KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern California Region

A nonprofit corporation and a Medicare Advantage Organization

Kaiser Permanente Senior Advantage with Part D Evidence of Coverage for
SF ELECTRICAL WKRS RET H&W TR HEALTH & WELFARE TRUST

Purchaser ID: 770 Contract: 1 Version: 54 *EOC* Number: 5

February 1, 2010, through July 31, 2010

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

TABLE OF CONTENTS FOR EOC #5

Benefit Highlights

Annual Out-of-Pocket Maximum for Certain Services	
For Services subject to the maximum, you will not pay any more Cost Sharing during a calendar year if the Copayments and Coinsurance you pay for those Services add up to one of the following amounts:	
For self-only enrollment (a Family of one Member)	$1,500 per calendar year
For any one Member in a Family of two or more Members	$1,500 per calendar year
For an entire Family of two or more Members	$3,000 per calendar year
Deductible or Lifetime Maximum	None
Professional Services (Plan Provider office visits)	**You Pay**
Routine preventive care:	
Physical exams	$20 per visit
Well-child visits (through age 23 months)	$15 per visit
Family planning visits	$20 per visit
Scheduled prenatal care visits and first postpartum visit	$15 per visit
Eye refraction exams and glaucoma screening	$20 per visit
Hearing tests	$20 per visit
Primary and specialty care visits	$20 per visit
Urgent care visits	$20 per visit
Physical, occupational, and speech therapy	$20 per visit
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$20 per procedure
Allergy injection visits	$3 per visit
Allergy testing visits	$20 per visit
X-rays, annual mammograms, and lab tests	No charge
Manual manipulation of the spine	$20 per visit
Health education:	
Individual visits	$20 per visit
Group educational programs	No charge
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, lab tests, and drugs	No charge
Emergency Health Coverage	**You Pay**
Emergency Department and Out-of-Area Urgent Care visits	$50 per visit (does not apply if admitted to the hospital as an inpatient within 24 hours for the same condition)
Ambulance Services	**You Pay**
Ambulance Services	No charge
Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary guidelines:	
Generic items from a Plan Pharmacy	$10 for up to a 30-day supply, $20 for a 31- to 60-day supply, or $30 for a 61- to 100-day supply
Generic refills from our mail-order service	$10 for up to a 30-day supply or $20 for a 31- to 100-day supply
Brand-name items from a Plan Pharmacy	$25 for up to a 30-day supply, $50 for a 31- to 60-day supply, or $75 for a 61- to 100-day supply
Brand-name refills from our mail-order service	$25 for up to a 30-day supply or $50 for a 31- to 100-day supply

Durable Medical Equipment (DME)	You Pay
Covered DME for home use in accord with our DME formulary and Medicare guidelines	No charge
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization and intensive psychiatric treatment programs	No charge
Outpatient individual and group visits	$20 per individual visit $10 per group visit
Chemical Dependency Services	**You Pay**
Inpatient detoxification	No charge
Outpatient individual visits	$20 per visit
Outpatient group visits	$5 per visit
Home Health Services	**You Pay**
Home health care (part-time, intermittent)	No charge
Other	**You Pay**
Eyewear purchased from Plan Optical Sales Offices every 24 months	Amount in excess of $150 Allowance
Skilled Nursing Facility care (up to 100 days per benefit period)	No charge
Prosthetic and orthotic devices or ostomy and urological supplies in accord with Medicare guidelines	No charge
Hospice care for Members without Medicare Part A	No charge

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

Introduction

Kaiser Foundation Health Plan, Inc. (Health Plan) has a contract with the Centers for Medicare & Medicaid Services (CMS) as a Medicare Advantage Organization, which is renewed annually. This contract provides Medicare Services (including Medicare Part D prescription drug coverage) through "Kaiser Permanente Senior Advantage with Part D" (Senior Advantage), except for hospice care for Members with Medicare Part A and qualifying clinical trials, which are covered under Original Medicare. Senior Advantage is for Members entitled to Medicare, providing the advantages of combined Medicare and Health Plan benefits. Enrollment in this Senior Advantage plan means that you are automatically enrolled in Medicare Part D.

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

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

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

Term of this *EOC*

This *EOC* is for the period February 1, 2010, through July 31, 2010, unless amended. Your Group can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has expired or been amended.

About Kaiser Permanente

Kaiser Permanente provides Services directly to our Members through an integrated medical care program. Health Plan, Plan Hospitals, and the Medical Group work together to provide our Members with quality care.

Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital care, laboratory and pharmacy Services, Emergency Care, Urgent Care, and other benefits described in the "Benefits and Cost Sharing" section. Plus, our healthy living (health education) programs offer you great ways to protect and improve your health.

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

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Cost Sharing" section
- Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency, Post-Stabilization, and Urgent Care from Non–Plan Providers" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Cost Sharing" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section
- Visiting member care as described under "Visiting Other Regions" in the "How to Obtain Services" section

Definitions

When capitalized and used in any part of this *EOC*, these terms have the following meanings:

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

Centers for Medicare & Medicaid Services (CMS): The Centers for Medicare & Medicaid Services is the federal agency that administers the Medicare program.

Charges: Charges means the following:

- For Services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health

Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members

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

Clinically Stable: You are considered Clinically Stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

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

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

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

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

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

Emergency Care:

- Evaluation by a physician (or other appropriate personnel under the supervision of a physician to the extent provided by law) to determine whether you have an Emergency Medical Condition
- Medically Necessary Services required to make you Clinically Stable within the capabilities of the facility
- Emergency ambulance Services covered under "Ambulance Services" in the "Benefits and Cost Sharing" section

Emergency Medical Condition: Either: (1) a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs; or (2) active labor when there isn't enough time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to your (or your unborn child's) health and safety.

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

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

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

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

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

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

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

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

Medicare Advantage Plan: Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. Medicare Advantage Plans may also offer Medicare Part D (prescription drug coverage). This *EOC* is a Medicare Part D plan.

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

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

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

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

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

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

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

Organization Determination: An initial determination we make about whether we will cover or pay for Part C Services that you believe you should receive.

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

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

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

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

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

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

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

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

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

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

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

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

Premiums: Periodic membership charges paid by your Group.

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

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

Service Area: The geographic area approved by CMS within which an eligible person may enroll in Senior Advantage. Note: Subject to approval by the Centers for Medicare & Medicaid Services (CMS), we may reduce our Service Area effective any January 1 by giving prior written notice to your Group. We may expand our Service Area at any time by giving written notice to your Group. ZIP codes are subject to change by the U.S. Postal Service.

The following counties are entirely inside our Service Area: Alameda, Contra Costa, Marin, Sacramento, San Francisco, San Joaquin, San Mateo, Solano, and Stanislaus.

Portions of the following counties are also inside our Service Area, as indicated by the ZIP codes below for each county:

- Amador: 95640, 95669
- El Dorado: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762
- Fresno: 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618–19, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701–12, 93714–18, 93720–30, 93741, 93744–45, 93747, 93750, 93755, 93760–61, 93764–65, 93771–80, 93784, 93786, 93790–94, 93844, 93888
- Kings: 93230, 93232, 93242, 93631, 93656
- Madera: 93601–02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, 93720
- Mariposa: 93601, 93623, 93653
- Napa: 94503, 94508, 94515, 94558–59, 94562, 94567, 94573–74, 94576, 94581, 94589–90, 94599, 95476
- Placer: 95602–04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95692, 95703, 95722, 95736, 95746–47, 95765
- Santa Clara: 94022–24, 94035, 94039–43, 94085–89, 94301–06, 94309, 94550, 95002, 95008–09, 95011, 95013–15, 95020–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95076, 95101, 95103, 95106, 95108–13, 95115–36, 95138–41, 95148, 95150–61, 95164, 95170, 95172–73, 95190–94, 95196
- Sonoma: 94515, 94922–23, 94927–28, 94931, 94951–55, 94972, 94975, 94999, 95401–07, 95409, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471–73, 95476, 95486–87, 95492
- Sutter: 95626, 95645, 95648, 95659, 95668, 95674, 95676, 95692, 95837
- Tulare: 93238, 93261, 93618, 93631, 93646, 93654, 93666, 93673
- Yolo: 95605, 95607, 95612, 95616–18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99
- Yuba: 95692, 95903, 95961

Note: A ZIP code is considered to be inside our Service Area only if it is in the county associated with that ZIP code. For example, since a ZIP code can span more than one county, it is possible for your ZIP code to be listed above, but you do not live inside our Service Area because the county you live in is not part of our Service Area. Also, the ZIP codes listed above may include ZIP codes for Post Office boxes and commercial rental mailboxes. A Post Office box or rental mailbox cannot be used to determine whether you meet the residence eligibility requirements for Senior Advantage. Your permanent residence address must be used to determine your Senior Advantage eligibility.

Services: Health care services or items.

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include

convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

Spouse: Your legal husband or wife. For the purposes of this *EOC*, the term "Spouse" includes your registered domestic partner who meets all of the requirements of Section 297 of the California Family Code, or your domestic partner in accord with your Group's requirements, if any, that we approve.

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

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

Premiums, Eligibility, and Enrollment

Premiums

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

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

Medicare Part D late enrollment penalty. If you don't join a Medicare Part D drug plan when you are first eligible, or you go without creditable prescription drug coverage for a continuous period of 63 days or more, you may have to pay a late enrollment penalty when you enroll in a Part D plan later (this *EOC* is a Part D plan). Your Group will inform you if the penalty applies to you. However, if you qualify for extra help, you may not have to pay a penalty.

If you disagree with your late enrollment penalty, you may be eligible to have it reconsidered (reviewed). Call our Member Service Call Center to find out more about the late enrollment penalty reconsideration process and how to ask for such a review. You can also visit **www.medicare.gov** on the web or call 1-800-MEDICARE/1-800-633-4227 (TTY users call 1-877-486-2048) 24 hours a days, seven days a week, for more information.

Extra help with drug plan expenses

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 may get help paying for any Medicare drug plan's monthly premium, and prescription Copayments. If you qualify, this extra help will count toward your out-of-pocket costs.

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

- **You automatically qualify for extra help and don't need to apply.** If you have full coverage from a state Medicaid program, get help from Medicaid paying your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare notifies people who automatically qualify for extra help
- **You apply and qualify for extra help.** You may qualify if your yearly income in 2009 is less than $16,245 (single with no dependents) or $21,855 (married and living with your spouse with no dependents), and your resources are less than $12,510 (single) or $25,010 (married and living with your spouse). These resource amounts include $1,500 per person for burial expenses. Resources include your savings and stocks but not your home or car. (The income amounts are for 2009 and will change in 2010.) If you think you may qualify, call Social Security toll free at 1-800-772-1213 (TTY users call 1-800-325-0778) or visit **www.socialsecurity.gov** on the Web. You may also be able to apply at your State Medical Assistance (Medicaid) office. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next

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

those who Receive Extra Help Paying for their Prescription Drugs.

