, and Complaints" section.

Where to send a request that asks us to pay for our share of the cost for Services or a Part D 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 the "Requests for Payment" section.

Note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See the "Coverage Decisions, Appeals, and Complaints" section for more information.

Payment Requests	
Call	**1-800-443-0815** Calls to this number are free. 8 a.m. to 8 p.m., seven days a week. Note: If you are requesting payment of a Part D drug that was prescribed by a Plan Provider and obtained from a Plan Pharmacy, call our Part D unit at **1-866-206-2973.** Calls to this number are free. 8:30 a.m. to 5 p.m., seven days a week.
TTY	**1-800-777-1370** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
Write	Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 24010 Oakland, CA 94623-1010 Note: If you are requesting payment of a Part D drug that was prescribed by a Plan Provider and obtained from a Plan Pharmacy, write to: Kaiser Foundation Health Plan, Inc. Part D Unit P.O. Box 23170 Oakland, CA 94623-0170

Medicare (how to get help and information directly from the federal Medicare program)

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant). The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage Organizations, including our Plan.

Medicare	
Call	**1-800-MEDICARE** or **1-800-633-4227** Calls to this number are free. 24 hours a day, seven days a week.
TTY	**1-877-486-2048** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
Website	**www.medicare.gov** This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare Prescription Drug Plans in your area. You can also find Medicare contacts in your state by selecting "Helpful Phone Numbers and Websites." If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

State Health Insurance Assistance Program (free help, information, and

answers to your questions about Medicare)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In California, the State Health Insurance Assistance Program is called the Health Insurance Counseling and Advocacy Program (HICAP).

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

The Health Insurance Counseling and Advocacy Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your Services or treatment, and help you straighten out problems with your Medicare bills. The Health Insurance Counseling and Advocacy Program counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Health Insurance Counseling and Advocacy Program (HICAP)	
Call	**1-800-434-0222** Calls to this number are free.
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	**Your HICAP office for your county.**
Website	**www.aging.ca.gov**

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

There is a Quality Improvement Organization in each state. In California, the Quality Improvement Organization is called the Health Services Advisory Group.

The Health Services Advisory Group has a group of doctors and other health care professionals who are paid by the federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. Health Services Advisory Group is an independent organization. It is not connected with our plan.

You should contact the Health Services Advisory Group in any of these situations:

- You have a complaint about the quality of care you have received
- You think coverage for your hospital stay is ending too soon
- You think coverage for your home health care, Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

Health Services Advisory Group, Inc.	
Call	**1-800-841-1602** Calls to this number are free. 24 hours a day, seven days a week.
TTY	**1-800-881-5980** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Fax	**1-866-800-8757**
Write	Health Services Advisory Group, Inc. Attn: Beneficiary Protection 5201 W. Kennedy Boulevard, Suite 900 Tampa, Florida 33609-1822

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 and pay the Medicare Part B premium. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security Administration	
Call	**1-800-772-1213** Calls to this number are free. Available 7:00 a.m. to 7:00 p.m., Monday through Friday. You can use the automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	**1-800-325-0778** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 7:00 a.m. to 7:00 p.m., Monday through Friday.
Website	**www.ssa.gov**

Medicaid (a joint federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, contact Medi-Cal.

Medi-Cal	
Call	**1-800-952-5253** 24 hours a day, seven days a week.
TTY	**1-800-952-8349** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	California Department of Social Services P.O. Box 944243 Sacramento, CA 94244

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.

If you think you may qualify for Extra Help, call Social Security (see "Social Security" in this "Important Phone Numbers and Resources" section for contact information) to apply for the program. You may also be able to apply at your State Medical Assistance or Medicaid Office (see "Medicaid" in this "Important Phone Numbers and Resources" section for contact information). After you apply, you will get a letter letting you know if you qualify for Extra Help and what you need to do next.

