NOTICE OF AWARD OF CONTRACT

TO: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc
2101 East Jefferson Street
Rockville, Maryland 20849

DATE ISSUED: December 17, 2014

CURRENT REFERENCE NO: 564-14

CONTRACT TITLE: Healthcare Services

PRIOR REFERENCE NO: N/A

THIS IS A NOTICE OF AWARD OF CONTRACT AND NOT AN ORDER. NO WORK IS AUTHORIZED UNTIL THE VENDOR RECEIVES A VALID COUNTY PURCHASE ORDER ENCUMBERING CONTRACT FUNDS.

Your firm is awarded the above referenced contract in accordance with the response submitted by you on SEPTEMBER 17, 2014. The contract term covered by this Notice of Award is effective JULY 1, 2014 and expires on DECEMBER 30, 2021. This contract includes annual extensions after December 30, 2021 through December 31, 2024.

This is the FIRST year award notice of a possible TEN year contract.

The contract documents consist of the terms, conditions, and specifications of Request for Proposal No. 564-14 and the bid of the Contractor, incorporated herein by reference.

The contract documents consist of the terms and conditions of Agreement No. 564.14, including any exhibits, attached or amendments thereto, full contract is available upon request.

CONTRACT PRICING:

1) REFER TO AGREEMENT NO. 564-14

ATTACHMENTS:

AGREEMENT NO. 564-14

EMPLOYEES NOT TO BENEFIT:

NO COUNTY EMPLOYEE SHALL RECEIVE ANY SHARE OR BENEFIT OF THIS CONTRACT NOT AVAILABLE TO THE GENERAL PUBLIC.

VENDOR CONTACT: CHRIS URBAN

VENDOR PAYMENT TERMS: NET 30 DAYS

EMAIL ADDRESS: Chris.Urbanc@kp.org

COUNTY CONTACT: KRISTIN YOUNG

VENDOR TEL. NO.: 301-816-5969

CONTACT NO.: 703-228-3485

CONTRACT AUTHORIZATION

Robert W. Jenkins, CPPB
Assistant Purchasing Agent

DATE 12/18/14

DISTRIBUTION

VENDOR: 1

BID FOLDER: 2
ARLINGTON COUNTY, VIRGINIA
OFFICE OF THE PURCHASING AGENT
SUITE 500, 2100 CLARENDON BOULEVARD
ARLINGTON, VA 22201

AGREEMENT NO. 564-14
KP Reference No. 827792v1

THIS AGREEMENT is made, on the date of execution by the County, between Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., 2101 East Jefferson Street, Rockville, Maryland 20849 (“Contractor”), a Maryland corporation authorized to do business in the Commonwealth of Virginia, and the County Board of Arlington County, Virginia (“County”). The County and the Contractor, for the consideration hereinafter specified, agree as follows:

1. CONTRACT DOCUMENTS
The Contract Documents consist of:

- This Agreement
- Exhibit A – Scope of Work
- Exhibit B – Contract Pricing and Performance Guarantees
- Exhibit C – Plan Designs for Non-Medicare Coverage
- Exhibit D – Plan Design for Medicare Advantage Coverage

Where the terms and provisions of this Agreement vary from the terms and provisions of the other Contract Documents, the terms and provisions of this Agreement shall prevail over the other Contract Documents and the remaining Contract Documents shall be complementary to each other and if there are any conflicts the most stringent terms or provisions shall prevail.

The Contract Documents set forth the entire agreement between the County and the Contractor. The County and the Contractor agree that no representative or agent of either of them has made any representation or promise with respect to the party’s agreement which is not contained in the Contract Documents. The Contract Documents may be referred to herein below as the “Contract” or the “Agreement.”

2. SCOPE OF WORK
The Contractor agrees to perform the services described in the Contract Documents (hereinafter “the Work”). The primary purpose of the Work is to provide healthcare services for County employees, pre-Medicare and Medicare retirees, and eligible dependents. The Contract Documents set forth the minimum work estimated by the County and the Contractor to be necessary to complete the Work. It shall be the Contractor’s responsibility, at the Contractor’s sole cost, to provide the specific services set forth in the Contract Documents and sufficient services to fulfill the purposes of the Work. Nothing in the Contract Documents shall be construed to limit the Contractor’s responsibility to manage the details and execution of the Work.

3. CONTRACT TERM
The Work shall commence on July 1, 2014, and shall be completed no later than December 30, 2021 (Contract Term), and may be extended on an annual basis through December 31, 2024, subject to any modifications as provided for in the Contract Documents regarding the Contract Term. No Work shall be deemed complete until it is accepted by the Project Officer.

4. CONTRACT AMOUNT
The County will pay the Contractor in accordance with the terms of the Payment paragraph below, and Exhibit B for the Contractor’s completion of the Work described and required in the Contract Documents. The Contractor agrees that it shall complete the Work for the total amount specified in this section (“Contract Amount”) unless such amount is modified as provided in this Agreement.
5. **PAYMENT**

Payment will be made by the County to the Contractor in accordance with terms specified in Exhibit B. The number of the County Purchase Order pursuant to which authority goods or services have been performed or delivered shall appear on all invoices.

6. **PROJECT OFFICER**

The performance of the Contractor is subject to the review and approval of the County Project Officer (“Project Officer”) who shall be appointed by the Director of the Arlington County department or agency requesting the work under this Contract. However, it shall be the responsibility of the Contractor to manage the details of the execution and performance of its work pursuant to the Contract Documents.

7. **ADJUSTMENTS FOR CHANGE IN SCOPE**

The County may order changes in the Work within the general scope of the Work consisting of additions, deletions or other revisions, including those required by changes in laws, rules and regulations. No claim may be made by the Contractor that the scope of the work or that the Contractor’s services have been changed requiring adjustments to the amount of compensation due the Contractor unless such adjustments have been made by a written amendment to the Contract signed by the County and the Contractor. If the Contractor believes that any particular work is not within the scope of the Work or is a material change or otherwise will call for more compensation to the Contractor, the Contractor must immediately notify the Project Officer after the change or event occurs and within ten (10) calendar days thereafter must provide written notice to the Project Officer. The Contractor’s notice must provide to the Project Officer the amount of additional compensation claimed, together with the basis therefor and documentation supporting the claimed amount. The Contractor will not be compensated for performing any work unless a proposal complying with this paragraph has been submitted in the time specified above and a written Contract amendment has been signed by the County and the Contractor and a County purchase order is issued covering the cost of the services to be provided pursuant to the amendment.

8. **ADDITIONAL SERVICES**

The Contractor shall not be compensated for any goods or services provided and included in the Contract Amount unless those goods or services are covered by a written amendment to this Contract signed by the County and the Contractor, and a County Purchase Order is issued covering the expected cost of such services.

Additional services agreed upon by the parties will be billed at the rates contained herein unless otherwise agreed by the parties in writing.

9. **REIMBURSABLE EXPENSES**

No reimbursable expenses are allowed under this Contract. The Contract Amount includes all costs and expenses of providing to the County the services described in this Contract.

10. **PAYMENT OF SUBCONTRACTORS**

The Contractor is obligated to take one of the two following actions within seven (7) days after receipt of amounts paid to the Contractor by the County for work performed by any subcontractor under this Contract:

   a. Pay the subcontractor for the proportionate share of the total payment received from the County attributable to the work performed by the subcontractor under this Contract; or

   b. Notify the County and the subcontractor, in writing, of the Contractor’s intention to withhold all or a part of the subcontractor’s payment with the reason for nonpayment.

The Contractor is obligated to pay interest to the subcontractor on all amounts owed by the Contractor to the subcontractor that remain unpaid after thirty (30) days following receipt by the Contractor of payment from the County for work performed by the subcontractor under this Contract, except for amounts withheld as allowed in subsection b., above. Unless otherwise provided under the terms of this Contract, interest shall accrue at the rate of one percent (1%) per month.
The Contractor shall include in each of its subcontracts, if any are permitted, a provision requiring each subcontractor to include or otherwise be subject to the same payment and interest requirements with respect to each lower-tier subcontractor.

The Contractor’s obligation to pay an interest charge to a subcontractor pursuant to this section may not be construed to be an obligation of the County. A Contract modification may not be made for the purpose of providing reimbursement for such interest charge. A cost reimbursement claim may not include any amount for reimbursement for such interest charge.

11. NON-APPROPRIATION
All funds for payments by the County to the Contractor pursuant to this Contract are subject to the availability of an annual appropriation for this purpose by the County Board of Arlington County, Virginia. In the event of non-appropriation of funds by the County Board of Arlington County, Virginia for the goods or services provided under this Contract or substitutes for such goods or services which are as advanced or more advanced in their technology, the County will terminate the Contract, without termination charge or other liability to the County, on the last day of the then current fiscal year or when the appropriation made for the then current year for the services covered by this Contract is spent, whichever event occurs first. If funds are not appropriated at any time for the continuation of this Contract, cancellation will be accepted by the Contractor on thirty (30) days prior written notice, but failure to give such notice shall be of no effect and the County shall not be obligated under this Contract beyond the date of termination specified in the County’s written notice.

12. COUNTY PURCHASE ORDER REQUIREMENT
County purchases are authorized only if a County Purchase Order is issued in advance of the transaction, indicating that the ordering agency has sufficient funds available to pay for the purchase. Such a Purchase Order is to be provided to the Contractor by the ordering agency. The County will not be liable for payment for any purchases made by its employees without appropriate purchase authorization issued by the County Purchasing Agent. If the Contractor provides goods or services without a signed County Purchase Order, it does so at its own risk and expense.

13. PROJECT STAFF
The County will, throughout the Initial Contract Term and any Subsequent Contract Term, have the right of reasonable rejection and approval of staff or subcontractors assigned to the project by the Contractor. If the County reasonably rejects staff or subcontractors pursuant to this section, the Contractor must provide replacement staff or subcontractors satisfactory to the County in a timely manner and at no additional cost to the County. The day-to-day supervision and control of the Contractor’s employees, and employees of any of its subcontractors, shall be the sole responsibility of the Contractor.

14. BACKGROUND CHECK
Any Contractor employee or subcontractor assigned by the Contractor to work under this Agreement at any County’s site shall be subject to a County standard background check, including fingerprinting by the County Sheriff’s Office and a credit check. Permission to work onsite shall be contingent on an outcome of the background check acceptable to the County. Prior to commencing work related to this Agreement, such employee or subcontractor shall provide required background check forms and undergo fingerprinting.

15. SUPERVISION BY CONTRACTOR
The Contractor shall at all times enforce strict discipline and good order among the workers performing under this Contract, and shall not employ on the work any person not reasonably proficient in the work assigned.