If you believe you have qualified for extra help and you believe that you are paying an incorrect Copayment amount when you get your prescription at a Plan Pharmacy, we have established a process that will allow you to either request assistance in obtaining evidence of your proper Copayment level, or, if you already have the evidence, to provide this evidence to us. If you aren't sure what evidence to provide us, please contact our Member Service Call Center. The evidence is often a letter from either your state Medicaid or Social Security office that states you are qualified for extra help. You will need to provide the evidence to a Plan Pharmacy when you obtain prescriptions so that we can charge you the appropriate Cost Sharing amount until the Centers for Medicare & Medicaid Services (CMS) updates its records to reflect your current status. Once CMS updates its records, you will no longer need to present the evidence to a Plan Pharmacy. In order for CMS to update its records, you must send your evidence to one of the following locations and we will forward your evidence to CMS for updating:

- Kaiser Foundation Health Plan, Inc.
  California Service Center
  Attn: Best Available Evidence
  P.O. Box 232407
  San Diego, CA 92193-2407
- Fax it toll free to 1-866-311-0514
- Bring it to a Plan Pharmacy or Member Services office at a Plan Facility listed in *Your Guidebook to Kaiser Permanente Services*

Please be assured that if you overpay your Copayment, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future Copayments. If a state paid on your behalf, we may make payment directly to the state. Please contact our Member Service Call Center if you have questions.

Who Is Eligible

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

Group eligibility requirements

You must meet your Group's eligibility requirements that we have approved. Your Group is required to inform Subscribers of its eligibility requirements, such as Dependent eligibility requirements. Please note that your Group might not allow enrollment to some persons who meet the requirements described under "Additional eligibility requirements" below.

Medicare eligibility requirements

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

Note: You may not be enrolled in two Medicare health plans at the same time. If you enroll in Senior Advantage, CMS will automatically disenroll you from any other Medicare health plan, including a Medicare Prescription Drug Plan.

Service Area eligibility requirements

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

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

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section

- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Cost Sharing" section
- Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency, Post-Stabilization, and Urgent Care from Non–Plan Providers" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Cost Sharing" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section
- Visiting member care as described under "Visiting Other Regions" in the "How to Obtain Services" section

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

Additional eligibility requirements

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

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

If you are a Subscriber, the following persons may be eligible to enroll as your Dependents under this *EOC* if they meet all the other requirements described under "Group eligibility requirements," "Medicare eligibility requirements," and "Service Area eligibility requirements" in this "Who Is Eligible" section:

- Your Spouse. For the purposes of this *EOC*, the term "Spouse" includes your registered domestic partner who meets all the requirements of Section 297 of the California Family Code, or your domestic partner in accord with your Group's requirements, if any, that we approve
- Your or your Spouse's unmarried children (including adopted children or children placed with you for adoption) who are under age 19, or under age 25 if a student as defined by your Group
- Other unmarried dependent persons (but not including foster children) who meet all of the following requirements:
  - they are under age 19, or under age 25 if a student as defined by your Group
  - they receive all of their support and maintenance from you or your Spouse
  - they permanently reside with you (the Subscriber)
  - you or your Spouse is the court-appointed guardian (or was before the person reached age 18) or the person's parent is an enrolled Dependent under your family coverage
- Dependents who meet the Dependent eligibility requirements, except for the age limit, may be eligible as a disabled dependent if they meet all the following requirements:
  - they are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness or condition that occurred prior to reaching the age limit for Dependents
  - they receive 50 percent or more of their support and maintenance from you or your Spouse
  - you give us proof of their incapacity and dependency within 60 days after we request it (see "Disabled dependent certification" below in this "Additional eligibility requirements" section)
- As determined by your Group, eligible family Dependents of deceased employees may continue coverage according to your Group's established policies

Disabled dependent certification. A dependent who meets the Dependent eligibility requirements except for the age limit may be eligible as a disabled dependent as described above under "Additional eligibility requirements" in this "Premiums, Eligibility and Enrollment" section. You must provide us documentation of your dependent's incapacity and dependency as follows:

- If your Dependent is a Member, we will send you a notice of his or her membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. Your Dependent's membership will terminate as described in our notice unless you provide us documentation of his or her incapacity and dependency within 60 days of receipt of our notice and we determine that he or she is eligible as a disabled dependent. If you provide

us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination. If we determine that your Dependent does not meet the eligibility requirements as a disabled dependent, we will notify you that he or she is not eligible and let you know the membership termination date. If we determine that your Dependent is eligible as a disabled dependent, there will be no lapse in coverage. Also, two years after the date that your Dependent reached the age limit, you must provide us documentation of his or her incapacity and dependency annually within 60 days after we request it so that we can determine if he or she continues to be eligible as a disabled dependent

- If your dependent is not a Member and you are requesting enrollment, you must provide us documentation of his or her incapacity and dependency within 60 days after we request it so that we can determine if he or she is eligible to enroll as a disabled dependent. If we determine that your dependent is eligible as a disabled dependent, you must provide us documentation of his or her incapacity and dependency annually within 60 days after we request it so that we can determine if he or she continues to be eligible as a disabled dependent

Dependents who do not have Medicare. If you have Dependents who are not entitled to Medicare, they may be eligible to enroll as your Dependents, but in a different Kaiser Permanente plan offered by your Group, for example, our Traditional Plan. Please contact your Group for details, including eligibility and benefit information and to request a copy of the other plan's *EOC*.

Persons barred from enrolling

- You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for failure to pay individual (nongroup) plan premiums, unless we agree to allow you to enroll after you pay all amounts owed by you and your dependents

When You Can Enroll and When Coverage Begins

Your Group is required to inform you when you are eligible to enroll and what your effective date of coverage is. If you are eligible to enroll as described under "Who Is Eligible" in this "Premiums, Eligibility, and Enrollment" section, you may enroll yourself and any eligible Dependents by submitting a Health Plan–approved enrollment application and a Senior Advantage Election Form (one form for each Medicare beneficiary) to your Group within 31 days.

If you are already a Health Plan Member who lives in the Senior Advantage Service Area, we will mail you information about joining Senior Advantage and a Senior Advantage Election Form shortly before you reach age 65.

Effective date of Senior Advantage coverage

After we receive your completed Senior Advantage Election Form, we will submit your enrollment to CMS and send you a notice indicating the proposed effective date of your Senior Advantage coverage, which is subject to confirmation by CMS. Your effective date will depend on whether you are first becoming entitled to Medicare Part B, or if you are already entitled to it.

If you will soon become entitled to Medicare Part B, your Senior Advantage effective date will be the first day of the month in which you are entitled to Medicare Part B. If you are already entitled to Medicare Part B, we will notify you of your effective date. Your effective date will generally be determined by the date we receive your completed Election Form and the effective date of your Group coverage.

Once CMS confirms your enrollment, we will send you written notification. If CMS does not confirm your enrollment in Medicare before your effective date, you still must receive your care from us, beginning on your effective date, just as if your enrollment had been confirmed. If CMS tells us that you are not entitled to Medicare Part B, we will notify you and request that you contact the Social Security Administration to clarify your Medicare status. If, after contacting the Social Security Administration, it is confirmed that you are still not entitled to Medicare Part B, you will be billed for any Services we have provided you unless you are an existing Member under another Kaiser Permanente plan (for example, Kaiser Permanente Traditional Plan). Members will be responsible for any amounts owed under their other Kaiser Permanente plan and should contact their Group for the *EOC* applicable to that plan.

Group open enrollment

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

How to Obtain Services

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

- Authorized referrals as described under "Getting a Referral" in this "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Cost Sharing" section
- Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency, Post-Stabilization, and Urgent Care from Non–Plan Providers" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Cost Sharing" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section
- Visiting member care as described under "Visiting Other Regions" in this "How to Obtain Services" section

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

Routine Care

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

Urgent Care

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

For information about Urgent Care from Non–Plan Providers, please refer to the "Emergency, Post-Stabilization, and Urgent Care from Non–Plan Providers" section.

Our Advice Nurses

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

Your Personal Plan Physician

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

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

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

Getting a Referral

Referrals to Plan Providers

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

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

Medical Group authorization procedure for certain referrals

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

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

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

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

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your physician will be informed of the scope of the authorized Services. If the Medical Group

does not authorize all of the Services, you will be sent a written decision and explanation within two business days after the decision is made. The letter will include information about your appeal rights, which are described in the "Requests for Services or Payment, Complaints, and Medicare Appeal Procedures" section. Any written criteria that the Medical Group uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request.

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

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

Second Opinions

If you request a second opinion, it will be provided to you when Medically Necessary by an appropriately qualified medical professional. This is a physician who is acting within his or her scope of practice and who possesses a clinical background related to the illness or condition associated with the request for a second medical opinion. Here are some examples of when a second opinion is Medically Necessary:

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

You can either ask your Plan Physician to help you arrange for a second medical opinion, or you can make an appointment with another Plan Physician. If the Medical Group determines that there isn't a Plan Physician who is an appropriately qualified medical professional for your condition, the Medical Group will authorize a referral to a Non–Plan Physician for a Medically Necessary second opinion.

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

Contracts with Plan Providers

How Plan Providers are paid

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

Financial liability

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

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

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

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

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

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

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

Visiting Other Regions

If you visit the service area of another Region temporarily (not more than 90 days), you can receive visiting member care from designated providers in that area. Visiting member care is described in our visiting member brochure. Visiting member care and your out-of-pocket costs may differ from the covered Services and Cost Sharing described in this *EOC*.

The 90-day limit on visiting member care does not apply to a Dependent child who attends an accredited college or accredited vocational school. The service areas and facilities where you may obtain visiting member care may change at any time without notice.

Please call our Member Service Call Center for more information about visiting member care, including facility locations in the service area of another Region, and to request a copy of the visiting member brochure.

Your Identification Card

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

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

Your Medicare card

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

Getting Assistance

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

Member Services

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

Member Services representatives at our Plan Facilities and Member Service Call Center can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace your ID card. These representatives can also help you if you need to file a claim as described in the "Emergency, Post-Stabilization, and Urgent Care from Non–Plan Providers" section or with any issues as described in the "Grievances" and "Requests for Services or Payment, Complaints, and Medicare Appeal Procedures" sections.

Interpreter services

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

Plan Facilities

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

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

Plan Hospitals and Plan Medical Offices

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

Alameda

- Medical Offices: 2417 Central Ave.

Antioch

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

Campbell

- Medical Offices: 220 E. Hacienda Ave.

Clovis

- Medical Offices: 2071 Herndon Ave.

Daly City

- Medical Offices: 395 Hickey Blvd.

Davis

- Medical Offices: 1955 Cowell Blvd.

Elk Grove

- Medical Offices: 9201 Big Horn Blvd.

Fairfield

- Medical Offices: 1550 Gateway Blvd.

Folsom

- Medical Offices: 2155 Iron Point Rd.

Fremont

- Hospital and Medical Offices: 39400 Paseo Padre Pkwy.

Fresno

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

Gilroy

- Medical Offices: 7520 Arroyo Circle

Hayward

- Hospital and Medical Offices: 27400 Hesperian Blvd.

Lincoln

- Medical Offices: 1900 Dresden Dr.

Livermore

- Medical Offices: 3000 Las Positas Rd.

Manteca

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

Martinez

- Medical Offices: 200 Muir Rd.

Milpitas

- Medical Offices: 770 E. Calaveras Blvd.

Modesto

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

Mountain View

- Medical Offices: 555 Castro St.

Napa

- Medical Offices: 3285 Claremont Way

Novato

- Medical Offices: 97 San Marin Dr.

Oakhurst

- Medical Offices: 40595 Westlake Dr.

Oakland

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

Petaluma

- Medical Offices: 3900 Lakeville Hwy.