Railroad Retirement Board

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

Railroad Retirement Board	
Call	**1-877-772-5772** Calls to this number are free. Available 9:00 a.m. to 3:30 p.m., Monday through Friday. If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	**1-312-751-4701** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
Website	**www.rrb.gov**

Group Insurance or Other Health Insurance From an Employer

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group, call the employer/union benefits administrator or our Member Service Call Center if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the 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.

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern California Region

Chiropractic Services Amendment of the Kaiser Foundation Health Plan, Inc., Evidence of Coverage for EL DORADO COUNTY

Purchaser ID: 34936 Contract: 1 Version: 48 *EOC* Number: 3

July 1, 2010, through June 30, 2011

ASH Plans Member Services Department
Weekdays 5 a.m. to 6 p.m.
1-800-678-9133 (TTY users call **711**) toll free
ashplans.com

Help in your language
Interpreters are available 24 hours a day, seven days a week, at no cost to you. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. In addition, you may be able to get materials written in your language. For more information, call our Member Service Call Center at 1-800-464-4000 or 1-800-777-1370 (TTY) weekdays from 7 a.m. to 7 p.m., and weekends from 7 a.m. to 3 p.m.

Ayuda en su propio idioma
Tenemos disponibles intérpretes 24 horas al día, 7 días a la semana, sin ningún costo para usted. También podemos ofrecerle a usted, sus familiares y sus amigos cualquier tipo de ayuda que necesiten para tener acceso a nuestras instalaciones y servicios. Además, usted puede obtener materiales escritos en su idioma. Para más información, llame a nuestro Centro de Llamadas de Servicios a los Miembros al 1-800-788-0616 ó 1-800-777-1370 (TTY) los días de semana de 7 a.m. a 7 p.m., y los fines de semana de 7 a.m. a 3 p.m.

語言翻譯協助
提供每週七天，每天廿四小時翻譯。我們也向會員及其親友提供利用我處設施及服務所需之任何協助。此外會員還可索取以其母語編寫的資料。若需更多資訊，請於週一至週五上午七時至下午七時及週末上午七時至下午三時致電會員服務電話中心，電話號碼爲 1-800-757-7585 或 1-800-777-1370（聽障專線）。

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Introduction

This document amends your Kaiser Foundation Health Plan, Inc. (Health Plan) *Evidence of Coverage (EOC)* to include coverage for Medically Necessary Chiropractic Services under the following terms and conditions.

Kaiser Foundation Health Plan, Inc. contracts with American Specialty Health Plans of California, Inc. (ASH Plans) to make the ASH Plans network of Participating Chiropractors available to you. When you need chiropractic care, you have direct access to more than 2,800 licensed chiropractors in California. You can obtain covered Services from any Participating Chiropractor without a referral from a Plan Physician. Cost Sharing is due when you receive covered Services.

Note: If you are a Kaiser Permanente Senior Advantage or Medicare Cost Member, please refer to your Health Plan *Evidence of Coverage* for information about the chiropractic Services that Medicare covers, which are separate from the Services covered under this "Chiropractic Services Amendment." This Amendment does not describe Services covered by Medicare. Medicare rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." Your Medicare coverage is primary unless Medicare is secondary by law.

Definitions

In addition to the terms defined in the "Definitions" section of your Health Plan *Evidence of Coverage*, the following terms, when capitalized in this "Chiropractic Services Amendment," mean:

Emergency Chiropractic Services: Covered chiropractic services provided for a sudden and unexpected onset of an injury or condition affecting the neuromusculoskeletal system which manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate chiropractic care to result in serious jeopardy to your health or body functions or organs.

Medically Necessary Chiropractic Services: Chiropractic services provided or prescribed by a chiropractor (including laboratory tests, X-rays, and chiropractic appliances) that are appropriate and required for the treatment of your Neuromusculoskeletal Disorder in accord with generally accepted professional standards of practice for the chiropractic treatment of Neuromusculoskeletal Disorders.