16. EMPLOYMENT DISCRIMINATION BY CONTRACTOR PROHIBITED
During the performance of this Contract, the Contractor agrees as follows:

a. The Contractor will not discriminate against any employee or applicant for employment because of race, religion, color, sex, national origin, age, disability or any other basis prohibited by state law related to discrimination in employment except where there is a bona fide occupational qualification reasonably
necessary to the normal operation of the Contractor. The Contractor agrees to post in conspicuous places, available to employees and applicants for employment, notices setting forth the provisions of this nondiscrimination clause.

b. The Contractor, in all solicitations or advertisements for employees placed by or on behalf of the Contractor, will state that such Contractor is an Equal Opportunity Employer.

c. Notices, advertisements and solicitations placed in accordance with federal law, rule or regulation shall be deemed sufficient for the purpose of meeting the requirements of this section.

d. The Contractor will comply with the provisions of the Americans with Disabilities Act of 1990 which prohibits discrimination against individuals with disabilities in employment and mandates their full participation in both publicly and privately provided services and activities.

e. The Contractor will include the provisions of the foregoing paragraphs in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

17. EMPLOYMENT OF UNAUTHORIZED ALIENS PROHIBITED
In accordance with §2.2-4311.1 of the Code of Virginia, as amended, the Contractor acknowledges that it does not, and shall not during the performance of this Contract for goods and/or services in the Commonwealth, knowingly employ an unauthorized alien as that term is defined in the federal Immigration Reform and Control Act of 1986.

18. DRUG-FREE WORKPLACE TO BE MAINTAINED BY CONTRACTOR
During the performance of this Contract, the Contractor agrees to (i) provide a drug-free workplace for the Contractor’s employees; (ii) post in conspicuous places, available to employees and applicants for employment, a statement notifying employees that the unlawful manufacture, sale, distribution, dispensation, possession, or use of a controlled substance or marijuana is prohibited in the Contractor’s workplace and specifying the actions that will be taken against employees for violations of such prohibition; (iii) state in all solicitations or advertisements for employees placed by or on behalf of the Contractor that the Contractor maintains a drug-free workplace; and (iv) include the provisions of the foregoing clauses in every subcontract or purchase order of over $10,000, so that the provisions will be binding upon each subcontractor or vendor.

For the purposes of this section, "drug-free workplace" means a site for the performance of work done in connection with a specific contract awarded to a contractor by Arlington County in accordance with the Arlington County Purchasing Resolution, the employees of which contractor are prohibited from engaging in the unlawful manufacture, sale, distribution, dispensation, possession or use of any controlled substance or marijuana during the performance of the contract.

19. SAFETY
The Contractor shall comply with, and ensure that the Contractor’s employees and subcontractors comply with, all current applicable local, state and federal policies, regulations and standards relating to safety and health, including, by way of illustration and not limitation, the standards of the Virginia Occupational Safety and Health program of the Department of Labor and Industry for General Industry and for the Construction Industry, the Federal Environmental Protection Agency standards and the applicable standards of the Virginia Department of Environmental Quality.

The Contractor shall provide, or cause to be provided, all technical expertise, qualified personnel, equipment, tools and material to safely accomplish the work specified to be performed by the Contractor and subcontractor(s).

The Contractor shall identify to the County Project Officer at least one (1) on-site person who is the Contractor’s competent, qualified, and authorized person on the worksite and who is, by training or experience, familiar with and trained in policies, regulations and standards applicable to the work being performed. The competent, qualified and authorized person must be capable of identifying existing and predictable hazards in the
surroundings or working conditions which are unsanitary, hazardous or dangerous to employees, shall be capable of ensuring that applicable safety regulations are complied with, and shall have the authority and responsibility to take prompt corrective measures, which may include removal of the Contractor's personnel from the work site.

The Contractor shall provide to the County, at the County’s request, a copy of the Contractor's written safety policies and safety procedures applicable to the scope of work. Failure to provide this information within seven (7) days of the County's request may result in cancellation of this Contract.

20. **TERMINATION FOR CAUSE, INCLUDING BREACH AND DEFAULT; CURE**

   a. The Contract will remain in force for the full period specified and until the County determines that all requirements and conditions have been satisfactorily met and the County has accepted the Work, and thereafter until the Contractor has met all requirements and conditions relating to the Work under the Contract Documents following the Initial Contract Term and all Subsequent Contract Terms, including warranty and guarantee periods. However, the County will have the right to terminate this Contract sooner if the Contractor has failed to perform satisfactorily the Work required, as determined by the County in its discretion.

   In the event the County decides to terminate this Contract for failure to perform satisfactorily, the County will give the Contractor at least thirty (30) days written notice before the termination takes effect. Such thirty (30) day period will begin upon the mailing of notice by the County.

   Except as otherwise directed by the County, or in the case of termination for default (in which event the Contractor may be entitled to cure, at the option of the County), the Contractor shall stop Work on the date of receipt of notice of the termination or other date specified in the notice, place no further orders or subcontracts for materials, services, or facilities except as are necessary for the completion of such portion of the Work not terminated, and terminate all vendors and subcontracts and settle all outstanding liabilities and claims.

   In the event any termination for default shall be found to be improper or invalid by any court of competent jurisdiction, then such termination shall be deemed to have been a termination for convenience.

   b. Contractor may terminate this Agreement for non-payment of Premium. Upon nonpayment of Premium, contractor will notify the County of the past-due amount and the effective date of termination, which will be 15 days from the date of the written notice. The 15 days from the written notice by the Contractor to the termination date will constitute a grace period. This Agreement will remain in full force and effect throughout the grace period. If the Contractor receives full payment within the grace period, this Agreement will continue in effect according to the terms and conditions in the Agreement.

   If the Contractor does not receive full payment by the end of the grace period, this Agreement will be terminated without further extension or consideration. The County will be liable for all unpaid amounts due through the date of termination.

   c. If the County fails to (a) adhere to the Contractor’s contribution or participation requirements or (b) performs an act that constitutes fraud or intentional misrepresentation of material information to Contractor under the terms of coverage, Contractor will terminate this Agreement with 31 days prior written notice to the County.

   d. Contractor may terminate this Agreement upon 31 days written notice to the County if no eligible person lives, resides, or works in the Contractor’s Service Area as described in Exhibits C and D.
e. Contractor may terminate a particular product or all products offered in a small or large group market as permitted by the Health Insurance Portability and Accountability Act of 1996 (HIPAA). If Contractor discontinues offering a particular product, Contractor may terminate this Agreement upon 90 days written notice prior to the date of nonrenewal to each affected policyholder, plan sponsor, participant and beneficiary.

Contractor shall offer the County another product then offered to groups in its respective market. Contractor shall act uniformly without regard to the claims experience of any affected plan sponsor, or any health status-related factor of any individual.

Health status-related factor means a factor related to (i) health status; (ii) medical condition; (iii) claims experience; (iv) receipt of health care; (v) medical history; (vi) genetic information; (vii) evidence of insurability including conditions arising out of acts of domestic violence; or, (viii) disability.

If Contractor discontinues offering all products to small and/or large group markets, Contract may terminate this Agreement upon 180 days written notice to County. Upon at least 30 working days before that notice, Contractor shall give notice to the Commissioner, and may not write new business for groups in the state for a five-year period beginning on the date of notice to the Commissioner, and no other product will be offered to the County. For purposes of this section, a “product” is a combination of benefits and services provided to members, each such product being defined by a distinct disclosure form or evidence of coverage.

f. Contractor may terminate the County for failure to comply with Contractor provisions that have been approved by the State Corporation Commission.

21. TERMINATION FOR THE CONVENIENCE OF THE COUNTY
The performance of work under this Contract may be terminated by the County’s Purchasing Agent in whole or in part whenever the Purchasing Agent shall determine that such termination is in the County’s best interest. Any such termination shall be effected by the delivery to the Contractor of a written notice of termination at least ninety (90) days before the date of termination, specifying the extent to which performance of the work under this Contract is terminated and the date upon which such termination becomes effective.

After receipt of a notice of termination and except as otherwise directed, the Contractor shall stop all designated work on the date of receipt of the notice of termination or other date specified in the notice; place no further orders or subcontracts for materials, services or facilities except as are necessary for the completion of such portion of the work not terminated; immediately transfer all documentation and paperwork for terminated work to the County; and terminate all vendors and subcontracts and settle all outstanding liabilities and claims.

22. INDEMNIFICATION
The Contractor covenants for itself, its employees, and subcontractors to save, defend, hold harmless and indemnify the County, and all of its elected and appointed officials, officers, current and former employees, agents, departments, agencies, boards, and commissions (collectively the “County” for purposes of this section) from and against any and all claims made by third parties or by the County for any and all losses, damages, injuries, fines, penalties, costs (including court costs and attorney’s fees), charges, liability, demands or exposure, however caused, resulting from, arising out of, or in any way connected with the Contractor’s acts or omissions, including the acts or omissions of its employees and/or subcontractors, in performance or nonperformance of the work called for by the Contract Documents. This duty to save, defend, hold harmless and indemnify shall survive the termination of this Contract. If, after notice by the County, the Contractor fails or refuses to fulfill its obligations contained in this section, the Contractor shall be liable for and reimburse the County for any and all expenses, including but not limited to, reasonable attorneys’ fees incurred and any settlements or payments made. The Contractor shall pay such expenses upon demand by the County and failure to do so may result in such amounts being withheld from any amounts due to Contractor under this Contract.
23. INTELLECTUAL PROPERTY INDEMNIFICATION
The Contractor warrants and guarantees that no intellectual property rights (including, but not limited to, copyright, patent, mask rights and trademark) of third parties are infringed or in any manner involved in or related to the services provided hereunder.

The Contractor further covenants for itself, its employees, and subcontractors to save, defend, hold harmless, and indemnify the County, and all of its officers, officials, departments, agencies, agents, and employees from and against any and all claims, losses, damages, injuries, fines, penalties, costs (including court costs and attorney's fees), charges, liability, or exposure, however caused, for or on account of any trademark, copyright, patented or unpatented invention, process, or article manufactured or used in the performance of this Contract, including its use by the County. If the Contractor, or any of its employees or subcontractors, uses any design, device, work, or materials covered by letters patent or copyright, it is mutually agreed and understood, without exception, that the Contract Amount includes all royalties, licensing fees, and any other costs arising from the use of such design, device, work, or materials in any way involved with the Work. This duty to save, defend, hold harmless and indemnify shall survive the termination of this Contract. If, after Notice by the County, the Contractor fails or refuses to fulfill its obligations contained in this section, the Contractor shall be liable for and reimburse the County for any and all expenses, including but not limited to, reasonable attorneys’ fees incurred and any settlements or payments made. The Contractor shall pay such expenses upon demand by the County and failure to do so may result in such amounts being withheld from any amounts due to Contractor under this Contract.