Pinole

- Medical Offices: 1301 Pinole Valley Rd.

Pleasanton

- Medical Offices: 7601 Stoneridge Dr.

Rancho Cordova

- Medical Offices: 10725 International Dr.

Redwood City

- Hospital and Medical Offices: 1150 Veterans Blvd.

Richmond

- Hospital and Medical Offices: 901 Nevin Ave.

Rohnert Park

- Medical Offices: 5900 State Farm Dr.

Roseville

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

Sacramento

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

San Bruno

- Medical Offices: 901 El Camino Real

San Francisco

- Hospital and Medical Offices: 2425 Geary Blvd.

San Jose

- Hospital and Medical Offices: 250 Hospital Pkwy.

San Rafael

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

Santa Clara

- Hospital and Medical Offices: 700 Lawrence Expwy.

Santa Rosa

- Hospital and Medical Offices: 401 Bicentennial Way

Selma

- Medical Offices: 2651 Highland Ave.

South San Francisco

- Hospital and Medical Offices: 1200 El Camino Real

Stockton

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

Tracy

- Medical Offices: 2185 W. Grant Line Rd.

Turlock

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

Union City

- Medical Offices: 3553 Whipple Rd.

Vacaville

- Hospital and Medical Offices: 1 Quality Dr.

Vallejo

- Hospital and Medical Offices: 975 Sereno Dr.

Walnut Creek

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

Your Guidebook to Kaiser Permanente Services (Your Guidebook)

Plan Medical Offices and Plan Hospitals for your area are listed in greater detail in *Your Guidebook to Kaiser Permanente Services (Your Guidebook). Your Guidebook* describes the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services. It includes additional facilities that are not listed in this

"Plan Facilities" section. Also, it explains how to use our Services and make appointments, lists hours of operation, and includes a detailed telephone directory for appointments and advice. *Your Guidebook* provides other important information, such as preventive care guidelines and your Member rights and responsibilities. *Your Guidebook* is subject to change and is periodically updated. We mail it annually and you can get a copy by visiting our Web site at **kp.org** or by calling our Member Service Call Center.

Provider Directory

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

Pharmacy Directory

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

Emergency, Post-Stabilization, and Urgent Care from Non–Plan Providers

This "Emergency, Post-Stabilization, and Urgent Care from Non–Plan Providers" section explains how to obtain covered Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care from Non–Plan Providers. We do not cover the Non–Plan Provider care discussed in this section unless it meets both of the following requirements:

- This "Emergency, Post-Stabilization, and Urgent Care from Non–Plan Providers" section says that we cover the care
- The care would be covered under the "Benefits and Cost Sharing" section (subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section) if you received the care from a Plan Provider

Prior Authorization

You do not need to get prior authorization from us to get Emergency Care or Out-of-Area Urgent Care from Non–Plan Providers. However, you must get prior authorization from us for Post-Stabilization Care from Non–Plan Providers (prior authorization means that we must approve the Services in advance for the Services to be covered), except as otherwise described in this section.

Emergency Care

If you have an Emergency Medical Condition, call 911 or go to the nearest hospital (including an emergency room or urgent care center). When you have an Emergency Medical Condition, we cover Emergency Care anywhere in the world.

An Emergency Medical Condition is: (1) a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs, or (2) active labor when there isn't enough time for safe transfer to a Plan Hospital (or designated hospital) before delivery or if transfer poses a threat to your (or your unborn child's) health and safety.

For ease and continuity of care, we encourage you to go to a Plan Hospital Emergency Department listed in *Your Guidebook* if you are inside our Service Area, but only if it is reasonable to do so, considering your condition or symptoms.

Post-Stabilization Care

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

We cover Post-Stabilization Care if one of the following is true:

- We provide or authorize the care
- The care was Medically Necessary to maintain stabilization and it was administered within one hour following a request for authorization and we have not yet responded
- The Non–Plan Provider and we do not agree about your care and a Plan Physician is not available for consultation

- In the rare circumstance that we are unavailable or cannot be contacted

Covered Post-Stabilization Care is effective until one of the following events occurs:

- You are discharged from the Non–Plan Hospital
- We assume responsibility for your care
- The Non–Plan Provider and we agree to other arrangements

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

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

Urgent Care

Inside the Service Area

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

Out-of-Area Urgent Care

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

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

Services Not Covered Under this "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non–Plan Providers" Section

The following Services are not covered under this "Emergency, Post-Stabilization, and Out-of-Area Urgent Care from Non–Plan Providers" section (instead, refer to the "Benefits and Cost Sharing" section):

- Services that are not Emergency Care, Post-Stabilization Care, or Out-of-Area Urgent Care, even if those services are related to your Emergency Medical Condition
- Emergency Care, Post-Stabilization Care, and Urgent Care from Plan Providers

Payment and Reimbursement

If you receive Emergency Care, Post-Stabilization Care, Out-of-Area Urgent Care, or out-of-area dialysis care from a Non–Plan Provider, ask the Non–Plan Provider to submit a claim to us within 60 days or as soon as possible, but no later than 15 months after receiving the care (or up to 27 months according to Medicare rules, in some cases). If the provider refuses to bill us, send us the unpaid bill with a claim form. Also, if you receive Services from a Plan Provider that are prescribed by a Non–Plan Provider in conjunction with covered Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care (for example, drugs), you may be required to pay for the Services and file a claim.

How to file a claim

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 our completed claim form 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

Cost Sharing

The Cost Sharing for Emergency Care, Post-Stabilization Care, Out-of-Area Urgent Care, and out-of-area dialysis care from a Non–Plan Provider is the Cost Sharing required for Services provided by a Plan Provider as described in the "Benefits and Cost Sharing" section. We will reduce any payment we make to you or the Non–Plan Provider by applicable Cost Sharing.

Also, if Medicare is the secondary payer by law, we will reduce our payment by any amounts paid or payable (or that in the absence of this plan would have been payable) for the Services under any insurance policy, or any other contract or coverage, or any government program except Medicaid.

Benefits and Cost Sharing

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

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except where specifically noted to the contrary in the sections listed below for the following Services:
  - emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Cost Sharing" section
  - Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency, Post-Stabilization, and Urgent Care from Non–Plan Providers" section
  - out-of-area dialysis care as described under "Dialysis Care" in this "Benefits and Cost Sharing" section
  - visiting member care as described under "Visiting Other Regions" in the "How to Obtain Services" section
- You receive the Services from Plan Providers inside our Service Area, except where specifically noted to the contrary in the sections listed below for the following Services:
  - authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
  - emergency ambulance Services as described under "Ambulance Services" in this "Benefits and Cost Sharing" section
  - Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency, Post-Stabilization, and Urgent Care from Non–Plan Providers" section
  - out-of-area dialysis care as described under "Dialysis Care" in this "Benefits and Cost Sharing" section
  - prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Cost Sharing" section
  - visiting member care as described under "Visiting Other Regions" in the "How to Obtain Services" section

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

- The "Emergency, Post-Stabilization, and Urgent Care from Non–Plan Providers" section for information about how to obtain covered Emergency Care, Post-Stabilization Care, and Out-of-Area Urgent Care from Non–Plan Providers
- *Your Guidebook* for the types of covered Services that are available from each Plan Facility in your

area, because some facilities provide only specific types of covered Services

Cost Sharing (Copayments and Coinsurance)

At the time you receive covered Services, you must pay your Cost Sharing amounts as described in this "Benefits and Cost Sharing" section. For covered inpatient care, the Cost Sharing in effect on the date you are admitted to the hospital or Skilled Nursing Facility applies until you are discharged.

If you receive more than one Service from a provider, or Services from more than one provider, you may be required to pay separate Cost Sharing amounts for each Service and each provider. For example, if you receive Services from two specialists in one visit, you may have to pay the Cost Sharing for two specialist visits. Similarly, if your physician performs a procedure immediately after a consultation, you may have to pay separate Cost Sharing amounts for the consultation visit and for the procedure. If you have questions about Cost Sharing, please contact our Member Service Call Center.

In some cases, we may agree to bill you for your Cost Sharing amounts.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service is described in this "Benefits and Cost Sharing" section. Cost Sharing is due at the time you receive the Services, except for the following:

- For items ordered in advance, you pay the Cost Sharing in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Sharing before the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all the information they need to fill the prescription
- Before starting or continuing a course of infertility Services, you may be required to pay initial and subsequent deposits toward your Cost Sharing for some or all of the entire course of Services, along with any past-due infertility-related Cost Sharing. Any unused portion of your deposit will be returned to you. When a deposit is not required, you must pay the Cost Sharing for the procedure, along with any past-due infertility-related Cost Sharing before you can schedule an infertility procedure

Annual out-of-pocket maximum

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

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

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

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

- Ambulance Services
- Blood
- Dental Services covered by Medicare
- Emergency Department and Out-of-Area Urgent Care visits
- Home health care
- Hospice care
- Hospital care
- Imaging, laboratory, and special procedures
- Immunizations covered under Medicare Part B
- Mental health care, including intensive psychiatric treatment programs
- Office visits (including professional Services such as dialysis treatment, diabetes monitoring, health education, and manual manipulation of the spine to correct subluxation covered by Medicare)
- Outpatient surgery
- Rehabilitation Services, including care in a Comprehensive Outpatient Rehabilitation Facility
- Skilled Nursing Facility care

- Transitional residential recovery Services for chemical dependency

Keeping track of the maximum. When you pay Cost Sharing amounts for a Service that applies toward the annual out-of-pocket maximum, ask for and keep the receipt. When the receipts add up to the annual out-of-pocket maximum, please call our Member Service Call Center to find out where to turn in your receipts. When you turn them in, we will give you a document stating that you don't have to pay any more Cost Sharing for Services subject to the annual out-of-pocket maximum through the end of the calendar year.

Special Note about Clinical Trials

We do not cover clinical trials because they are experimental or investigational, but you do have coverage through Original Medicare for certain clinical trials. Original Medicare covers routine costs if you take part in a clinical trial that meets Medicare requirements. Routine costs include costs like room and board for a hospital stay that Medicare would pay for even if you weren't in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, the Original Medicare Plan (and not Senior Advantage) pays the clinical trial doctors and other providers for the covered services you get that are related to the clinical trial. When you are in a clinical trial, you may stay enrolled in Senior Advantage. You should continue to come to Plan Providers for all covered Services that are not part of the clinical trial.

You will have to pay the Cost Sharing charged under Original Medicare for the services you receive when participating in a qualifying clinical trial. To find out how much you will have to pay for Medicare covered clinical trials, please refer to the "Medicare & You" handbook. Also, to learn more about what Medicare covers, please refer to the "Medicare and Clinical Trials" brochure. To get a free copy, call Medicare directly toll free at 1-800-MEDICARE (1-800-633-4227) (TTY users call 1-877-486-2048) 24 hours a day, seven days a week, or visit **www.medicare.gov** on the Web.

You don't need to get a referral from a Plan Provider to join a clinical trial covered by Medicare, and the clinical trial providers don't need to be Plan Providers. However, you should tell us before you join a clinical trial outside of Kaiser Permanente so we can keep track of your Services.