Neuromusculoskeletal Disorders: Conditions with associated signs and symptoms related to the nervous, muscular, or skeletal systems. Neuromusculoskeletal Disorders are conditions typically categorized as structural, degenerative, or inflammatory disorders, or biomechanical dysfunction of the joints of the body or related components of the motor unit (muscles, tendons, fascia, nerves, ligaments/capsules, discs, and synovial structures), and related neurological manifestations or conditions.

Non–Participating Chiropractor: A chiropractor other than a Participating Chiropractor.

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

Participating Chiropractor: A chiropractor who is licensed to provide chiropractic services in California and who has a contract with ASH Plans to provide Medically Necessary Chiropractic Services to you. A list of Participating Chiropractors is available on the ASH Plans Web site at **ashplans.com** or from the ASH Plans Member Services Department at 1-800-678-9133 (TTY users call 711). The list of Participating Chiropractors is subject to change at any time, without notice. If you have questions, please call the ASH Plans Member Services Department.

Participating Provider: A Participating Chiropractor, or any licensed provider with which ASH Plans contracts to provide covered laboratory tests or X-rays.

Treatment Plan: A proposed course of treatment for your Neuromusculoskeletal Disorder, which may include laboratory tests, X-rays, chiropractic appliances, and a specific number of visits for chiropractic manipulations, adjustments, and therapies that are Medically Necessary Chiropractic Services for you.

Participating Providers

Please read the following information so you will know from whom or what group of providers you may receive covered Services.

ASH Plans contracts with Participating Chiropractors and other Participating Providers to provide covered chiropractic services, including laboratory tests, X-rays, and chiropractic appliances. You must receive covered Services from a Participating Provider, except for Emergency Chiropractic Services and Services that are not available from Participating Providers that have been preauthorized by ASH Plans.

How to obtain Services

To obtain covered Services, call a Participating Chiropractor to schedule an initial examination. If additional Services are required, your Participating Chiropractor will prepare a Treatment Plan. The ASH Plans Clinical Services Manager will authorize the Treatment Plan if the Services are Medically Necessary Chiropractic Services for you. ASH Plans will disclose to you, upon request, the process that it uses to authorize a Treatment Plan. If you have questions or concerns, please contact ASH Plans or Kaiser Permanente as described under "Member Services" in this "Chiropractic Services Amendment."

Covered Services

We cover the Services listed in this "Covered Services" section if ASH Plans has authorized the Services as part of your Treatment Plan. Covered Services are provided at the Cost Sharing listed in this "Covered Services" section. However, you may be liable for the cost of noncovered Services you obtain from Participating Providers or Non–Participating Providers.

Office visits

We cover up to 30 of the following types of office visits per calendar year at **$10 Copayment per visit**. Each office visit counts toward the calendar year visit limit even if an adjustment is not provided during the visit:

- **Initial examination:** An examination performed by a Participating Chiropractor to determine the nature of your problem (and, if appropriate, to prepare a Treatment Plan), and to provide Medically Necessary Chiropractic Services, which may include an adjustment and adjunctive therapy (such as ultrasound, hot packs, cold packs, or electrical muscle stimulation). We cover an initial examination only if you have not already received covered Services from a Participating Chiropractor in the same calendar year for your Neuromusculoskeletal Disorder
- **Subsequent office visits:** Subsequent Participating Chiropractor office visits for Medically Necessary Chiropractic Services, which may include an adjustment, adjunctive therapy, and a re-examination to assess the need to continue, extend, or change a Treatment Plan

Laboratory tests and X-rays

We cover Medically Necessary laboratory tests and X-rays when prescribed as part of covered care described under "Office visits" in this "Covered Services" section at **no charge** when a Participating Chiropractor provides the Services or refers you to a Participating Provider for the Services.