24. OWNERSHIP AND RETURN OF RECORDS
The Contractor agrees that all findings, memoranda, correspondence, documents or records of any type, whether written or oral, and all documents generated by the Contractor or its subcontractors as a result of the County's request for services under this Contract, are confidential records ("Record" or "Records"), and neither the Records nor their contents shall be released by the Contractor, its subcontractors, or other third parties; nor shall their contents be disclosed to any person other than the Project Officer or designee. The Contractor agrees that all oral or written inquiries from any person or entity regarding the status of any Record generated as a result of the existence of this Contract shall be referred to the Project Officer or designee for response. Except for those Records containing information which is Protected Health Information (PHI), as defined by HIPAA and implementing regulations issued thereunder from time to time, for which Contractor is subject to privacy and security obligations under HIPAA, at the County’s request, the Contractor shall deliver all Records to the Project Officer, including “hard copies" of computer records, and at the County’s request, shall destroy all computer records created as a result of the County’s request for services under this Contract.

The Contractor agrees to include the provisions of this section as part of any Contract or Agreement the Contractor enters into with subcontractors or other third parties for work related to work pursuant to this Agreement.

No termination of this Agreement shall have the effect of rescinding, terminating or otherwise invalidating this section. The Contractor’s obligations under this section are also subject to the Section entitled “HIPAA Compliance”.

25. DATA SECURITY AND PROTECTION
The Contractor shall hold County Information in the strictest confidence and comply with all applicable County security and network resources policies as well as all local, state and federal laws or regulatory requirements concerning data privacy and security. The Contractor shall develop, implement, maintain, continually monitor and use appropriate administrative, technical and physical security measures to preserve the confidentiality, privacy, integrity and availability of all electronically maintained or transmitted County Information received from, created or maintained on behalf of the County and strictly control access to County Information. For purposes of this provision, and as more fully described in this Contract, “County Information" (also referred to as “County Data” or “data”) includes, but is not limited to, electronic information, documents, data, images, and records including, but not limited to, financial records, personally identifiable information. Contractor shall safeguard PHI in accordance with HIPAA and all other applicable state and federal law concerning the privacy, security and integrity of health information] personnel, educational, voting, registration, tax or assessment records, information related to public
safety, County networked resources, and County databases, software and security measures which is created, maintained, transmitted or accessed to perform the work under this Contract.

a. **Use of Data.** The Contractor shall ensure that the use, distribution, disclosure or access (“use”) to County Information and County networked resources shall not occur in an unauthorized manner. Use of County Information for other than as specifically outlined in this Contract is strictly prohibited, unless such other use is agreed to in writing by the parties. The Contractor will be solely responsible for any unauthorized use, reuse, distribution, transmission, manipulation, copying, modification, access or disclosure of County Information and any non-compliance with this DATA SECURITY AND PROTECTION provision.

b. **Data Protection.** The Contractor agrees that it will protect the County’s Information according to standards established by the National Institute of Standards and Technology, including 201 CMR 17.00, Standards for the Protection of Personal Information of Residents of the Commonwealth and the Payment Card Industry Data Security Standard (PCI DSS), as applicable, and no less rigorously than it protects its own data, proprietary and/or confidential information. The Contractor shall allow the County access to its data security policy and procedures for securing County Information and a copy of its disaster recovery plan/s. The Contractor shall provide, if requested by the County, on an annual basis, results of an internal Information Security Risk Assessment provided by an outside firm.

c. **Data Sharing.** Except as otherwise specifically provided for in this Contract, the Contractor agrees that it shall not share, disclosure, sell or grant access to County Information to any third party without the express written authorization of the County’s Chief Information Security Officer or designee.

d. **Security Requirements.** The Contractor shall maintain industry standard anti-virus, industry accepted firewalls and/or other protections on its systems and networking equipment. The Contractor certifies that all systems and networking equipment that support, interact or store County Information meet the above standards and industry best practices for physical, network and system security requirements. Printers, copiers or fax machines that store County Data into hard drives must provide data at rest encryption. Significant deviation from these standards must be approved by the County’s Chief Information Security Officer or designee. The downloading of County information onto laptops or other portable storage medium is prohibited without the express written authorization of the County’s Chief Information Security Officer or designee.

e. **Data Protection Upon Conclusion of Contract.** Upon termination, cancellation, expiration or other conclusion of this Contract, the Contractor shall return all County Information to the County unless the County requests that such data be destroyed. This provision shall also apply to all County Information that is in the possession of subcontractors or agents of the Contractor. The Contractor shall complete such return or destruction not less than thirty (30) days after the conclusion of this Agreement and shall certify completion of this task, in writing, to the County Project Officer.

f. **Notification of Security Incidents.** The Contractor agrees to notify the County Chief Information Officer and County Project Officer within twenty-four (24) hours of the discovery of any unintended access to, use or disclosure of County Information.

g. **Subcontractors.** To the extent the use of subcontractors is permitted under this Contract, the requirements of this entire section shall be incorporated into any subcontractor agreement entered into by the Contractor and any data sharing shall be compliant with these security and protection requirements. In the event of data sharing, subcontractors shall provide to the Contractor a copy of their data security policy and procedures for securing County Information and a copy of their disaster recovery plan/s.
26. **ETHICS IN PUBLIC CONTRACTING**
This Contract incorporates by reference Article 9 of the Arlington County Purchasing Resolution, as well as any state or federal law related to ethics, conflicts of interest, or bribery, including by way of illustration and not limitation, the State and Local Government Conflict of Interests Act (Code of Virginia § 2.2-3100 et seq.), the Virginia Governmental Frauds Act (Code of Virginia § 18.2-498.1 et seq.), and Articles 2 and 3 of Chapter 10 of Title 18.2 of the Code of Virginia, as amended (§ 18.2-438 et seq.). The Contractor certifies that its offer was made without collusion or fraud and that it has not offered or received any kickbacks or inducements from any other offeror, supplier, manufacturer, or subcontractor and that it has not conferred on any public employee having official responsibility for this procurement any payment, loan, subscription, advance, deposit of money, services, or anything of more than nominal value, present or promised unless consideration of substantially equal or greater value was exchanged.

27. **COUNTY EMPLOYEES**
No employee of Arlington County, Virginia, shall be admitted to any share in any part of this Contract or to any benefit that may arise therefrom which is not available to the general public.

28. **FORCE MAJEURE**
The Contractor shall not be held responsible for failure to perform the duties and responsibilities imposed by this Contract if such failure is due to fires, riots, rebellions, natural disasters, wars, or an act of God beyond control of the Contractor, and outside and beyond the scope of the Contractor’s then current, by industry standards, disaster plan, that make performance impossible or illegal, unless otherwise specified in the Contract.

The County shall not be held responsible for failure to perform its duties and responsibilities imposed by the Contract if such failure is due to fires, riots, rebellions, natural disasters, wars, or an act of God beyond control of the County that make performance impossible or illegal, unless otherwise specified in the Contract.

29. **AUTHORITY TO TRANSACT BUSINESS**
The Contractor shall pursuant to Code of Virginia § 2.2-4311.2, be and remain authorized to transact business in the Commonwealth of Virginia during the Initial Term and any Subsequent Contract Term(s) of this Contract. A contract entered into by a Contractor in violation of this requirement is voidable, without any cost or expense, at the sole option of the County.

30. **RELATION TO COUNTY**
The Contractor is an independent contractor and neither the Contractor nor its employees or subcontractors will, under any circumstances, be considered employees, servants or agents of the County. The County will not be legally responsible for any negligence or other wrongdoing by the Contractor, its employees, servants or agents. The County will not withhold payments to the Contractor for any federal or state unemployment taxes, federal or state income taxes, Social Security tax, or any other amounts for benefits to the Contractor. Furthermore, the County will not provide to the Contractor any insurance coverage or other benefits, including workers’ compensation, normally provided by the County for its employees.

31. **ANTI TRUST**
By entering into this Contract, the Contractor conveys, sells, assigns and transfers to the County all rights, title, and interest in and to all causes of action the Contractor may now have or hereafter acquire under the antitrust laws of the United States or the Commonwealth of Virginia, relating to the goods or services purchased or acquired by the County under this Contract.
32. REPORT STANDARDS
Reports or written material prepared by the Contractor in response to the requirements of this Contract or a request of the Project Officer shall, unless otherwise provided for in the Contract, meet standards of professional writing established for the type of report or written material provided, shall be thoroughly researched for accuracy of content, shall be grammatically correct and not contain spelling errors, shall be submitted in a format approved in advance by the Project Officer, and shall be submitted for advance review and comment by the Project Officer. The cost of correcting grammatical errors, correcting report data, or other revisions required to bring the report or written material into compliance with these requirements shall be borne by the Contractor.

When submitting documents to the County, the Contractor shall comply with the following guidelines:

- All submittals and copies shall be printed on at least thirty percent (30%) recycled-content and/or tree-free paper;
- All copies shall be double-sided;
- Report covers or binders shall be recyclable, made from recycled materials, and/or easily removable to allow for recycling of report pages (reports with glued bindings that meet all other requirements are acceptable);
- The use of plastic covers or dividers should be avoided; and
- Unnecessary attachments or documents not specifically asked for should not be submitted, and superfluous use of paper (e.g. separate title sheets or chapter dividers) should be avoided.

33. AUDIT
Subject to its obligations to protect PHI under HIPAA and applicable state and federal law, the Contractor agrees to retain all books, records and other documents related to this Contract for at least five (5) years after final payment. The County or its authorized agents shall have access to and the right to examine any of the above documents during this period and during the Initial Contract Term and any Subsequent Contract Term. If the Contractor wishes to destroy or dispose of records (including confidential records to which the County does not have ready access) within five (5) years after final payment, the Contractor shall notify the County at least thirty (30) days prior to such disposal, and if the County objects, shall not dispose of the records.

34. ASSIGNMENT
The Contractor shall not assign, transfer, convey, sublet, or otherwise dispose of any award, or any or all of its rights, obligations, or interests under this Contract, without the prior written consent of the County.

35. AMENDMENTS
a. This Contract shall not be amended except by written amendment executed by persons duly authorized to bind the Contractor and the County.

b. Upon 45 days prior written notice to the County, Contractor may amend this Agreement with regard to premiums, benefits, limitations, exclusions, or conditions, to be effective on the Anniversary Date.

c. When decreasing benefits or increasing rates by more than 35%, Contractor must notify County at least 60 days prior to the effective date of such change.

d. In addition, Contractor may, subject to government approval, amend this Agreement at any time by giving 45 days prior written notice to County in order to (a) comply with applicable law; (b) reduce or expand Service Area; or, (c) increase any benefits of any Medicare product approved by CMS, if applicable to this Agreement.