Outpatient Care

We cover the following outpatient care for preventive medicine, diagnosis, and treatment subject to the Cost Sharing indicated:

- Routine preventive care:
  - physical exams, including well-woman visits and the Welcome to Medicare Exam during the first year after Part B enrollment in accord with Medicare guidelines: **a $20 Copayment per visit**
  - well-child visits for Members through age 23 months: **a $15 Copayment per visit**
  - family planning visits for counseling, or to obtain emergency contraceptive pills, injectable contraceptives, internally implanted time-release contraceptives, or intrauterine devices (IUDs): **a $20 Copayment per visit**
  - after confirmation of pregnancy, the normal series of regularly scheduled preventive care prenatal visits and the first postpartum visit: **a $15 Copayment per visit**
  - glaucoma screenings in accord with Medicare guidelines and eye refraction exams to determine the need for vision correction and to provide a prescription for eyeglass lenses: **a $20 Copayment per visit**
  - hearing tests to determine the need for hearing correction: **a $20 Copayment per visit**
  - vaccines (immunizations) covered by Medicare Part B and administered to you in a Plan Medical Office: **no charge**
- Primary and specialty care visits: **a $20 Copayment per visit**
- Allergy injection visits: **a $3 Copayment per visit**
- Outpatient surgery and other outpatient procedures: **a $20 Copayment per procedure**
- Voluntary termination of pregnancy: **a $20 Copayment per procedure**
- Physical, occupational, and speech therapy in accord with Medicare guidelines: **a $20 Copayment per visit**
- Physical, occupational, and speech therapy provided in our organized, multidisciplinary rehabilitation day-treatment program in accord with Medicare guidelines: **a $20 Copayment per day**

- Manual manipulation of the spine to correct subluxation, in accord with Medicare guidelines, is provided when prescribed by a Plan Physician and performed by a Plan Provider who is an osteopath or chiropractor: **a $20 Copayment per visit**
- Urgent Care visits: **a $20 Copayment per visit**
- Emergency Department and Out-of-Area Urgent Care visits: **a $50 Copayment per visit**. This Copayment does not apply if you are admitted directly to the hospital as an inpatient within 24 hours for the same condition (it does apply if you are admitted as anything other than an inpatient; for example, it does apply if you are admitted for observation)
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician: **no charge**
- Blood, blood products, and their administration: **no charge**
- Administered drugs (drugs, injectables, radioactive materials used for therapeutic purposes, and allergy test and treatment materials) prescribed in accord with our drug formulary guidelines, if administration or observation by medical personnel is required and they are administered to you in a Plan Medical Office or during home visits: **no charge**
- Preventive health screenings, such as screening and tests for colorectal cancer in accord with Medicare guidelines: **a $20 Copayment per procedure**
- Some types of outpatient visits may be available as group appointments, which are covered at **a $10 Copayment per visit**

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

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

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

Hospital Inpatient Care

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

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

- Medical social services and discharge planning

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

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

Ambulance Services

Emergency

When you have an Emergency Medical Condition, we cover emergency Services of a licensed ambulance anywhere in the world at **no charge**. In accord with the "Emergency, Post-Stabilization, and Urgent Care from Non–Plan Providers" section, we cover emergency ambulance Services that are not ordered by us only if one of the following is true:

- Your treating physician determines that you must be transported to another facility when you are not Clinically Stable because the care you need is not available at the treating facility
- You are not already being treated, and you reasonably believe that your condition requires ambulance transportation

Nonemergency

Inside our Service Area, we cover nonemergency ambulance Services in accord with Medicare guidelines at **no charge** if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to or from covered Services in accord with Medicare guidelines.

Ambulance Services exclusion

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

Chemical Dependency Services

Inpatient detoxification

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

Outpatient chemical dependency care

We cover the following Services for treatment of chemical dependency:

- Day-treatment programs
- Intensive outpatient programs
- Individual and group chemical dependency counseling visits
- Visits for the purpose of medical treatment for withdrawal symptoms

You pay the following for these covered Services:

- Individual visits: **a $20 Copayment per visit**
- Group visits: **a $5 Copayment per visit**

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

Transitional residential recovery Services

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

Services not covered under this "Chemical Dependency Services" section

Coverage for the following Services is described 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 self-administered drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Special Procedures")

Chemical dependency Services exclusion

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

Dental Services for Radiation Treatment and Dental Anesthesia

Dental Services for radiation treatment

We cover services covered by Medicare, including dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck at **a $20 Copayment per visit** if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental anesthesia

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

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

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

For covered dental anesthesia Services, you will pay the **Cost Sharing that you would pay for hospital inpatient care or outpatient surgery, depending on the setting**.

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

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

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

Dialysis Care

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

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

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

Out-of-area dialysis care

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

The procedure for obtaining reimbursement for out-of-area dialysis care is described in the "Emergency, Post-Stabilization, and Urgent Care from Non–Plan Providers" section.

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

- Inpatient dialysis care: **no charge**
- One routine office visit per month with the multidisciplinary nephrology team: **no charge**
- All other office visits: **a $20 Copayment per visit**
- Hemodialysis treatment: **no charge**

Services not covered under this "Dialysis Care" section

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

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

- Outpatient administered drugs (refer to "Outpatient Care")

Durable Medical Equipment for Home Use

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

Coverage is limited to the standard item of equipment that adequately meets your medical needs. Covered DME, including repair and replacement of covered DME, is covered at **no charge**. We decide whether to rent or purchase the equipment, and we select the vendor. We will repair or replace the equipment, unless the repair or replacement is due to misuse.

DME items for diabetes

The following diabetes blood-testing supplies and equipment and insulin-administration devices are covered under this "Durable Medical Equipment for Home Use" section:

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

About our DME formulary

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

Our formulary guidelines allow you to obtain nonformulary DME items (those not listed on our DME 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.

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

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

- Diabetes urine testing supplies and insulin-administration devices other than insulin pumps (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- DME related to the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")

Durable medical equipment for home use exclusions

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

Health Education

We cover a variety of healthy living (health education) programs to help you take an active role in protecting and improving your health, including programs for tobacco cessation, stress management, and chronic conditions (such as diabetes and asthma). We cover individual office visits at **a $20 Copayment per visit**. We provide all other covered Services at **no charge**. You can also participate in programs that we don't cover, which may require that you pay a fee.

For more information about our healthy living programs, please contact your local Health Education Department or our Member Service Call Center, or go to our Web site at **kp.org.** *Your Guidebook* also includes information about our healthy living programs.

Note: In accord with Medicare guidelines, any diabetes self-management training courses accredited by the

American Diabetes Association may be available to you if you receive a referral from a Plan Physician.

Home Health Care

Home health care means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists. We cover part-time or intermittent home health care in accord with Medicare guidelines at **no charge** only if all of the following are true:

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

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

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

Home health care exclusion

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

Hospice Care

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

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

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

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

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, or speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from Plan Pharmacies. Certain drugs are limited to a maximum 30-day supply in any 30-day period (please call our Member Service Call Center for the current list of these drugs)
- Durable medical equipment

- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling
- The following care during periods of crisis when you need continuous care to achieve palliation or management of acute medical symptoms:
  - nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
  - short-term inpatient care required at a level that cannot be provided at home

Special note if you have Medicare Part A

You may receive care from any Medicare-certified hospice program. The Original Medicare plan (rather than our Plan) will pay the hospice provider for the services you receive. Your hospice provider can be a Plan Provider or a Non–Plan Provider. If you elect hospice care, you are not entitled to any other benefits for the terminal illness under this *EOC* or Medicare. However, we will continue to cover the Services described in this *EOC* that are not related to the terminal illness. Also, we do cover hospice consultation services for terminally ill Members who have not yet elected the hospice benefit. You may change your decision to receive hospice care at any time.

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

Infertility Services

We cover the following Services related to involuntary infertility:

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

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

- Office visits: **a $20 Copayment per visit**
- Outpatient surgery: **a $50 Copayment per procedure** if it is provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. Any other outpatient surgery is covered at **a $20 Copayment per procedure**
- Outpatient procedures (other than surgery): **a $50 Copayment per procedure** if a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort. All outpatient procedures related to involuntary infertility that do not require a licensed staff member to monitor your vital signs as described above are covered **at the Cost Sharing that would otherwise apply for the procedure** in this "Infertility Services" section
- Outpatient laboratory, imaging, and special procedures: **no charge**
- Hospital inpatient care (including room and board, imaging, laboratory, and special procedures, and Plan Physician Services): **a $500 Copayment per admission**

Services not covered under this "Infertility Services" section

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

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

Infertility Services exclusions

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

Mental Health Services

We cover Services specified in this "Mental Health Services" section only when both of the following requirements have been met:

- The Services are for the diagnosis or treatment of mental disorders
- The Services are provided by a Plan Physician or other Plan Provider who is a licensed health care professional acting within the scope of his or her license

A mental disorder is a mental health condition as identified in the *Diagnostic and Statistical Manual of Mental* Disorders, *Fourth Edition, Text Revision* that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

Mental Disorders include the Severe Mental Illness of a person of any age and the Serious Emotional Disturbance of a Child:

- Severe Mental Illness means the following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, and bulimia nervosa.
- A Serious Emotional Disturbance of a child under age 18 means mental disorders as identified in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:
  - as a result of the mental disorder 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:

- 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

You pay the following for these covered Services:

- Individual visits: **a $20 Copayment per visit**
- Group visits: **a $10 Copayment per visit**

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

Inpatient psychiatric hospitalization and intensive psychiatric treatment programs

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

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

Services not covered under this "Mental Health Services" section

Coverage for the following Services is described 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 by Medicare 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** except that certain imaging procedures are covered at **a $20 Copayment per procedure** if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort
- Magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET): **no charge**
- Nuclear medicine: **no charge**
- Laboratory tests (including screening tests for diabetes, cardiovascular disease, cervical cancer, and HPV, and tests for specific genetic disorders for which genetic counseling is available): **no charge**
- Routine preventive retinal photography screenings: **no charge**
- All other diagnostic procedures provided by Plan Providers who are not physicians (such as electrocardiograms and electroencephalograms): **no charge** except that certain diagnostic procedures are covered at **a $20 Copayment per procedure** if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort
- Radiation therapy: **no charge**
- Ultraviolet light treatments: **no charge**

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

Coverage for the following Services is described 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 level.
- 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. Please refer to "Medicare Part D formulary" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section for more information about this formulary.

Cost Sharing for Medicare Part D drugs. Unless you reach the catastrophic coverage level in a calendar year, you will pay the following Cost Sharing for covered Medicare Part D drugs:

- Generic drugs:
  - **a $10 Copayment** for up to a 30-day supply, **a $20 Copayment** for a 31- to 60-day supply, or **a $30 Copayment** for a 61- to 100-day supply at a Plan Pharmacy
  - **a $10 Copayment** for up to a 30-day supply or **a $20 Copayment** for a 31- to 100-day supply through our mail-order service
- For brand-name drugs and specialty drugs:
  - **a $25 Copayment** for up to a 30-day supply, **a $50 Copayment** for a 31- to 60-day supply, or **a $75 Copayment** for a 61- to 100-day supply at a Plan Pharmacy
  - **a $25 Copayment** for up to a 30-day supply or **a $50 Copayment** for a 31- to 100-day supply through our mail-order service
- Emergency contraceptive pills: **no charge**
- The following insulin-administration devices at **a $10 Copayment**: needles, syringes, alcohol swabs, and gauze

Catastrophic coverage level. All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend **$4,550** out-of-pocket during 2009. When the total amount you have paid for your Cost Sharing reaches **$4,550**, you will qualify for

catastrophic coverage, and then you will pay the following for the remainder of 2009:

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

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

The amounts you paid for Medicare Part D drugs are computed by adding up the following:

- The amounts you paid for Medicare Part D drugs we covered in the calendar year under this and any other Kaiser Permanente Senior Advantage with Part D evidence of coverage
- If you had previous Medicare Part D coverage from another organization, that organization's calculation of the amount you paid under that coverage for Medicare Part D drugs during the calendar year (including amounts you paid toward a Medicare Part D drug deductible)

In order for a Part D drug to count toward the catastrophic coverage level, it must either be a covered drug or a drug that would have been covered if you had met your deductible or you were not in a coverage level in which you had to pay full price (your previous coverage may or may not consider drugs to be covered in those circumstances). If you obtain noncovered Medicare Part D drugs from us, you will pay the full price of the drug and that amount does not count toward the catastrophic coverage level.