Chiropractic appliances

We provide a **$50 Allowance per calendar year**, toward the ASH Plans fee schedule price for chiropractic appliances listed in this paragraph when the item is prescribed and provided to you by a Participating Chiropractor as part of covered care described under "Office visits" in this "Covered Services" section. If the price of the item(s) in the ASH Plans fee schedule exceeds **$50** (the Allowance), you will pay the amount in excess of **$50** (and that payment does not apply toward your annual out-of-pocket maximum). Covered chiropractic appliances are limited to: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces and supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units (cervical or lumbar), ankle braces, knee braces, rib supports, and wrist braces.

Second opinions

If you request a second opinion, it will be provided to you by a Participating Chiropractor who is an appropriately qualified chiropractor (a chiropractor who is acting within his or her scope of practice and who possesses a clinical background related to the illness or condition associated with the request for a second medical opinion). To get a second opinion, make an appointment with a Participating Chiropractor. Second opinion office visits are provided at **$10 Copayment per visit**, and count toward your annual visit limit unless a Participating Chiropractor refers you to another Participating Chiropractor for a consultation that does not include treatment. If ASH Plans determines that there isn't a Participating Chiropractor who is an appropriately qualified chiropractor for your condition, ASH Plans will authorize a referral to a Non–Participating Chiropractor for a second opinion.

Emergency Chiropractic Services

We cover Emergency Chiropractic Services provided by a Participating Chiropractor or a Non–Participating Chiropractor at **$10 Copayment per visit**. We do not cover follow-up or continuing care from a Non–Participating Chiropractor unless ASH Plans has authorized the Services. Also, we do not cover Services from a Non-Participating Chiropractor that ASH Plans determines are not Emergency Chiropractic Services.

As soon as possible after receiving Emergency Chiropractic Services, you must file an ASH Plans claim form. To request a claim form or for more information, please call ASH Plans at 1-800-678-9133. You must send the completed claim form to:

ASH Plans
P.O. Box 509002
San Diego, CA 92101-9002

Member Services

If you have a question or concern regarding the Services you received from a Participating Provider, you may call ASH Plans Member Services at 1-800-678-9133 (TTY users call 711) weekdays from 5 a.m. to 6 p.m., or write ASH Plans at:

American Specialty Health Plans of California, Inc.
Appeals and Grievance Coordinator
P.O. Box 509002
San Diego, CA 92150-9002

You can file a grievance regarding any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about Services you received. You may submit your grievance orally or in writing to Kaiser Permanente as described in the "Dispute Resolution" or "Requests for Services or Payment, Complaints, and Medicare Appeal Procedures" section, as applicable to your Health Plan *Evidence of Coverage*.

Exclusions and Limitations

The following Services are not covered under this "Chiropractic Services Amendment:"

- Any Services not provided by a Participating Chiropractor or Participating Provider, except for Emergency Chiropractic Services and Services that are not available from Participating Providers that are prior authorized by ASH Plans
- Services for conditions other than Neuromusculoskeletal Disorders
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Thermography
- Experimental or investigational Services. Please refer to the "Dispute Resolution" section in your Health Plan *Evidence of Coverage* for information about Independent Medical Review related to denied requests for Medically Necessary and experimental or investigational Services
- Magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), bone scans, nuclear radiology, and any types of diagnostic radiology other than X-rays covered under the "Covered Services" section of this "Chiropractic Services Amendment"
- Ambulance and other transportation
- Education programs, non-medical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing
- Services for pre-employment physicals or vocational rehabilitation
- Air conditioners, air purifiers, therapeutic mattresses, chiropractic appliances, durable medical equipment, supplies, devices, appliances, and any other item except those listed as covered under "Chiropractic appliances" under the "Covered Services" section of this "Chiropractic Services Amendment"
- Drugs and medicines, including non-legend or proprietary drugs and medicines
- Services you receive outside the state of California, except for Emergency Chiropractic Services
- Hospital Services, anesthesia, manipulation under anesthesia, and related Services
- Adjunctive therapy not associated with spinal, muscle, or joint manipulations
- Vitamins, minerals, nutritional supplements, and similar products
- Services provided by a chiropractor that are not within the scope of licensure for a chiropractor licensed in California

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