36. ARLINGTON COUNTY PURCHASING RESOLUTION AND COUNTY POLICIES
Notwithstanding any provision to the contrary herein, no provision of the Arlington County Purchasing Resolution or any applicable County policy is waived in whole or in part.
37. DISPUTE RESOLUTION
All disputes arising under this Agreement, or its interpretation, whether involving law or fact, or extra work, or extra compensation or time, and all claims for alleged breach of Contract shall be submitted to the Project Officer for decision at the time of the occurrence or beginning of the work upon which the claim is based, whichever occurs first. Any such claims shall state the facts surrounding it in sufficient detail to identify it together with its character and scope. In accordance with the Arlington County Purchasing Resolution, claims denied by the Project Officer may be submitted to the County Manager in writing no later than sixty (60) days after final payment. The time limit for final written decision by the County Manager in the event of a contractual dispute, as that term is defined in the Arlington County Purchasing Resolution, is thirty (30) days. Procedures for considering contractual claims, disputes, administrative appeals, and protests are contained in the Purchasing Resolution, which is incorporated herein by reference. A copy of the Arlington County Purchasing Resolution is available upon request from the Office of the Purchasing Agent. The Contractor shall not cause a delay in the Work pending a decision of the Project Officer, County Manager, County Board, or a court.

38. APPLICABLE LAW, FORUM, VENUE AND JURISDICTION
This Contract and the work performed hereunder shall be governed in all respects by the laws of the Commonwealth of Virginia and the jurisdiction, forum, and venue for any litigation with respect thereto shall be in the Circuit Court for Arlington County, Virginia, and in no other court. In performing the Work under this Contract, the Contractor shall comply with applicable federal, state, and local laws, ordinances and regulations.

39. ARBITRATION
It is expressly agreed that nothing under the Contract shall be subject to arbitration, and any references to arbitration are expressly deleted from the Contract.

40. NONEXCLUSIVITY OF REMEDIES
All remedies available to the County under this Contract are cumulative, and no such remedy shall be exclusive of any other remedy available to the County at law or in equity.

41. NO WAIVER
The failure of either party to exercise in any respect a right provided for in this Contract shall not be deemed to be a subsequent waiver of the same right or any other right.

42. SEVERABILITY
The sections, paragraphs, sentences, clauses and phrases of this Contract are severable, and if any phrase, clause, sentence, paragraph or section of this Contract shall be declared invalid by a court of competent jurisdiction, such invalidity shall not affect any of the remaining phrases, clauses, sentences, paragraphs and sections of this Contract.

43. NO WAIVER OF SOVEREIGN IMMUNITY
Notwithstanding any other provision of this Contract, nothing in this Contract or any action taken by the County pursuant to this Contract shall constitute or be construed as a waiver of either the sovereign or governmental immunity of the County. The parties intend for this provision to be read as broadly as possible.

44. SURVIVAL OF TERMS
In addition to any numbered section in this Agreement which specifically state that the term or paragraph survives the expiration of termination of this Contract, the following sections if included in this Contract also survive: INDEMNIFICATION; RELATION TO COUNTY; OWNERSHIP AND RETURN OF RECORDS; AUDIT; WARRANTY; CONFIDENTIAL INFORMATION; AND DATA SECURITY.

45. HEADINGS
The section headings in this Contract are inserted only for convenience and are not to be construed as part of this Contract or a limitation on the scope of the particular section to which the heading precedes.
46. AMBIGUITIES
Each party and its counsel have participated fully in the review and revision of this Agreement. Any rule of construction to the effect that ambiguities are to be resolved against the drafting party shall not apply in interpreting this Agreement. The language in this Agreement shall be interpreted as to its fair meaning and not strictly for or against any party.

47. NOTICES
Unless otherwise provided herein, all notices and other communications required by this Contract shall be deemed to have been given when made in writing and either (a) delivered in person, (b) delivered to an agent, such as an overnight or similar delivery service, or (c) deposited in the United States mail, postage prepaid, certified or registered, addressed as follows:

TO THE CONTRACTOR:

Chris Urban
Senior Manager
KPMAS Large Group Account Management
2101 E. Jefferson Street
Rockville, MD 20849

TO THE COUNTY:

Kristin L. Young, Project Officer
2100 Clarendon Blvd, Suite 511
Arlington, VA 22201

AND

Richard D. Warren, Jr., Purchasing Agent
Arlington County Government
2100 Clarendon Boulevard, Suite 500
Arlington, Virginia 22201

48. NON-DISCRIMINATION NOTICE
Arlington County does not discriminate against faith-based organizations.

49. INSURANCE REQUIREMENTS
The Contractor shall provide to the County Purchasing Agent a Certificate of Insurance indicating that the Contractor has in force the coverage below prior to the start of any Work under this Contract and upon any contract extension. The Contractor agrees to maintain such insurance until the completion of this Contract or as otherwise stated in the Contract Documents. All required insurance coverage must be acquired from insurers authorized to do business in the Commonwealth of Virginia, with a rating of “A-“ or better and a financial size of “Class VII“ or better in the latest edition of the A.M. Best Co. Guides, and acceptable to the County. The minimum insurance coverage shall be:

a. Workers Compensation - Virginia Statutory Workers Compensation (W/C) coverage including Virginia benefits and employers liability with limits of $100,000/100,000/500,000. The County will not accept W/C coverage issued by the Injured Worker’s Insurance Fund, Towson, MD.
b. Commercial General Liability - $1,000,000 combined single limit coverage with $2,000,000 general aggregate covering all premises and operations and including Personal Injury, Completed Operations, Contractual Liability, Independent Contractors, and Products Liability. The general aggregate limit shall apply to this Contract. Evidence of Contractual Liability coverage shall be typed on the certificate.

c. Business Automobile Liability - $1,000,000 Combined Single Limit ( Owned, non-owned and hired).

d. The Contractor shall carry Errors and Omissions or Professional Liability insurance which will pay for injuries arising out of errors or omissions in the rendering, or failure to render services or perform Work under the contract, in the amount of $1,000,000.

e. Additional Insured - Arlington County, and its officers, elected and appointed officials, employees, and agents shall be named as additional insured’s on all policies except Workers Compensation and Auto and Professional Liability; and evidence of the Additional Insured endorsement shall be typed on the certificate.

f. Cancellation - All insurance policies required by this Contract shall be endorsed to include the following provision: "It is agreed that this policy is not subject to cancellation or non-renewal until thirty (30) days prior written notice has been given to the Purchasing Agent, Arlington County, Virginia." If there is a material change or reduction in coverage the Contractor shall notify the Purchasing Agent immediately upon Contractor's notification from the insurer. Any policy on which the Contractor has received notification from an insurer that the policy has or will be cancelled or materially changed or reduced must be replaced with another policy consistent with the terms of this Contract, and the County notified of the replacement, in such a manner that there is no lapse in coverage. Not having the required insurance throughout the Contract Term is grounds for termination of the Contract.

g. Healthcare Liability – Prior to award, the Contractor will provide evidence of professional liability insurance for each healthcare provider employed by the Contractor or otherwise providing medical services through this plan.

h. The Contractor shall carry Professional Liability insurance which will pay for injuries arising out of errors or omissions in the rendering, or failure to render professional services or perform Work under the contract, in the amount of $1,000,000.

i. Contract Identification - The insurance certificate shall state this Contract’s number and title.

The Contractor must disclose the amount of any deductible or self-insurance component applicable to the General Liability, Automobile Liability, Professional Liability, Intellectual Property or any other policies required herein, if any. The County reserves the right to request additional information to determine if the Contractor has the financial capacity to meet its obligations under a deductible. Thereafter, at its option, the County may require a lower deductible, funds equal to the deductible be placed in escrow, a certificate of self-insurance, collateral, or other mechanism in the amount of the deductible to ensure protection for the County.

The Contractor shall require all subcontractors to maintain during the term of this Contract, Commercial General Liability insurance, Business Automobile Liability insurance, and Workers’ Compensation insurance in the same form and manner as specified for the Contractor. The Contractor shall furnish subcontractors’ certificates of insurance to the County immediately upon request by the County.

No acceptance or approval of any insurance by the County shall be construed as relieving or excusing the Contractor from any liability or obligation imposed upon the Contractor by the provisions of the Contract Documents.

The Contractor shall be responsible for the work performed under the Contract Documents and every part thereof, and for all materials, tools, equipment, appliances, and property of any description used in connection with the
work. The Contractor assumes all risks for direct and indirect damage or injury to the property or persons used or employed on or in connection with the Work contracted for, and of all damage or injury to any person or property wherever located, resulting from any action, omission, commission or operation under the Contract, or in connection in any way whatsoever with the contracted work.

The Contractor shall be as fully responsible to the County for the acts and omissions of its subcontractors and of persons employed by them as it is for acts and omissions of persons directly employed by it.

Notwithstanding any of the above, the Contractor may satisfy its obligations under this section by means of self-insurance for all or any part of the insurance required, provided that the Contractor can demonstrate financial capacity and the alternative coverage is submitted to and acceptable to the County. The Contractor must also provide its most recent actuarial report and provide a copy of its self-insurance resolution to determine the adequacy of the insurance funding.

50. ACCESSIBILITY OF WEB SITE
If any work performed under this Contract results in design, development, maintenance or responsibility for content and/or format of any County websites, or County’s presence on other third party websites, the Contractor shall perform such work in compliance with the Americans with Disabilities Act of 1990 (“ADA”).

51. HIPAA COMPLIANCE
The Contractor shall comply with all applicable legislative and regulatory requirements of privacy, security, and electronic transaction components of the Health Insurance Portability and Accountability Act of 1996, as amended (“HIPAA”). Contractor takes full responsibility for any failure to execute the appropriate Business Associate Agreements with its subcontractors and for the failure of its subcontractors to comply with the existing or future regulations of HIPAA and/or HITECH, and shall indemnify County for any and all loss, damages, liability, exposure, or costs resulting therefrom.

52. ADA COMPLIANCE
Compliance with the Americans with Disabilities Act (ADA) shall be the sole responsibility of the Contractor. The Contractor shall defend and hold the County harmless from any expense or liability arising from the Contractor’s non-compliance therewith. The Contractor’s responsibilities related to ADA compliance shall include, but not be limited to, the following:

a. Access to Programs, Services and/or Facilities: The Contractor shall ensure its programs; services and facilities are accessible to persons with disabilities. If a particular facility or program is not accessible, the Contractor shall provide equivalent services in an accessible alternate location or manner to ensure that persons with disabilities are not denied access to services.

b. Effective Communication: The Contractor, upon request, shall provide appropriate aids and services leading to effective communication for qualified persons with disabilities so they can participate equally in the Contractor’s programs, services, and activities, including qualified sign language interpreters, documents in Braille, and other ways of making information and communications accessible to people who have speech, hearing, or vision impairments, as required by the ADA.

c. Modifications to Policies and Procedures: The Contractor shall make the necessary modifications to its policies and procedures to ensure that people with disabilities have an equal opportunity to enjoy the Contractor’s programs, services, and activities, as may be required by the ADA. For example, individuals with service animals are welcomed in the Contractor’s offices or facilities, even where pets are generally prohibited.

d. The Contractor shall not place a surcharge on a person with a disability or any group of individuals with disabilities to cover the cost of providing auxiliary aids/services or reasonable modifications of policy.
e. Employment: The Contractor shall not discriminate on the basis of disability in its hiring or employment practices.

f. Responding to inquiries from the U.S. Department of Labor.