Also, when the following individuals or organizations pay your costs for such drugs, these payments will count toward your out-of-pocket costs and will help you qualify for catastrophic coverage:

- Family members or other individuals
- Medicare programs that provide extra help with prescription drug coverage
- Most charities or charitable organizations that pay Cost Sharing on your behalf. Please note that if the charity is established, run, or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs

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.

Extra help for covered Medicare Part D drugs. Medicare provides "extra help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you will get help paying for any Medicare drug plan's monthly premium and Cost Sharing for Part D drugs. If you qualify, this extra help will count toward your out-of-pocket costs. Please see "Extra help with drug plan expenses" in the "Premiums, Eligibility, and Enrollment" section for more information.

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 "Requests for Services or Payment, Complaints, and Medicare Appeal Procedures" 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. If a drug is not covered by Medicare Part D, any amounts you pay for that drug will not count toward reaching the catastrophic coverage level. 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. We will send you a Medicare secondary payor survey so that we can know what other health care or drug coverage you have besides our Plan. Medicare requires us to collect this information from you, so when you get the survey, please fill it out and send it back. If you have additional health care or drug coverage, you must provide that information to our Plan. The information you provide helps us calculate how much you and others have paid for your prescription drugs. In addition, if you lose or gain additional 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. 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

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

- Generic drugs:
  - **a $10 Copayment** for up to a 30-day supply, **a $20 Copayment** for a 31- to 60-day supply, or **a $30 Copayment** for a 61- to 100-day supply at a Plan Pharmacy
  - **a $10 Copayment** for up to a 30-day supply or **a $20 Copayment** for a 31- to 100-day supply through our mail-order service
- Brand-name drugs, specialty drugs, and compounded products:
  - **a $25 Copayment** for up to a 30-day supply, **a $50 Copayment** for a 31- to 60-day supply, or **a $75 Copayment** for a 61- to 100-day supply at a Plan Pharmacy
  - **a $25 Copayment** for up to a 30-day supply or **a $50 Copayment** for a 31- to 100-day supply through our mail-order service

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

Other outpatient drugs, supplies, and supplements

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

- Drugs for which a prescription is required by law that are not covered by Medicare Part B or D. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary applicable to non–Part D items. 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 *EOC* is amended to exclude a non-Part D drug that we have been covering and providing to you under this *EOC*, 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 FDA

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

- Generic items:
  - **a $10 Copayment** for up to a 30-day supply, **a $20 Copayment** for a 31- to 60-day supply, or **a $30 Copayment** for a 61- to 100-day supply at a Plan Pharmacy
  - **a $10 Copayment** for up to a 30-day supply or **a $20 Copayment** for a 31- to 100-day supply through our mail-order service
  - drugs prescribed for the treatment of sexual dysfunction disorders: **25 percent Coinsurance** for up to a 100-day supply at a Plan Pharmacy or through our mail-order service
- Brand-name items, specialty drugs, and compounded products:
  - **a $25 Copayment** for up to a 30-day supply, **a $50 Copayment** for a 31- to 60-day supply, or **a $75 Copayment** for a 61- to 100-day supply at a Plan Pharmacy
  - **a $25 Copayment** for up to a 30-day supply or **a $50 Copayment** for a 31- to 100-day supply through our mail-order service
  - drugs prescribed for the treatment of sexual dysfunction disorders: **25 percent Coinsurance** for up to a 100-day supply at a Plan Pharmacy or through our mail-order service
- 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
- Diaphragms and cervical caps: **a $25 Copayment per item**
- Diabetes urine-testing supplies: **no charge** for up to a 100-day supply

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 "Requests for Services or Payment, Complaints, and Medicare Appeal Procedures" 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 IV drugs, supplies, and supplements

We cover certain self-administered IV drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as an IV 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 Services or Payment, Complaints, and Medicare Appeal Procedures" section.

Notes:

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

Outpatient prescription drugs, supplies, and supplements limitations

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

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, 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 external hearing devices, and hip joints that are covered by Medicare.

External devices

We cover the following external prosthetic and orthotic devices, including repair and replacement of covered devices, at **no charge**:

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

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

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

- Eyeglasses and contact lenses (refer to "Vision 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

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: **a $20 Copayment per visit**
- Outpatient surgery: **a $20 Copayment per procedure**
- Hospital inpatient care (including room and board, drugs, and Plan Physician Services): **no charge**

Services not covered under this "Reconstructive Surgery" section

Coverage for the following Services is described 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 medical care or treatment that you receive involuntarily or that is required under federal, state, or local law. "Nonexcepted" medical treatment is any other medical care 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** up to 100 days per benefit period of skilled inpatient Services in a Plan Skilled Nursing Facility and in accord with Medicare guidelines. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

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

We cover the following Services:

- Physician and nursing Services
- Room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment in accord with our DME 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 pay Cost Sharing for a facility that isn't a Plan provider, if the facility accepts our Plan's amounts for payment.

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides Skilled Nursing Facility care)
- A 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 **$150 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.

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 *EOC*. 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 Services covered under "Hospice Care" in the "Benefits and Cost Sharing" section for Members who do not have Part A.

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 by Medicare 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 by Medicare 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.

Hearing aids

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

This exclusion does not apply to cochlear implants and osseointegrated external hearing devices covered under "Prosthetic and Orthotic Devices" in the "Benefits and Cost Sharing" section.

Intermediate care

Care in a licensed intermediate care facility. This exclusion does not apply to Services covered under "Hospice Care" in the "Benefits and Cost Sharing" section for Members who do not have Part A.

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, 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 by Medicare.

Services not approved by the FDA

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 *EOC* 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 by Medicare.

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.

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

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

- Coverage that you have from an employer's group health care coverage for employees or retirees, either through yourself or your spouse
- Coverage that you have under workers' compensation because of a job-related illness or injury, or under the Federal Black Lung Program
- Coverage you have for an accident where no-fault insurance or liability insurance is involved
- Coverage you have through Medicaid
- Coverage you have through the "TRICARE for Life" program (veteran's benefits)

- Coverage you have for dental insurance or prescription drugs
- "Continuation coverage" you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions)

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

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

If you have additional health coverage, please call our Member Service Call Center to find out which rules apply to your situation, and how payment will be handled. Also, the Medicare program has written a booklet with general information about what happens when people with Medicare have additional coverage. It's called *Medicare and Other Health Benefits: Your Guide to Who Pays First.* You can get a copy by calling toll free 1-800-MEDICARE/1-800-633-4227 (TTY users call 1-877-486-2048) 24 hours a day, seven days a week, or by visiting the **www.medicare.gov** Web site.

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.

Medicare benefits

As a Senior Advantage Member, you receive all Medicare-covered benefits through us (except as otherwise noted) and these benefits are not duplicated.

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

Grievances

We are committed to providing you with quality care and with a timely response to your concerns. If you have a complaint or issue, you may file a grievance with us in certain cases. This section describes the complaints and issues that are subject to this grievance procedure and how to file a grievance. The grievance procedure applies to any complaint or issue unless it involves a request for an initial determination, an appeal, or a complaint about certain Services ending too soon as described in the "Requests for Services or Payment, Complaints, and Medicare Appeal Procedures" section.

If you have one of the following types of problems and want to make a complaint, you may file a grievance:

- Problems with the quality of the Services you receive
- If you feel that you are being encouraged to leave (disenroll from) our Plan
- If you disagree with our decision not to give you a "fast" initial determination or appeal (see "Fast grievances" in this "Grievances" section for more information)
- We don't forward your case to the Independent Review Entity (IRE) if we do not give you our appeal decision on time
- For drugs you have already received, you believe that you waited too long for the prescription to be filled
- Problems with how long you had to wait for Services that you have already received, including appointments and your wait time on the phone, in the waiting room, or in the exam room
- You believe our notices and other written materials are hard to understand
- Problems with the Service you receive from Member Services
- Rude behavior by Plan Providers or staff
- Cleanliness or condition of Plan Facilities

This grievance procedure does not apply to the following complaints or issues, instead please refer to the "Requests for Services or Payment, Complaints, and Medicare Appeal Procedures" section:

- Problems related to the coverage we provide for Part C Services or Part D drugs (including requests for Services you have not received and payment or reimbursement for Services you have already received)
- Complaints about having to leave the hospital too soon
- Complaints about having Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) Services ending too soon, instead refer to the "Initial Determinations" in the "Requests for Services or Payment, Complaints, and Medicare Appeal Procedures" section to learn how to resolve these issues

Special note about hospice care

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

Filing a Grievance

If you have a complaint or issue, you or your representative may call the phone number listed in the "Helpful Phone Numbers and Resources" section under "Contact information for grievances, organization determinations, coverage determinations, and appeals." We will try to resolve your complaint or issue 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 or issue over the phone, we have a formal procedure to review your complaints and issues, which we call a "grievance procedure."**

To file a grievance you or your representative should call, fax, or write us at the numbers or address listed in the "Helpful Phone Numbers and Resources" section under "Contact information for grievances, organization determinations, coverage determinations, and appeals." Please see "Fast grievances" below for information about fast grievances.

You must submit your grievance within 60 days of the event or incident. We must address your grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the time frame by up to 14 days if you ask for the extension, or if we justify a need for additional information and the delay is in your best interest. If we deny your grievance in whole or in part, our written decision will explain why we denied it, and will tell you about any dispute resolution options you may have (for example, binding arbitration).

Who may file a grievance

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

Fast Grievances

As described in the "Requests for Services or Payment, Complaints, and Medicare Appeal Procedures" section, you may request a "fast grievance," which means we will answer your grievance within 24 hours in the following situations:

- We deny your request to expedite an initial determination related to a Service that you have not yet received
- We deny your request to expedite your Medicare appeal
- We decide to extend the time we need to make a standard or expedited initial determination or appeal

Quality Improvement Organization (QIO)

You may complain about the quality of care received under Medicare, including care during a hospital stay. You may complain to us using the grievance process, to the Quality Improvement Organization (QIO), or both. If you file with the QIO, we must help the QIO resolve the complaint.

To file a complaint with the local Quality Improvement Organization, you should write to Health Services Advisory Group, Inc., Attn: Beneficiary Protection, 5201 W. Kennedy Boulevard, Suite 900, Tampa, Florida 33609-1822 (fax number 1-415-677-2185), or call toll free 1-800-841-1602, 24 hours a day, seven days a week (TTY users call 1-800-881-5980).