WITNESS these signatures:

THE COUNTY BOARD OF ARLINGTON COUNTY, VIRGINIA

AUTHORIZED SIGNATURE: [Signature]

NAME: RICHARD D. WARREN, JR.
TITLE: PURCHASING AGENT
DATE: 12/16/14

KAISER FOUNDATION HEALTH PLAN OF THE MID- ATLANTIC STATES, INC.
EIN: 52-0954463

AUTHORIZED SIGNATURE: [Signature]

NAME: Mark Ruszczyk
TITLE: Vice President, Marketing, Sales and Business Development

DATE: [Signature]

Agreement 684-14
AGREEMENT 564-14
EXHIBIT A
SCOPE OF SERVICES

Plan Year:
The County’s plan years shall be as follows:

For services provided to Active Employees and Pre-Medicare Retirees, the plan year shall be from July 1st to June 30th of the following calendar year.

For service provided to Medicare eligible participants, the plan year shall be from January 1 to December 31 of each calendar year.

Scope of Work

Contractor shall provide and administer fully insured medical and prescription drug plan services for County employees, pre-Medicare and Medicare retirees, and their eligible dependents as outlined in Exhibit C throughout the plan year. The Contractor shall provide a fully insured Medicare Advantage plan (a plan that receives reimbursement from Medicare for Medicare covered services) for the benefit of Medicare eligible retirees and dependents enrolled in Medicare Parts A and B, as outlined in Exhibit D.

A detailed listing of other services is as follows:

Administration

1. Provide enrollment, transfer and termination services through secure electronic file transfer from the County to the Contractor for active employees and through paper forms for retirees. Provide quality assurance procedures to ensure enrollment data is accurate in the Contractor’s information.
2. Review weekly electronic enrollment files and identify discrepancies. Communicate discrepancies via a weekly error report to the County Benefits staff.
3. Attend annual County Open Enrollment meetings -- approximately 5 per plan year -- and other benefits-related events as requested by County staff.
4. Provide enrollment materials (plan summaries and additional benefit literature) in hardcopy and electronic copy.
5. Provide enrollment/identification cards and member handbooks (plan descriptions) to all new enrollees and upon request from members.
6. Administer an individual direct pay COBRA services for members identified by the County as eligible for continuation of coverage and who have elected Kaiser for this purpose. The County Benefits staff shall identify and contact former group members eligible for COBRA, and provide individuals with the required paperwork to continue coverage through Contractor. Eligible members shall send their Kaiser COBRA election forms directly to the Contractor. The Contractor shall provide COBRA coverage to individuals on an individual direct pay basis.
7. Provide terminating members with HIPAA certificates of coverage.
8. Directly contact and assist newly Medicare eligible retirees with enrollment in Kaiser’s Medicare product.
9. Monitor and confirm disabled dependent status of dependents by directly requesting confirmation of status for over-age dependents from the plan participant/member.
10. Provide the County with a monthly listing of dependents on the plan who turn 26 years old within the next 90 days.
11. Partner with the County on wellness and disease management by providing services outlined in the Wellness and Disease Management section and by recommending cost saving strategies for our plan.
12. Each year, upon request from the County Benefits Staff, provide analysis and recommendations to the County Benefits staff regarding plan design changes. Detail any potential cost impact to the County and/or participating Kaiser members.

Wellness and Disease Management
1. Provide evidence-based prevention and care management programs to participating members, including but not limited to:
   • Disease management and prevention programs
   • Gaps in care
   • Medication adherence
   • Coaching programs for chronic conditions such as diabetes, low back pain and osteoarthritis
   • Programs to promote healthy pregnancies and babies
   • Tobacco cessation programs
   • Programs to address lifestyle issues such as weight management and stress management
2. Provide participating members with access to interactive seminars, health fairs, communication resources, and presentations aimed at helping members achieve health goals.
3. Provide participating members with discounts at select fitness centers.
4. Provide health education materials and information to members via a website or toll free “health phone” number, which contains prerecorded messages on 200+ health and wellness topics.
5. Provide online wellness tools to participating members, including a health risk assessment.
6. Provide participating members with discounts of up to 20% to Weight Watchers.

Customer Service/Communication
1. Provide telephone customer service at a minimum of 7:30 a.m. to 5:30 p.m., Monday through Friday, EST.
2. Maintain a toll-free access to customer service call center with TTD or TTY services for hearing impaired members.
3. Maintain a multi-lingual customer service unit to respond to member inquiries.
4. Website and mobile application to provide secure online access for members to perform such functions as: view lab results, email physician, schedule and view appointments, request changes to medical records, order prescription refills, view immunization records, view benefits.
5. Resolve claim or membership issues.
6. Respond to requests from employees and dependents for access, amendment, and accounting of Protected Health Information and to requests for restrictions and alternative communications as required under Federal HIPAA law and regulations pursuant to terms set out in this Agreement and its Exhibits.

Reporting
1. Provide County Benefits staff with quarterly and annual reports to include at least premium to claims ratios, high cost claimant report, utilization of services, and identification of cost drivers.
2. Provide County Benefits staff with annual reporting on performance measures and guarantees
3. Provide County Benefits staff with a monthly billing roster that provides enrollment data, coverage tier, and cost.
4. Provide County Benefits staff with ad hoc reports upon request including: plan census information, dependents aging out and members eligible for Medicare due to age and/or disability.
AGREEMENT 564-14
EXHIBIT B
PRICING, PAYMENTS, AND PERFORMANCE GUARANTEES

Monthly pricing and annual performance guarantees will be negotiated for each plan for each plan year. Below are the negotiated rates and performance guarantees for the initial plan years.

I. Pricing:

Non-Medicare Plan (Exhibit C)
Monthly rates (also referred to as “premiums”) per enrolled employee/retiree for July 1, 2014 through June 30, 2015:

Subscriber: $472.80
Subscriber plus Spouse: $995.61
Subscriber plus 1 Child: $877.13
Subscriber plus 2 or more Children: $877.13
Subscriber plus Spouse plus 1 or more Children $1,442.97

Medicare Advantage Plan (Exhibit D)
Monthly rate (premium) per enrolled employee/retiree for January 1, 2014 through December 31, 2014:
Single: $267.70
2 Party: $535.40

Rate changes may only occur at the beginning of a plan year (July 1 for Non-Medicare Plans; January 1 for Medicare Plans). Amendments to this contract will be issued if plan design changes are implemented or rate changes occur for any particular plan or plan year.

Contractor shall provide the County with estimated rate changes prior to the beginning of the plan year.

- Estimated rate changes for Non-Medicare plans shall be presented to the County no later than October 15th for the plan year beginning the following July 1st.
- Estimated rate changes for Medicare plans shall be presented to the County no later than September 15th for the following January 1st.

II. Premiums and Payments

County shall pay to Contractor, for each employee/retiree and his or her covered dependents (collectively, “members”), the rates specified above for each month on or before the first of the month for which the coverage is effective. A grace period of 15 days from receipt is provided to review monthly billing statement received from Contractor.

a. New Members – Premiums are payable for new Members for the entire month regardless of the membership effective date. County shall continue to pay the premiums for each employee/retiree and his or her covered dependents covered under this Agreement until County provides electronic or written notice to Contractor to terminate such coverage.

b. Terminating Members – Premiums are payable for Members for the entire month regardless of the membership termination date from the County. County shall continue to pay the premiums for each employee/retiree and his or her dependents covered under this Agreement until County provides electronic or written notice to Contractor to terminate such coverage. Contractor will not terminate coverage until it has received County’s electronic or written notice. The effective date of termination will be the last day of the month in which the electronic or written notice is received by the Contractor, or the effective date stated by the County in the electronic or written notice.
c. **Premium Increase Due to Tax or Other Charge** - If a government agency or other taxing authority imposes or increases a tax or other charge (excluding a tax on or measured by revenue or net income) beyond that in place on January 1, 2014, upon Contractor or any of its contracting providers (or any of their activities) directly related to this Contract, then beginning on the effective date of that tax or charge, Contractor may calculate County’s Premiums to include County’s share of the new or increased tax or charge, subject to regulatory approval where required. County’s share is determined by dividing the number of Members enrolled through County by the total number of Members enrolled in the applicable Service Area.

d. **Clerical Errors** - If a clerical or administrative error made by County or Contractor results in an eligible person being incorrectly enrolled or not enrolled, then such error will be rectified by County and Contractor within 90 days of the error being found. County will receive a credit for monthly premiums paid in error. Credit of premiums will be for no more than 3 months of retroactive erroneous premiums paid. County will pay Contractor for all months of coverage for retroactive additions to the policy.

### III. Performance Standards and Guarantees

**A. Guaranteed Performance**

Contractor agrees to performance guarantees backed by a portion of County’s annual, non-Medicare premium for County’s Kaiser Permanente health coverage (hereafter “Health Plan”), provided County maintains an average of 1,000 or more members during plan year. The proposed penalty amounts shown on the following page assume an average Arlington County Government (hereafter “County”) membership of at least 1,000 non-Medicare members in the health plan. Penalties are calculated by multiplying the percentage shown by County’s total year-end, non-Medicare premium. If the plan year’s average membership is less than 1,000, no money will be placed at risk under this agreement.

**B. Changes in Measures**

If Contractor is unable to provide any of the information guaranteed in this agreement due to changes in any federal, state or local statutory or regulatory requirements, the measures affected by such action will not be subject to penalties. This includes any changes by NCQA in reporting rules, or decisions by NCQA regarding publication of the Quality Compass. Contractor does not accept conversions or substitutions of HEDIS or CAHPS measures. Should any guaranteed HEDIS or CAHPS measure be rotated by NCQA for calendar year 2014, it will be ignored for purposes of performance evaluation and penalty calculation.

**C. Penalty Thresholds and Reporting Frequency**

To the extent possible, Contractor sets the penalty thresholds (i.e., the performance level Contractor guarantees, and below which Contractor pays County a penalty) in alignment with industry benchmarks. Penalty thresholds for HEDIS or CAHPS measures are based on national or regional HMO averages as reported in the NCQA Quality Compass. Typically, in the fall of each year (after the annual release of HEDIS and CAHPS results) Contractor provides an annual performance report for the preceding year and a semi-annual performance report for the current year. If these reports are delayed due to circumstances beyond Contractor’s control, Health Plan will not be liable for any penalties related to these reporting measures.

Performance guarantees are offered on a calendar year basis (January 1 – December 31) and automatically renew during the term of the contract.

**D. Penalty Payments**

Contractor agrees to report performance results based on their annual (calendar year) performance. Thus, any penalty payments will be determined after the end of the year and will be based on County’s total non-Medicare premium for the calendar year. It is Contractor’s policy to pay agreed-upon penalties by check.

Penalty payments for sample-based measures are contingent on statistically meaningful variations from penalty thresholds. A standard statistical test is used to determine whether results are above or below the applicable state/regional or national average. If the test shows that the differences in the results are too large to be explained by random chance, but are true differences at least 95% of the time, the results are considered statistically different from the penalty threshold.
Issues leading to failure on measures of satisfaction with account management are defined as those related to the administration of the plan that are under the direct control of the account management team (e.g. adequately answers customer questions, keeps customer informed of new developments, effectively resolves administrative problems). Issues related to other health plan areas (e.g. pricing, member call centers, claims, or eligibility processing) are not applicable to these measures and/or may be covered by other measures in this agreement.

Account management measures are assumed met unless we are informed otherwise. Forfeiture on account management satisfaction measures will be contingent on prompt notification (within 30 days of a dissatisfying event and no later than November 1st of the agreement year) to account management staff of specific issues which may result in service failure, and adequate opportunity for resolution (agreement on corrective action plan and timeline). Failure of account management to develop and execute a corrective action plan constitutes failure on such measures.

Contractor requires that the County must be currently enrolled, and its account in good standing, at the end of the reporting period in order to receive any penalty payments for missed performance measures due under this agreement. Contractor also requires County to respond to Contractor in writing, either via mail or email, stating that County agrees with the penalty amount shown in Contractor’s final report and that County provides Contractor with the necessary information to send any penalties due to County under this agreement. County’s written response must be received within 60 days of County’s receipt of Contractor’s final report or County will forfeit any penalties otherwise due to County under this agreement.

E. Independent Auditing of Performance Results
Contractor’s performance guarantee results are self-reported. Independent and third-party audits of Contractor’s reported performance results are permitted for groups with an average enrollment of 1,000 or more non-Medicare members during the plan year. However, the audit must be conducted at the County’s expense. It is important to note that some information related to Personal Health Information (PHI) will not be available for auditing or may be “blinded” prior to review to protect patient confidentiality. All auditing entities and individuals will be required to sign appropriate confidentiality and disclosure statements, as specified by Contractor, prior to conducting the audit.

Audits must be requested with sufficient prior notice, as mutually determined by the County and Contractor, to allow Contractor to provide the necessary documentation and resources to support the audit. Furthermore, the requested documentation cannot be so great as to cause or create an unreasonable expense or interruption of service for Health Plan. Contractor reserves the right to negotiate with the County if it determines the request is unreasonable.

Audits must be requested within 30 calendar days of receiving Health Plan’s final annual report and may not be conducted more than once per calendar year.

All measures are based on plan-wide performance unless specified otherwise. Penalty thresholds and results are rounded to the nearest whole number or whole dollar (in the case of penalty amounts).
<table>
<thead>
<tr>
<th>Performance Guarantees</th>
<th>Penalty Threshold</th>
<th>Penalty¹</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Member Services &amp; Membership Administration Measures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Member Services call abandonment rate</td>
<td>≤ 5%</td>
<td>0.1%</td>
</tr>
<tr>
<td>2. Initial call resolution rate</td>
<td>≥ 90%</td>
<td>0.1%</td>
</tr>
<tr>
<td>3. ID cards distributed within 8 business days of receipt of eligibility file (guaranteed as accurate as Purchaser’s eligibility file)</td>
<td>≥ 90%</td>
<td>0.1%</td>
</tr>
<tr>
<td><strong>Access &amp; Satisfaction Measures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Health Plan will conduct an annual, Purchaser-specific member satisfaction survey and report results of members stating that they are “satisfied” or “very satisfied” with the overall care they receive from Health Plan.</td>
<td>≥ 80%</td>
<td>0.25%</td>
</tr>
<tr>
<td>5. PCPs with open panels (accepting new members)</td>
<td>≥ 85%</td>
<td>0.1%</td>
</tr>
<tr>
<td><strong>Claims Processing Measures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Complete, clean claims processed within 30 calendar days</td>
<td>≥ 95%</td>
<td>0.1%</td>
</tr>
<tr>
<td>7. Claims financial (dollar) accuracy rate</td>
<td>≥ 98.5%</td>
<td>0.1%</td>
</tr>
<tr>
<td>8. Claims procedural (clerical) accuracy rate</td>
<td>≥ 97%</td>
<td>0.1%</td>
</tr>
<tr>
<td><strong>Account Management Measures</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9. Overall satisfaction with account management</td>
<td>Satisfied; assumed met unless informed otherwise</td>
<td>0.25%</td>
</tr>
<tr>
<td>10. Satisfaction with account manager responsiveness (account manager responds to calls within one business day)</td>
<td>Satisfied; assumed met unless informed otherwise</td>
<td>0.1%</td>
</tr>
</tbody>
</table>

¹ Penalty amounts are determined by multiplying the percentage shown by the total non-Medicare premium dollars paid to Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. for the calendar year indicated.
<table>
<thead>
<tr>
<th>Performance Guarantees</th>
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</tr>
</thead>
<tbody>
<tr>
<td>11. Provide mutually agreed upon reports at mutually agreed intervals</td>
<td>Satisfied; assumed met unless informed otherwise</td>
<td>0.1%</td>
</tr>
<tr>
<td>12. Distribute up-to-date enrollment kits to Purchaser prior to open enrollment meetings</td>
<td>Satisfied; assumed met unless informed otherwise</td>
<td>0.1%</td>
</tr>
<tr>
<td>13. Provide Purchaser with benefits and financial contract within two months of effective date</td>
<td>Satisfied; assumed met unless informed otherwise</td>
<td>0.1%</td>
</tr>
<tr>
<td>14. Account management team is available for all employee and open enrollment events unless waived by Purchaser</td>
<td>Satisfied; assumed met unless informed otherwise</td>
<td>0.1%</td>
</tr>
<tr>
<td>15. Account management team ensures accurate benefits loaded into Health Plan claim adjudication system</td>
<td>Satisfied; assumed met unless informed otherwise</td>
<td>0.1%</td>
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<td>16. Health Plan agrees to update online provider directory on at least a quarterly basis</td>
<td>Satisfied; assumed met unless informed otherwise</td>
<td>0.1%</td>
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<td>17. Account management will report significant network changes and/or losses of providers with a panel of 50 or more Purchaser employees in a timely manner</td>
<td>Satisfied; assumed met unless informed otherwise</td>
<td>0.1%</td>
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<td><strong>TOTAL AT RISK</strong></td>
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<td><strong>2.0%</strong></td>
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AGREEMENT 564-14

EXHIBIT C

NON-MEDICARE PLAN DESIGN
KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.

GROUP
EVIDENCE OF COVERAGE

VIRGINIA

SIGNATURE CARE DELIVERY SYSTEM

This plan has Excellent accreditation from the NCQA
See 2014 NCQA Guide for more information on Accreditation

KAISER PERMANENTE
Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
2101 East Jefferson Street
Rockville, Maryland 20852

KFHP-EOC COVER (01/14)VA HMO

Agreement 564-14
IMPORTANT INFORMATION REGARDING YOUR INSURANCE

This company is subject to regulation in this Commonwealth by the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and by the Virginia Department of Health pursuant to Title 32.1.

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions you may contact Kaiser Permanente at the following address and telephone number:

   Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
   Box 6831
   2101 East Jefferson Street
   Rockville, MD 20852
   (301) 468-6000 or toll-free (800) 777-7902

We recommend that you familiarize yourself with our Getting Assistance; Claims and Appeal Procedures; and Customer Satisfaction Procedure as described in Section 5 of your Group Evidence of Coverage, and make use of it before taking any other action.

If you have been unable to contact or obtain satisfaction from the company or your agent, you may contact the Virginia State Corporation Commission’s Bureau of Insurance at:

   State Corporation Commission
   Bureau of Insurance
   P.O. Box 1157
   Richmond, VA 23218
   Consumer Services: (804) 371-9741 or toll-free (800) 552-7945
   National toll-free (877) 310-6560

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, Kaiser Permanente or the Bureau of Insurance, have your policy number available.
Table of Contents

SECTION 1 – INTRODUCTION ........................................................................................................... 1.1
   KAISER PERMANENTE SIGNATURESM ................................................................. 1.1
   HOW TO USE THIS EOC ................................................................................... 1.1
   WHO IS ELIGIBLE .............................................................................................. 1.1
       General ........................................................................................................... 1.1
       Subscribers .................................................................................................. 1.2
       Dependents .................................................................................................. 1.2
       Disabled Dependent Certification .............................................................. 1.2
       Genetic Information ..................................................................................... 1.2
   ENROLLMENT AND EFFECTIVE DATE OF COVERAGE .................................... 1.3
       New Employees and Their Dependents ....................................................... 1.3
       Special Enrollment ....................................................................................... 1.3
       Special Enrollment Due to New Dependents ............................................ 1.3
       Special Enrollment due to Court or Administrative Order ..................... 1.3
       Special Enrollment due to Loss of Other Coverage .................................... 1.4
       Special Enrollment due to Reemployment After Military Service ........... 1.4
       Special Enrollment due to Eligibility for Premium Assistance under Medicaid or CHIP 1.4
   OPEN ENROLLMENT .......................................................................................... 1.4
   PREMIUM ......................................................................................................... 1.4

SECTION 2 – HOW TO OBTAIN SERVICES ............................................................................... 2.1
   YOUR PRIMARY CARE PLAN PHYSICIAN ...................................................... 2.1
   CONTINUITY OF CARE .................................................................................. 2.1
   GETTING A REFERRAL ................................................................................... 2.1
   SERVICES RECEIVED FROM NON-PLAN PROVIDERS AT NON-PLAN FACILITIES WITHOUT A REFERRAL 2.2
   STANDING REFERRALS TO SPECIALISTS ................................................ 2.2
   SECOND OPINIONS ......................................................................................... 2.2
   GETTING THE CARE YOU NEED; EMERGENCY SERVICES, URGENT CARE AND ADVICE NURSES .... 2.2
   GETTING ADVICE FROM OUR ADVICE NURSES ....................................... 2.3
   MAKING APPOINTMENTS ............................................................................. 2.3
   MISSED APPOINTMENT FEE ......................................................................... 2.3
   USING YOUR IDENTIFICATION CARD .......................................................... 2.4
   VISITING OTHER KAISER PERMANENTE REGIONS OR GROUP HEALTH COOPERATIVE SERVICE AREAS 2.3
       Pre-Authorization Required for Certain Services .................................... 2.4
       Visiting Member Service Exclusions ......................................................... 2.4
   MOVING TO ANOTHER KAISER PERMANENTE REGION OR .... 2.3
   GROUP HEALTH COOPERATIVE SERVICE AREA ...................................... 2.4
   VALUE ADDED SERVICES ............................................................................. 2.5