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 *EOC*. 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 *EOC* 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. (Health Plan)
- Kaiser Foundation Hospitals (KFH)
- KP Cal, LLC (KP Cal)
- The Permanente Medical Group, Inc. (TPMG)
- Southern California Permanente Medical Group (SCPMG)
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any KFH, TPMG, or SCPMG 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, KFH, KP Cal, TPMG, SCPMG, 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.

Requests for Services or Payment, Complaints, and Medicare Appeal Procedures

This section explains how you ask for coverage of your Part C Services and Part D drug or payments in different situations. This section also explains how to make complaints when you think you are being asked to leave the hospital too soon, or you think your Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) Services are ending too soon. These types of requests and complaints are discussed below in Part 1, Part 2, and Part 3.

Other complaints that do not involve the types of requests or complaints discussed below in Part 1, Part 2, or Part 3 are considered **grievances**. You would file a grievance if you have any type of problem with us or one of our Plan Providers that does not relate to coverage for Part C Services and Part D drugs. For more information about grievances, see the "Grievances" section.

Part 1. Requests for Part C Services and Part D drugs or payments.

Part 2. Complaints if you think you are asked to leave the hospital too soon.

Part 3. Complaints if you think your Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) Services are ending too soon.

PART 1. Requests for Part C Services and Part D Drugs or Payment

This part explains what you can do if you have problems getting the Part C Services or Part D drugs you request,

or payment (including the amount you paid) for a Part C Service or Part D drug you have already received.

If you have problems getting the Part C Services or Part D drugs you need, or payment for a Part C Service or Part D drug you have already received, you must request an initial determination from our Plan.

Initial Determinations

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

The following are examples of requests for initial determinations:

- You ask us to pay for a prescription drug you have received
- You ask for a Part D drug that is not on our Plan's list of covered drugs (called a "formulary"). This is a request for a "formulary exception." See "Requests for a Part D exception" below for more information about the exception process
- You ask for an exception to our utilization management tools, such as dosage limits. Requesting an exception to a utilization management tool is a type of formulary exception. See "Requests for a Part D exception" below for more information about the exceptions process
- You ask us to pay for the cost of a drug you bought at a Non–Plan Pharmacy. In certain circumstances, out-of-network purchases, including drugs provided to you in a physician's office, will be covered by our Plan. See "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section for a description of these circumstances
- You are not getting Part C Services you want, and you believe that this care is covered by our Plan
- We will not approve the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by our Plan
- You are being told that a medical treatment or Service you have been getting will be reduced or stopped, and you believe that this could harm your health
- You have received Part C Services that you believe should be covered by our Plan, but we have refused to pay for this care

Requests for a Part D exception

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

- You may ask us to cover your Part D drug even if it is not on our formulary
- You may ask us to waive coverage restrictions or limits on your Part D drug. For example, for certain Part D drugs, we limit the amount of the drug that we will cover. If your Part D drug has a quantity limit, you may ask us to waive the limit and cover more. See "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Cost Sharing" section to learn more about our additional coverage restrictions or limits on certain drugs

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

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

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

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

You may call us at the phone number shown for Part D coverage determinations in the "Helpful Phone Numbers and Resources" section under "Contact information for grievances, organization determinations, coverage determinations, and appeals."

Who may ask for an initial determination?

You, your prescribing physician, or someone you name may ask us for an initial determination. The person you name would be your "appointed representative." You may name a relative, friend, lawyer, advocate, doctor, or anyone else to act for you. Other persons may already be authorized by the Court or in accordance with state law to act for you. If you want someone to act for you who is not already authorized by the Court or under state law, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. If you are requesting Part C Services or Part D drugs, this statement must be sent to us at the address or fax number listed in the "Helpful Phone Numbers and Resources" section under "Contact information for grievances, organization determinations, coverage determinations, and appeals."

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

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

Asking for a standard decision. To ask for a standard decision for a Part C Service or Part D drug you, your doctor, or your representative should call, fax or write us at the numbers or address listed in the "Helpful Phone Numbers and Resources" section under "Contact information for grievances, organization determinations, coverage determinations, and appeals" (for an initial determination about Part D drugs or Part C Services).

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

If you are requesting a Part C Service or Part D drug that you have not yet received, you, your doctor, or your representative may ask us to give you a fast decision by calling, faxing, or writing us at the numbers or address listed in the "Helpful Phone Numbers and Resources" section under "Contact information for grievances, organization determinations, coverage determinations, and appeals" (for an initial determination about Part D drugs or Part C Services).

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

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

What happens when you request an initial determination?

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

  Generally, we must give you our decision no later than 72 hours after we receive your request, but we will make it sooner if your request is for a Part D drug that you have not received yet and your health condition requires us to. However, if your request involves a request for an exception (including a formulary exception, tiering exception, or an exception from utilization management rules, such as dosage limits), we must give you our decision no later than 72 hours after we receive your physician's "supporting statement" explaining why the drug you are asking for is Medically Necessary. If you have not received an answer from us within 72 hours after we receive your request (or your physician's supporting statement if your request involves an exception), your request will automatically go to Appeal Level 2

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

  If we give you a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review. We will give you the decision sooner if your health condition requires us to. If your request involves a request for an exception, we will give you our decision no later than 24 hours after we have received your physician's "supporting statement," which explains why the drug you are asking for is Medically Necessary. If we decide you are eligible for a fast review and you have not

received an answer from us within 24 hours after receiving your request (or your physician's supporting statement if your request involves an exception), your request will automatically go to Appeal Level 2

- **For a decision about payment for Part C Services you have already received**
  If we do not need more information to make a decision, we have up to 30 days to make a decision after we receive your request. However, if we need more information in order to make a decision, we have up to 60 days from the date of the receipt of your request to make a decision. You will be told in writing when we make a decision. If you have not received an answer from us within 60 days of your request, this is the same as denying your request and you have the right to appeal
- **For a standard decision about Part C Services you have not yet received**
  We have 14 days to make a decision after we receive your request. However, we can take up to 14 more days if you ask for additional time, or if we need more information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a "fast grievance." For more information about fast grievances, see the "Grievances" section. If you have not received an answer from us within 14 days of your request (or by the end of any extended time period), you have the right to appeal
- **For a fast decision about Part C Services you have not yet received**
  If you receive a "fast" decision, we will give you our decision about your requested Services within 72 hours after we receive the request. 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 more time to prepare for this review. If we take additional days, we will notify you in writing. If you believe that we should not take any extra days, you can file a fast grievance. We will call you as soon as we make the decision. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), this is the same as denying the request and you have the right to appeal. If we deny your request for a fast decision, you may file a "fast grievance." For more information about fast grievances, see the "Grievances" section

What happens if we decide completely in your favor?

- **For a standard decision about a Part D drug (including a request to pay for a Part D drug that you have already received)**
  - We must cover the Part D drug you requested as quickly as your health requires, but no later than 72 hours after we receive the request
  - If your request involves a request for an exception, we must cover the Part D drug you requested no later than 72 hours after we receive your physician's "supporting statement"
  - If you are asking us to pay for a Part D drug that you have already received, we must send payment no later than 30 calendar days after we receive your request (or supporting statement if your request involves an exception)
- **For a fast decision about a Part D drug that you have not yet received**
  We must cover the Part D drug you requested no later than 24 hours after we receive your request. If your request involves a request for an exception, we must cover the Part D drug you requested no later than 24 hours after we receive your physician's "supporting statement"
- **For a decision about payment for Part C Services you have already received**
  Generally, we must send payment no later than 30 days after we receive your request, although some decisions may take up to 60 days when we need more information to make a decision
- **For a standard decision about Part C Services you have not yet received**
  We must authorize or provide your requested care within 14 days of receiving your request. If we extended the time needed to make our decision, we will authorize or provide your medical care before the extended time period expires
- **For a fast decision about Part C Services you have not yet received**
  We must authorize or provide your requested care within 72 hours of receiving your request. If we extended the time needed to make our decision, we will authorize or provide your medical care before the extended time period expires

What happens if we decide against you?

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

Appeal Level 1: Appeal to our Plan

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

Who may file your appeal of the initial determination?

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

If you are appealing an initial decision about Part C Services, the rules about who may file an appeal are the same as the rules about who may ask for an organization determination. Follow the instructions under "Who may ask for an initial determination?" However, providers who do not have a contract with our Plan may also appeal a payment decision as long as the provider signs a "waiver of payment" statement saying it will not ask you to pay for the Part C Service under review, regardless of the outcome of the appeal.

How soon must you file your appeal?

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

How to file your appeal

Asking for a standard appeal: To ask for a standard appeal about a Part C Service or Part D drug a signed, **written** appeal request must be sent to the address listed in the "Helpful Phone Numbers and Resources" section under "Contact information for grievances, organization determinations, coverage determinations, and appeals" (for appeals about Part D drugs or Part C Services).

Asking for a fast appeal: If you are appealing a decision we made about giving you a Part C Service or Part D drug that you have not received yet, you and/or your doctor will need to decide if you need a fast appeal. The rules about asking for a fast appeal are the same as the rules about asking for a fast initial determination. You, your doctor, or your representative may ask us for a fast appeal by calling, faxing, or writing us at the numbers or address listed in the "Helpful Phone Numbers and Resources" section under "Contact information for grievances, organization determinations, coverage determinations, and appeals" (for appeals about Part D drugs or Part C Services).

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

Getting information to support your appeal

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

You may give us your additional information to support your appeal by calling, faxing, or writing us at the numbers or address listed in the "Helpful Phone Numbers and Resources" section under "Contact information for grievances, organization determinations, coverage determinations, and appeals" (for appeals about Part D drugs or Part C Services).

You may also deliver additional information in person to address listed in the "Helpful Phone Numbers and Resources" section under "Contact information for grievances, organization determinations, coverage determinations, and appeals" (for appeals about Part D drugs or Part C Services).

You also have the right to ask us for a copy of information regarding your appeal. You may call or write us at the phone number or address listed in the "Helpful Phone Numbers and Resources" section under "Contact information for grievances, organization determinations,

coverage determinations, and appeals" (for appeals about Part D drugs or Part C Services). We are allowed to charge a fee for copying and sending this information to you.

How soon must we decide on your appeal?

- **For a standard decision about a Part D drug (including a request to pay for a Part D drug you have already received)**
  We will give you our decision within seven calendar days of receiving the appeal request. We will give you the decision sooner if you have not received the drug yet and your health condition requires us to. If we do not give you our decision within seven calendar days, your request will automatically go to Appeal Level 2
- **For a fast decision about a Part D drug that you have not yet received**
  We will give you our decision within 72 hours after we receive the appeal request. We will give you the decision sooner if your health condition requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2
- **For a decision about payment for Part C Services you have already received**
  After we receive your appeal request, we have 60 days to decide. If we do not decide within 60 days, your appeal automatically goes to Appeal Level 2
- **For a standard decision about Part C Services you have not yet received**
  After we receive your appeal, we have 30 days to decide, but we will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will automatically go to Appeal Level 2
- **For a fast decision about Part C Services you have not yet received**
  After we receive your appeal, we have 72 hours to decide, but we will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not decide within 72 hours (or by the end of the extended time period), your request will automatically go to Appeal Level 2

What happens if we decide completely in your favor?