SECTION 3 – BENEFITS ............................................................................................................. 3.1
   A. OUTPATIENT CARE ....................................................................................... 3.1
   B. HOSPITAL INPATIENT CARE ..................................................................... 3.2
   C. ACCIDENTAL DENTAL INJURY SERVICES ................................................ 3.2
   D. ALLERGY SERVICES .................................................................................... 3.2
   E. AMBULANCE SERVICES ............................................................................. 3.2
   F. ANESTHESIA FOR DENTAL SERVICES .................................................... 3.3
   G. BLOOD, BLOOD PRODUCTS AND THEIR ADMINISTRATION ................ 3.3
   H. CHEMICAL DEPENDENCY AND MENTAL HEALTH SERVICES .......... 3.3
   I. CLEFT LIP, CLEFT PALATE OR BOTH ...................................................... 3.4
<table>
<thead>
<tr>
<th>Section</th>
</tr>
</thead>
<tbody>
<tr>
<td>J. CLINICAL TRIALS</td>
</tr>
<tr>
<td>K. DIABETIC EQUIPMENT, SUPPLIES, AND SELF-MANAGEMENT</td>
</tr>
<tr>
<td>L. DIALYSIS</td>
</tr>
<tr>
<td>M. DRUGS, SUPPLIES, AND SUPPLEMENTS</td>
</tr>
<tr>
<td>N. DURABLE MEDICAL EQUIPMENT</td>
</tr>
<tr>
<td>O. EARLY INTERVENTION SERVICES</td>
</tr>
<tr>
<td>P. EMERGENCY SERVICES</td>
</tr>
<tr>
<td>Q. FAMILY PLANNING SERVICES</td>
</tr>
<tr>
<td>R. HEARING SERVICES</td>
</tr>
<tr>
<td>S. HOME HEALTH SERVICES</td>
</tr>
<tr>
<td>T. HOSPICE CARE SERVICES</td>
</tr>
<tr>
<td>U. INFERTILITY SERVICES</td>
</tr>
<tr>
<td>V. MATERNITY SERVICES</td>
</tr>
<tr>
<td>W. MEDICAL FOODS</td>
</tr>
<tr>
<td>X. MORBID OBESITY</td>
</tr>
<tr>
<td>Y. ORAL SURGERY</td>
</tr>
<tr>
<td>Z. PREVENTIVE HEALTH CARE SERVICES</td>
</tr>
<tr>
<td>AA. PROSTHETIC DEVICES</td>
</tr>
<tr>
<td>BB. RECONSTRUCTIVE SURGERY</td>
</tr>
<tr>
<td>CC. SKILLED NURSING FACILITY CARE</td>
</tr>
<tr>
<td>DD. THERAPY AND REHABILITATION SERVICES</td>
</tr>
<tr>
<td>EE. TELEMEDICINE SERVICES</td>
</tr>
<tr>
<td>FF. TRANSPLANT SERVICES</td>
</tr>
<tr>
<td>GG. URGENT CARE</td>
</tr>
<tr>
<td>HH. VISION SERVICES</td>
</tr>
<tr>
<td>JJ. X-RAY, LABORATORY, AND SPECIAL PROCEDURES</td>
</tr>
</tbody>
</table>
SECTION 4 – EXCLUSIONS, LIMITATIONS, AND REDUCTIONS................................................. 4.1

EXCLUSIONS ......................................................................................................................... 4.1
LIMITATIONS ......................................................................................................................... 4.2

SECTION 5 – GETTING ASSISTANCE, CLAIMS AND APPEAL PROCEDURES; AND
CUSTOMER SATISFACTION PROCEDURE ........................................................................ 5.1

GETTING ASSISTANCE ......................................................................................................... 5.1
WHO TO CONTACT .................................................................................................................. 5.1
DEFINITIONS .......................................................................................................................... 5.1
PROCEDURE FOR FILING A CLAIM AND INITIAL CLAIM DECISIONS ............................... 5.1
PRE-SERVICE CLAIMS ............................................................................................................ 5.4
POST-SERVICE CLAIMS ......................................................................................................... 5.4
RECONSIDERATION OF AN ADVERSE DECISION ................................................................ 5.4
APPEAL OF CLAIM DECISIONS .............................................................................................. 5.4
OFFICE OF THE MANAGED CARE OMBUDSMAN ................................................................. 5.6
THE OFFICE OF LICENSURE AND CERTIFICATION .......................................................... 5.8
CUSTOMER SATISFACTION PROCEDURE ........................................................................ 5.8

SECTION 6 – TERMINATION OF MEMBERSHIP .................................................................. 6.1

TERMINATION DUE TO LOSS OF ELIGIBILITY ..................................................................... 6.1
TERMINATION OF GROUP AGREEMENT ............................................................................... 6.1
TERMINATION FOR CAUSE ..................................................................................................... 6.1
TERMINATION FOR NONPAYMENT ..................................................................................... 6.1
EXTENSION OF BENEFITS ................................................................................................... 6.1
CONTINUATION OF GROUP COVERAGE UNDER FEDERAL LAW ..................................... 6.2
USERRA .................................................................................................................................. 6.2
CONVERSION OF MEMBERSHIP ........................................................................................ 6.2

SECTION 7 – MISCELLANEOUS PROVISIONS .................................................................. 7.1

ADMINISTRATION OF AGREEMENT .................................................................................. 7.1
ADVANCE DIRECTIVES .......................................................................................................... 7.1
AMENDMENT OF AGREEMENT ........................................................................................... 7.1
APPLICATIONS AND STATEMENTS ..................................................................................... 7.1
ASSIGNMENT .......................................................................................................................... 7.1
ATTORNEY FEES AND EXPENSES .................................................................................... 7.1
CONTRACTS WITH PLAN PROVIDERS ............................................................................... 7.1
GOVERNING LAW .................................................................................................................. 7.1
NOTICE OF NON-GRANDFATHERED COVERAGE ............................................................. 7.1
GROUPS AND MEMBERS NOT HEALTH PLAN’S AGENTS ..................................................... 7.1
MEMBER RIGHTS AND RESPONSIBILITIES ....................................................................... 7.1
NAMED FIDUCIARY ................................................................................................................ 7.3
NO WAIVER ............................................................................................................................ 7.3
NONDISCRIMINATION .......................................................................................................... 7.3
NOTICES ................................................................................................................................ 7.3
OVERPAYMENT RECOVERY ............................................................................................... 7.3
PRIVACY PRACTICES ............................................................................................................ 7.3

APPENDICES

DEFINITIONS

SUMMARY OF SERVICES AND COST SHARES
SECTION 1 – Introduction

This Evidence of Coverage (EOC) describes “Kaiser Permanente Signature℠” health care coverage provided under the Agreement between Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. and your Group. In this EOC, Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. is sometimes referred to as “Health Plan”, “we”, or “us.” Members are sometimes referred to as “you.” Some capitalized terms have special meaning in this EOC, please see the “Definitions” section of this EOC for terms you should know.

The term of this EOC is based on your Group’s contract year and your effective date of coverage. Your Group’s benefits administrator can confirm that this EOC is still in effect.

Health Plan provides health care Services directly to its Members through an integrated medical care system, rather than reimburse expenses on a fee-for-service basis. The EOC should be read with this direct-service nature in mind. Under our Agreement with your Group, we have assumed the role of a “named fiduciary,” a party responsible for determining whether you are entitled to benefits under this EOC. Also, as named fiduciary, we have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC.

Please note that Health Plan is subject to the regulations of the Commonwealth of Virginia by both the State Corporation Commission Bureau of Insurance, as well as the Virginia Department of Health.

Kaiser Permanente Signature℠

Kaiser Permanente Signature℠ provides health care Services to Members using Plan Providers located in our Plan Medical Centers and through affiliated Plan Providers located throughout our Service Area, which is described in the “Definitions” section of this EOC.

To make your health care easily accessible, Health Plan provides conveniently located Plan Medical Centers and medical offices throughout the Washington and Baltimore metropolitan areas. We have placed an integrated team of specialists, nurses, and technicians alongside our physicians, all working together at our state-of-the-art Plan Medical Centers. In addition, we have added pharmacy, optical, laboratory, and x-ray facilities at most of our Plan Medical Centers.
this or any other plan who had entitlement to receive Services through us terminated for:
(a) failure of you or your Dependent to pay any amounts owed to us, Kaiser Foundation Hospitals, or Medical Group, or
(b) failure to pay your Cost Share to any Plan Provider, or
(c) failure to pay non-group Premium.

Subscribers
You may be eligible to enroll as a Subscriber if you are entitled to Subscriber coverage under your Group's eligibility requirements that we have approved (for example, an employee of your Group who works at least the number of hours specified in those requirements).

Dependents
If you are a Subscriber, the following persons may be eligible to enroll as your Dependents:

A. Your Spouse;
B. Your or your Spouse’s children, who are under the age limit specified on the Summary of Services and Cost Shares section;
C. Other Dependent persons (but not including foster children) who meet all of the following requirements:
   (1) they are under the age limit specified on the Summary of Services and Cost Shares section; and
   (2) you or your Spouse is the child’s court-appointed guardian (or was when the person reached age 18).

Dependents who meet the Dependent eligibility requirements, except for the age limit, may be eligible as a disabled dependent if they meet all of the following requirements:

A. they are incapable of self-sustaining employment because of physically- or mentally-disabling injury, illness, or condition that occurred prior to reaching the age limit for Dependents;
B. they receive 50 percent or more of their support and maintenance from you or your Spouse;
C. you provide us proof of their incapacity and dependency within 60 days after we request it (see “Disabled Dependent Certification” section below for additional eligibility requirements).

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 in this 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.

Genetic Information
Note: We will not use, require or request a genetic test, the results of a genetic test, genetic information, or genetic Services for the purpose of rejecting, limiting, canceling or refusing to renew a health insurance policy or contract. In addition, genetic information or the request for such information shall not be used to increase the rates of, affect the terms or conditions of, or otherwise affect a Member’s coverage.
Your Group Evidence of Coverage

We will not release identifiable genetic information or the results of a genetic test to any person who is not an employee of Health Plan or a Plan Provider who is active in the Member’s health care, without prior written authorization from the Member from whom the test results or genetic information was obtained.

Enrollment and Effective Date of Coverage

Membership begins at 12:00 a.m. on the membership effective date. Eligible people may enroll as follows:

New Employees and Their Dependents
If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible (you should check with your Group to see when new employees become eligible). Your memberships will become effective as determined by Group.

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

A. You become eligible as described in this "Special enrollment" section

B. You did not enroll in any coverage through your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future. The effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application from the Subscriber.

Special enrollment due to new Dependents
Subscribers may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may add any or all eligible Dependents, within 31 days after marriage, birth, adoption, or placement for adoption by submitting to your Group a Health Plan–approved enrollment application.