- **For a standard decision about a Part D drug (including a request to pay for a Part D drug that you have already received)**
  We must cover the Part D drug you requested as quickly as your health requires, but no later than seven calendar days after we receive the request. If you are asking us to pay for a Part D drug that you have already received, we must send payment to you no later than 30 calendar days after we receive the request
- **For a fast decision about a Part D drug that you have not yet received**
  We must cover the Part D drug you requested as quickly as your health requires, but no later than 72 hours after we receive your appeal request
- **For a decision about payment for Part C Services you have already received**
  We must pay within 60 days of receiving your appeal request
- **For a standard decision about Part C Services you have not yet received**
  We must authorize or provide your requested care within 30 days of receiving your appeal request. If we extended the time needed to decide your appeal, we will authorize or provide your requested care before the extended time period expires
- **For a fast decision about Part C Services you have not yet received**
  We must authorize or provide your requested care within 72 hours of receiving your appeal request. If we extended the time needed to decide your appeal, we will authorize or provide your requested care before the extended time period expires

What happens if we decide against you?

- For Part D drugs, if we deny any part of your first appeal, we will send you a written decision explaining why we denied your request. If the first appeal does not give you all that you requested, you may ask for a review by a government-contracted independent review organization (see Appeal Level 2)
- For Part C Services, if our decision is not fully in your favor, we will automatically forward your appeal to a government-contracted independent review organization (see Appeal Level 2) and so notify you in writing

Appeal Level 2: Independent Review Entity (IRE)

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

How to file your appeal

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

If you asked for Part C Services, or payment for Part C Services, and we did not rule completely in your favor at Appeal Level 1, your appeal is automatically sent to the IRE.

How soon must the IRE decide?

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

If the IRE decides completely in your favor

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

- **For a decision to pay for a Part D drug you have already received**
  We must send payment within 30 calendar days from the date we receive notice reversing our decision
- **For a standard decision about a Part D drug you have not yet received**
  We must cover the Part D drug you asked for within 72 hours after we receive notice reversing our decision
- **For a fast decision about a Part D drug you have not yet received**
  We must authorize or provide the Part D drug you asked for within 24 hours after we receive notice reversing our decision
- **For a decision about payment for Part C Services you have already received**
  We must pay within 30 days after we receive notice reversing our decision
- **For a standard decision about Part C Services you have not yet received**
  We must authorize your requested Part C Service within 72 hours, or provide it to you within 14 days after we receive notice reversing our decision
- **For a fast decision about Part C Services**
  We must authorize or provide your requested Part C Services within 72 hours after we receive notice reversing our decision

What happens if the IRE decides against you?

If the organization that reviews your case in this Appeal Level 2 does not rule completely in your favor, you may be able to ask for a review by an Administrative Law Judge (see Appeal Level 3).

Appeal Level 3: Administrative Law Judge (ALJ)

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

How to file your appeal

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

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

How soon will the judge make a decision?

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

If the judge decides in your favor

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

What happens if the Judge decides against you?

If an ALJ does not rule in your favor, your case may be reviewed by the Medicare Appeals Council (see Appeal Level 4).

Appeal Level 4: Medicare Appeals Council (MAC)

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

How to file your appeal

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

How soon will the council make a decision?

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

If the council decides in your favor

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

What happens if the Council decides against you?

You have the right to continue your appeal by asking a Federal Court Judge to review your case if the amount involved meets the minimum requirement specified in the Medicare Appeals Council's decision (see Appeal Level 5).

Appeal Level 5: Federal Court

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

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

How to file your appeal

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

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

How soon will the judge make a decision?

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

If the judge decides in your favor

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

If the judge decides against you

You may have further appeal rights in the federal courts. Please refer to the Judge's decision for further information about your appeal rights.

Favorable Decisions by the ALJ, MAC, or a Federal Court Judge

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

- **For a decision to pay for a Part D drug you have already received**

  We must send payment within 30 calendar days from the date we receive notice reversing our decision

- **For a standard decision about a Part D drug you have not yet received**

  We must cover the Part D drug you asked for within 72 hours after we receive notice reversing our decision

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

  We must cover the Part D drug you asked for within 24 hours after we receive notice reversing our decision

- **For a decision about Part C Services**

  We must pay for, authorize, or provide the Service you have asked for as quickly as your health condition requires, but no later than 60 days after we receive notice reversing our decision

PART 2. Complaints (Appeals) if You Think You are Being Discharged From the Hospital Too Soon

When you are admitted to the hospital, you have the right to get all the hospital care covered by our Plan that is necessary to diagnose and treat your illness or injury. The day you leave the hospital (your discharge date) is based on when your stay in the hospital is no longer Medically Necessary. This part explains what to do if you believe that you are being discharged too soon.

Information you should receive during your hospital stay

Within two days of admission as an inpatient or during preadmission, someone at the hospital must give you a notice called the "Important Message from Medicare" (call our Member Service Call Center or 1-800-MEDICARE/1-800-633-4227 (TTY users call 1-877-486-2048) to get a sample notice or see it online at **www.cms.hhs.gov/BNI**). This notice explains:

- Your right to get all Medically Necessary hospital Services paid for by our Plan (except for any applicable Copayments or deductibles)
- Your right to be involved in any decisions that the hospital, your doctor, or anyone else makes about your hospital Services and who will pay for them
- Your right to get Services you need after you leave the hospital
- Your right to appeal a discharge decision and have your hospital Services paid for by us during the appeal (except for any applicable Copayments or deductibles)

You (or your representative) will be asked to sign the "Important Message from Medicare" to show that you received and understood this notice. **Signing the notice does not mean that you agree that the coverage for your Services should end, only that you received and understand the notice.** If the hospital gives you the "Important Message from Medicare" more than two days before your discharge day, it must give you a copy of your signed "Important Message from Medicare" before you are scheduled to be discharged.

Review of your hospital discharge by the Quality Improvement Organization

You have the right to request a review of your discharge. You may ask the Quality Improvement Organization to review whether you are being discharged too soon.

What is the "Quality Improvement Organization"?

"QIO" stands for Quality Improvement Organization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of our Plan or the hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. In California, the QIO is called Health Services Advisory Group, Inc., located at 5201 W. Kennedy Boulevard, Suite 900, Tampa, Florida. The doctors and other health experts in the QIO review certain types of complaints made by Medicare patients. These include complaints from Medicare patients who think their hospital stay is ending too soon.

Getting the QIO to review your hospital discharge

You must quickly contact the QIO. The "Important Message from Medicare" gives the name and telephone number of the QIO and tells you what you must do.

- You must ask the QIO for a **"fast review"** of your discharge. This "fast review" is also called an "immediate review"
- You must request a review from the QIO no later than the day you are scheduled to be discharged from the hospital. **If you meet this deadline, you may stay in the hospital after your discharge date without paying for it while you wait to get the decision from the QIO**
- The QIO will look at your medical information provided to the QIO by us and the hospital
- During this process you will get a notice, called the "Detailed Notice of Discharge," giving the reasons why we believe that your discharge date is medically appropriate. Call our Member Service Call Center or 1-800-MEDICARE/1-800-633-4227 (TTY users call 1-877-486-2048) to get a sample notice or see it online at **www.cms.hhs.gov/BNI**)
- The QIO will decide, within one day after receiving the medical information it needs, whether it is medically appropriate for you to be discharged on the date that has been set for you

What happens if the QIO decides in your favor?

We will continue to cover your hospital stay (except for any applicable Cost Sharing) for as long as it is Medically Necessary and you have not exceeded our Plan coverage limitations as described in the "Benefits and Cost Sharing" Section.

What happens if the QIO agrees with the discharge?

You will not be responsible for paying the hospital charges until noon of the day after the QIO gives you its decision. However, you could be financially liable for any inpatient hospital Services provided after noon of the day after the QIO gives you its decision. You may leave the hospital on or before that time and avoid any possible financial liability.

If you remain in the hospital, you may still ask the QIO to review its first decision if you make the request within 60 days of receiving the QIO's first denial of your request. However, you could be financially liable for any inpatient hospital Services provided after noon of the day after the QIO gave you its first decision.

What happens if you appeal the QIO decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive inpatient care. If the QIO agrees that your care should continue, we must pay for, or reimburse you for, any care you have received since the discharge date on the "Important Message from Medicare," and provide you with inpatient care (except for any applicable Cost Sharing) for as long as it is Medically Necessary and you have not exceeded our Plan coverage limitations as described in the "Benefits and Cost Sharing" Section.

If the QIO upholds its original decision, you may be able to appeal its decision to an Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this "Requests for Services or Payment, Complaints, and Medicare Appeal Procedures" section for guidance on the ALJ appeal. If the ALJ upholds the decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a federal court. If any of these decision makers agree that your stay should continue, we must pay for, or reimburse you for, any care you have received since the discharge date, and provide you with inpatient care (except for any applicable Cost Sharing) for as long as it is Medically Necessary and you have not exceeded our Plan coverage limitations as described in the "Benefits and Cost Sharing" Section.

What if you do not ask the QIO for a review by the deadline?

If you do not ask the QIO for a fast review of your discharge by the deadline, you may ask us for a "fast appeal" of your discharge, which is discussed in Part 1 of this section. If you ask us for a fast appeal of your discharge and you stay in the hospital past your discharge date, you may have to pay for the hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the hospital, we will continue to cover your hospital care (except for any applicable Cost Sharing) for as long as it is Medically Necessary and you have not exceeded our Plan coverage limitations as described in the "Benefits and Cost Sharing" Section
- If we decide that you should not have stayed in the hospital beyond your discharge date, we will not cover any hospital care you received after the discharge date

If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours. Please see Appeal Level 2 in Part 1 of this "Requests for Services or Payment, Complaints, and Medicare Appeal Procedures" section for guidance on the IRE appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a federal court. If any of these decision makers agree that your stay should continue, we must pay for, or reimburse you for, any care you have received since the discharge date on the notice you got from your provider, and provide you with any Services you asked for (except for any applicable Cost Sharing) for as long as it is Medically Necessary and you have not exceeded our Plan coverage limitations as described in the "Benefits and Cost Sharing" Section.

PART 3. Complaints (Appeals) If You Think Coverage for Your SNF, HHA, or CORF Services is Ending Too Soon

When you are a patient in a Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF), you have the right to get all the SNF, HHA, or CORF care covered by our Plan that is necessary to diagnose and treat your illness or injury. The day we end coverage for your SNF, HHA, or CORF Services is based on when these Services are no longer Medically Necessary. This part explains what to do if you believe that coverage for your Services is ending too soon.

Information you will receive during your SNF, HHA, or CORF stay

Your provider will give you written notice called the "Notice of Medicare Non-Coverage" at least two days before coverage for your Services ends (call our Member Service Call Center or 1-800-MEDICARE/1-800-633-4227 (TTY users call 1-877-486-2048) to get a sample notice or see it online at **www.cms.hhs.gov/BNI**). You (or your representative) will be asked to sign and date this notice to show that you received it. **Signing the notice does not mean that you agree that coverage for**

your Services should end, only that you received and understood the notice.

Getting QIO review of our decision to end coverage

You have the right to appeal our decision to end coverage for your Services. As explained in the notice you get from your provider, you may ask the Quality Improvement Organization (the "QIO") to do an independent review of whether it is medically appropriate to end coverage for your Services.

How soon do you have to ask for QIO review?

You must quickly contact the QIO. The written notice you got from your provider gives the name and telephone number of your QIO and tells you what you must do.

- If you get the notice two days before your coverage ends, you must contact the QIO no later than noon of the day after you get the notice
- If you get the notice more than two days before your coverage ends, you must make your request no later than noon of the day before the date that your Medicare coverage ends

What will happen during the QIO's review?

The QIO will ask 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 QIO will also look at your medical information, talk to your doctor, and review information that we have given to the QIO. During this process, you will get a notice called the "Detailed Explanation of Non-Coverage" giving the reasons why we believe coverage for your Services should end. Call our Member Service Call Center or 1-800-MEDICARE/1-800-633-4227 (TTY users call 1-877-486-2048) to get a sample notice or see it online at **www.cms.hhs.gov/BNI**).

The QIO will make a decision within one full day after it receives all the information it needs.

What happens if the QIO decides in your favor?

We will continue to cover your SNF, HHA, or CORF Services (except for any applicable Cost Sharing) for as long as it is Medically Necessary and you have not exceeded any coverage limitations described in the "Benefits and Cost Sharing" Section.

What happens if the QIO agrees that your coverage should end?

You will not be responsible for paying for any SNF, HHA, or CORF Services provided before the termination date on the notice you get from your provider. You may stop getting Services on or before the date given on the notice and avoid any possible financial liability. If you continue receiving Services, you may still ask the QIO to review its first decision if you make the request within 60 days of receiving the QIO's first denial of your request.

What happens if you appeal the QIO decision?

The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive Services. If the QIO agrees that your Services should continue, we must pay for, or reimburse you for, any care you have received since the termination date on the notice you got from your provider, and provide you with any Services you asked for (except for any applicable Cost Sharing) for as long as it is Medically Necessary and you have not exceeded our Plan coverage limitations as described in the "Benefits and Cost Sharing" Section.

If the QIO upholds its original decision, you may be able to appeal its decision to an Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this "Requests for Services or Payment, Complaints, and Medicare Appeal Procedures" section for guidance on the ALJ appeal. If the ALJ upholds our decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a federal court. If either the MAC or federal court agrees that your stay should continue, we must pay for, or reimburse you for, any care you have received since the termination date on the notice you got from your provider, and provide you with any Services you asked for (except for any applicable Cost Sharing) for as long as it is Medically Necessary and you have not exceeded our Plan coverage limitations as described in the "Benefits and Cost Sharing" Section.

What if you do not ask the QIO for a review by the deadline?

If you do not ask the QIO for a review by the deadline, you may ask us for a fast appeal, which is discussed in Part 1 of this "Requests for Services or Payment, Complaints, and Medicare Appeal Procedures" section.

If you ask us for a fast appeal of your coverage ending and you continue getting Services from the SNF, HHA, or CORF, you may have to pay for the care you get after your termination date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that coverage for your Services should continue, we will continue to cover your SNF, HHA, or CORF Services (except for any applicable Cost Sharing) for as long as it is Medically Necessary and you have not exceeded our Plan coverage limitations as described in the "Benefits and Cost Sharing" Section

- If we decide that you should not have continued getting Services, we will not cover any Services you received after the termination date

If we uphold our original decision, we will forward our decision and case file to the Independent Review Entity (IRE) within 24 hours. Please see Appeal Level 2 in Part 1 of this "Requests for Services or Payment, Complaints, and Medicare Appeal Procedures" section for guidance on the IRE appeal. If the IRE upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a federal court. If any of these decision makers agree that your stay should continue, we must pay for, or reimburse you for, any care you have received since the discharge date on the notice you got from your provider, and provide you with any Services you asked for (except for any applicable Cost Sharing) for as long as it is Medically Necessary and you have not exceeded our Plan coverage limitations as described in the "Benefits and Cost Sharing" 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, 2009, your last minute of coverage was at 11:59 p.m. on December 31, 2008). 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 *EOC* 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.

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, 2008, your termination date is January 1, 2009, and your last minute of coverage is at 11:59 p.m. on December 31, 2008.

Also, we will terminate your Senior Advantage membership on the last day of the month if you:

- Are temporarily absent from our Service Area for more than six months in a row
- Permanently move outside our Service Area
- No longer are entitled to Medicare Part B
- Enroll in another Medicare health plan (for example, a Medicare Advantage Plan or a Medicare Prescription Drug Plan). CMS 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 these circumstances, you may be eligible to transfer your membership to another Kaiser Permanente plan offered by your Group. Please contact your Group for information.

Termination of *Agreement*

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

Disenrolling from Senior Advantage

You may terminate (disenroll from) your Senior Advantage membership at any time. However, before you request disenrollment, please check with your Group to determine if you are able to continue your Group membership.

If you request disenrollment during your Group's open enrollment, your disenrollment effective date is determined by the date your written request is received

by us and the date your Group coverage ends. The effective date will not be earlier than the first day of the following month after we receive your written request, and no later than three months after we receive your request.

If you request disenrollment at a time other than your Group's open enrollment, your disenrollment effective date will be the first day of the month following our receipt of your disenrollment request.

You may request disenrollment by calling toll free 1-800-MEDICARE/1-800-633-4227 (TTY users call 1-877-486-2048) 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).

CMS 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 CMS

If our contract with CMS to offer Senior Advantage terminates, your membership will terminate on the same date. We will send you advance written notice and advise you of your health care options. Also, you may be eligible to transfer your membership to another Kaiser Permanente plan offered by your Group.

Termination for Cause

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

- 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 Plan for this reason unless we get permission first from Medicare
- If you let someone else use your Plan membership card to get medical care. If you are disenrolled for this reason, CMS may refer your case to the Inspector General for additional investigation
- 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 the appropriate 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 upon 90 days prior written notice to you. If we discontinue offering all products to groups in a small or large group market, as applicable, we may terminate your Group's *Agreement* upon 180 days prior written notice to you.

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 "Emergency, Post-Stabilization, and Urgent Care from Non–Plan Providers" and "Requests for Services or Payment, Complaints, and Medicare Appeal Procedures" sections. 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 membership because of your ill health or your need for care, you may file a grievance as described in the "Grievances" section.

Continuation of Membership

If your membership under this *EOC* ends, you may be eligible to maintain Health Plan membership without a break in coverage under this *EOC* (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 *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. COBRA applies to most employees (and most of their covered family Dependents) of most employers with 20 or more employees.

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 your Group 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 *EOC* 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 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 this *EOC*.

How to convert

If you no longer qualify as a Member described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section, we will automatically convert your Group membership to our *Senior Advantage Individual Plan Agreement* if you still meet the eligibility requirements for Senior Advantage and have not disenrolled. The premiums and coverage under our individual plan will differ from those under this *EOC* and will include Medicare Part D prescription drug coverage.

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 *EOC*.

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 *EOC*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *EOC*.

Amendment of *Agreement*

Your Group's *Agreement* with us will change periodically. If these changes affect this *EOC*, 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 *EOC*.

Assignment

You may not assign this *EOC* 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 *EOC* and we have the discretionary authority to review and evaluate claims that arise under this *EOC*. We conduct this evaluation independently by interpreting the provisions of this *EOC*. If this *EOC* 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 *EOC*.

Governing law

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

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 *EOC* 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, or physical or mental disability.

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 *EOC* 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 *EOC* formats

You can request a copy of this *EOC* 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 (PHI). We also require contracting providers to protect your PHI. PHI 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 PHI, correct or update your PHI, and ask us for an accounting of certain disclosures of your PHI.

We may use or disclose your PHI 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 PHI 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 PHI 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 PHI 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.

Helpful Phone Numbers and Resources

Contact Information for our Member Services

If you have any questions or concerns, please call or write to our Member Services. We will be happy to help you.

Call

1-800-443-0815, 8 a.m. to 8 p.m., seven days a week. Calls to this number are free.

TTY

1-800-777-1370.
This number requires special telephone equipment. Calls to this number are free.

Write

Member Services office located at a Plan facility listed in *Your Guidebook to Kaiser Permanente Services*.

Web Site

kp.org

Contact information for grievances, organization determinations, coverage determinations, and appeals

Call

1-800-443-0815, 8 a.m. to 8 p.m., seven days a week. Calls to this number are free.

If your grievance, organization or coverage determination, or appeal **qualifies for a fast review**, call the Expedited Review Unit, 8:30 a.m. to 5 p.m., seven days a week, at:

- **1-888-987-7247** for Part C Services
- **1-866-206-2973** for Part D drugs

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. Calls to this number are free.

Fax

If your grievance, organization or coverage determination, or appeal **qualifies for a fast review**, fax your request to our Expedited Review Unit at:

- **1-888-987-2252** for Part C Services
- **1-866-206-2974** for Part D drugs

Write

Member Services office located at a Plan facility listed in *Your Guidebook to Kaiser Permanente Services*, unless you are requesting an appeal, fast grievance, fast organization or coverage determination, or payment for emergency or urgent care or Part D drugs you have received out-of-network. In these cases, 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 review).
- If your grievance, organization or coverage determination, or appeal **qualifies for a fast review**, write to:

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

- For an **initial determination** about payment (including a Part D reimbursement request) for emergency or urgent care or Part D drugs you received out-of-network, write to:

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

For information about grievances, see the "Grievances" section. For information about organization or coverage determinations and appeals, see the "Requests for Services or Payment, Complaints, and Medicare Appeal Procedures" section.

Other Important Contacts

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

The Health Insurance Counseling and Advocacy Program (HICAP)

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

You may contact HICAP toll free at 1-800-434-0222 (TTY users call 711) for a referral to your local HICAP

office, or visit the Web site **www.aging.ca.gov** to locate an office in your area. You may also find the website for HICAP at **www.medicare.gov**, under "Search Tools" by selecting "Helpful Phone Numbers and Websites."

Quality Improvement Organization

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

The QIO for California residents is Health Services Advisory Group, Inc., and you may contact them by writing to Health Services Advisory Group, Inc., Attn: Beneficiary Protection, 5201 W. Kennedy Boulevard, Suite 900, Tampa, Florida 33609-1822 (fax number 1-415-677-2185), or call toll free 1-800-841-1602, 24 hours a day, seven days a week (TTY users call 1-800-881-5980).

Medicare program

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). Our organization contracts with the federal government.

- Call 1-800-MEDICARE/1-800-633-4227 (TTY users call 1-877-486-2048) to ask questions or get free information booklets from Medicare, 24 hours a day, seven days a week
- Visit **www.medicare.gov** for information. This is the official government website for Medicare**.** This website gives you up-to-date information about Medicare and nursing homes and other current Medicare issues. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Advantage Plans and Medicare Prescription Drug Plans in your area. You can also search under "Search Tools" for Medicare contacts in your state, select "Helpful Phone Numbers and Websites." If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer

Medicaid

Medicaid is a state government program that helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid has programs that can help pay for your Medicare premiums and other costs if you qualify. To find out more about Medicaid and its programs, contact your county's Medi-Cal office, the California Department of Social Services at **1-800-952-5253,** 24 hours a day, seven days a week, (TTY 1-800-952-8349), or write to the California Department of Social Services at Post Office Box 944243, Sacramento, CA 94244.

Social Security

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

Railroad Retirement Board

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