The effective date of an enrollment resulting from marriage is no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber.

The effective date of an enrollment as the result of other newly acquired Dependents will be:

A. For newborn children, the moment of birth.

If payment of additional Premium is required to provide coverage for the newborn child then, in order for coverage to continue beyond 31 days from the date of birth, notification of birth and payment of additional Premium must be provided within 31 days of the date of birth, otherwise coverage for the newborn will terminate 31 days from the date of birth.

B. For newly adopted children, the date of adoptive or parental placement with a Subscriber or Subscriber's Spouse, for the purpose of adoption. If a child is placed with the Subscriber within 31 days of birth, such child will be considered a newborn of the Subscriber as of the date of adoptive or parental placement.

If payment of additional Premium is required to provide coverage for the child then, in order for coverage to continue beyond 31 days from the date of adoption, notification of adoption and payment of additional Premium must be provided within 31 days of the date of adoption, otherwise coverage for the newly adopted child will terminate 31 days from the date of adoption.

Once coverage is in effect, it will continue according to the terms of this EOC, unless the placement is disrupted prior to a final decree of adoption and the child is removed from placement with the Subscriber. In such case, coverage will terminate on the date the child is removed from placement.

C. For children who are newly eligible for coverage as the result of guardianship granted by court or testamentary appointment, the date of court or testamentary appointment.

If payment of additional Premium is required to provide coverage for the child, notification of the court or testamentary appointment may be provided at any time but, payment of Premium must be provided within 31 days of the enrollment of the child, otherwise, enrollment of the child terminates 31 days from the date of court or testamentary appointment.

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

If the Subscriber fails to enroll a child under a court or administrative order, the child’s other parent or the Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. VA-GRP-SEC1(01/13) 31 Agreement 564-14
Department of Social Services may apply for coverage. A Dependent child enrolled under this provision may not be disenrolled unless we receive satisfactory written proof that: (a) the court or administrative order is no longer in effect; and (b) the child is or will be enrolled in comparable health coverage that will take effect not later than the effective date of termination under this EOC; or (c) family coverage has been eliminated under this EOC.

Your Group will determine the effective date of an enrollment resulting from a court or administrative order, except that the effective date cannot be earlier than the date of the order and cannot be later than the first day of the month following the date of the order.

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

A. The Subscriber or at least one of the Dependents had other coverage when he or she previously declined all coverage through your Group

B. The loss of the other coverage is due to one of the following:
   - (1) exhaustion of COBRA coverage;
   - (2) termination of employer contributions for non-COBRA coverage;
   - (3) loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, reaching the age limit for dependent children, or the Subscriber’s death, termination of employment, or reduction in hours of employment;
   - (4) loss of eligibility for Medicaid coverage or Child Health Insurance Program coverage, but not termination for cause; or
   - (5) reaching a lifetime maximum on all benefits

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

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 31 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for Medicaid or Child Health Insurance Program coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

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

**Special enrollment due to eligibility for premium assistance under Medicaid or CHIP**
You may enroll as a Subscriber (along with any or all eligible Dependents), and existing Subscribers may add any or all eligible Dependents, if the Subscriber or at least one of the enrolling Dependents becomes eligible to receive premium assistance under Medicaid or CHIP. To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 60 days after the Subscriber or Dependent is determined eligible for premium assistance. The effective date of an enrollment resulting from eligibility for the premium assistance under Medicaid or CHIP is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

**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 to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and your membership effective date.

**Premium**
Members are entitled to health care coverage only for the period for which we have received the appropriate Premium from your Group. You are responsible for the Member contribution to the Premium. Your Group will tell you the amount and how you will pay it to your Group (through payroll deduction, for example).
SECTION 2 – How to Obtain Services

To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be billed for any Services we provide at Allowable Charges, and claims for Emergency or Urgent Care Services from non-Plan Providers will be denied.

As a Member, you are selecting our medical care system to provide your health care. You must receive all covered Services from Plan Providers inside our Service Area, except as described under the following headings:

- Emergency Services, in the “Benefits” section
- Urgent Care Outside our Service Area, in the “Benefits” section
- Getting a Referral, in this section
- Visiting Other Kaiser Permanente Regions or Group Health Cooperative Service Areas, in this section
- Visiting Member Services, in the “Benefits” section
- Services Received from Non-Plan Providers at Non-Plan Facilities Without a Referral

Your Primary Care Plan Physician

Your primary care Plan Physician plays an important role in coordinating your health care needs, including hospital stays and referrals to specialists. We encourage you to choose a primary care Plan Physician when you enroll. Each Member of your family should have his or her own primary care Plan Physician. If you do not select a primary care Plan Physician upon enrollment, we will assign you one near your home.

You may select any primary care Plan Physician, who is available to accept new Members, from the following areas: internal medicine, family practice and pediatrics. A listing of all primary care Plan Physicians is provided to you on an annual basis.

You may also access our Provider Directory online at the following website address:

www.kp.org

To learn how to choose or change your primary care Plan Physician, please call our Member Services Department at:

Inside the Washington, D.C., Metropolitan area
(301) 468-6000
TTY (301) 879-6380

Outside the Washington, D.C. Metropolitan area
1-800-777-7902

Our Member Services Representatives are available to assist you Monday through Friday from 7:30 a.m. until 5:30 p.m.

Continuity of Care

Member may request to continue to receive health care services for a period of 90 days from the date of the Plan Provider’s notification of termination from the Health Plan’s provider panel, except when terminated for cause.

In addition, under the following special situations, Health Plan will continue to provide benefits for Plan Provider’s care beyond a period of 90 days when the Member:

1) Has entered at least the second trimester of pregnancy at the time of the provider's termination, except when terminated for cause. Such treatment may continue, at the Member's option, through the provision of postpartum care; or

2) Is determined to be terminally ill at the time of the Plan Provider's termination, except when terminated for cause. Such treatment may continue, at the Member's option, for the remainder of the Member's life.

Getting a Referral

Plan Providers offer primary medical, pediatric, and obstetrics/gynecology care as well as specialty care in areas such as general surgery, orthopedic surgery, dermatology, and other medical specialties. If your primary care Plan Physician decides that you require covered Services from a specialist, you will be referred (as further described in this EOC) to a Plan Provider in your Signature provider network who is a specialist that can provide the care you need. All referrals will be subject to review and approval (authorization) in accordance with the terms of this EOC. We will notify you when our review is complete.

Our facilities include Plan Medical Centers and specialty facilities, such as imaging centers, located within our Service Area. You will receive most of the covered Services that you routinely need at these facilities unless you have an approved referral to another Plan Provider.

When you need covered Services (that are authorized) at a Plan Hospital, you will be referred to a Plan Hospital. We may direct that you receive
covered hospital Services at a particular Plan Hospital so that we may better coordinate your care using Medical Group Plan Physicians and our electronic medical record system.

There are specific Services that do not require a referral from your primary care Plan Physician. However, you must obtain the care from a Plan Provider. These Services include the following:

1. The initial consultation for treatment of mental illness, emotional disorders, drug or alcohol abuse provided by a Plan Provider. For continued treatment, you or your Plan Provider must contact the Behavioral Health Access Unit for assistance with arranging for and scheduling of covered Services. The Behavioral Health Access Unit may be reached at 1-866-530-8778.

2. Female Members do not need a referral or prior authorization in order to obtain access to obstetrical or gynecological care from a Plan Provider who specializes in obstetrics or gynecology.

3. Optometry services.

4. Urgent Care services provided within our Service Area.

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

For the most up-to-date list of Plan Medical Centers and other Plan Providers, visit our website at www.kp.org. To request a provider directory, please call our Member Services Department at the number listed on your Health Plan identification card.

Services Received from Non-Plan Providers at Non-Plan Facilities Without a Referral

There may be circumstances where Health Plan determines that it is responsible for payment to a non-Plan Provider. In these circumstances, Health Plan will send to a Member the payment amount determined, in Health Plan’s discretion, to be the appropriate payment for services furnished by a Non-Plan Provider where such services require prior authorization. Application of the payment from Health Plan to the Non-Plan Provider's charges is the Member's responsibility. This provision does not affect a Member’s obligations to pay applicable Cost-sharing, including Copayments and/or Coinsurance.

Standing Referrals to Specialists

If you suffer from a life-threatening, degenerative, chronic or disabling disease or condition that requires specialized care, your primary care Plan Physician may determine, in consultation with you and the specialist, that your needs would be best served through the continued care of a specialist. In such instances, your primary care Plan Physician will issue a standing referral to the specialist.

If a Member has been diagnosed with cancer, Health Plan will allow for the Member's Primary Care Physician to issue a standing referral to any Health Plan authorized oncologist or board-certified physician in pain management, as the Member chooses.

Standing referrals will be made in accordance with a written treatment plan developed by the primary care Plan Physician, specialist, and the Member. The treatment plan may limit the number of visits to the specialist or the period of time in which visits to the specialist are authorized. We retain the right to require the specialist to provide the primary care Plan Physician with ongoing communication about your treatment and health status.

Second Opinions

You may receive a second medical opinion from a Plan Physician upon request.

Getting the Care You Need; Emergency Services, Urgent Care and Advice Nurses

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

Emergency Services are available from Plan Hospital emergency departments 24 hours a day, seven days a week.

Getting Advice from Our Advice Nurses

If you are not sure you are experiencing a medical emergency, or may require Urgent Care Services (for example, a sudden rash, high fever, severe vomiting, ear infection, or a sprain), you may call our advice nurses at:
Making Appointments

When scheduling appointments it is important to have your identification card handy. If your primary care Plan Physician is located in a Plan Medical Center, please call:

Inside the Washington, D.C. Metropolitan Area
(703) 359-7878
TTY (703) 359-7616

Outside the Washington, D.C. Metropolitan Area
1-800-777-7904
TTY at 1-800-700-4901

If your primary care Plan Physician is not located in a Plan Medical Center, please call his or her office directly. You will find his or her telephone number on the front of your identification card.

Missed Appointment Fee

If you cannot keep a scheduled medical appointment, please notify your health care professional’s office at least one day prior to the appointment. If you fail to cancel your appointment, you may be responsible for the payment of an administrative fee for the missed appointment. The fee for a missed appointment at a Plan Medical Center is shown in the Appendix - Summary of Services and Cost Shares section of this EOC. This will not count toward your Deductible or Out-of-Pocket maximum, if applicable.

Using Your Identification Card

Each Member has a Health Plan ID card with a Medical Record Number on it to use when you call for advice, make an appointment, or go to a Plan Provider for care. The Medical Record Number is used to identify your medical records and membership information. You should always have the same Medical Record Number. If you need to replace your card, or if we ever inadvertently issue you more than one Medical Record Number, please let us know by calling our Member Services Department in the Washington, D.C., Metropolitan area at 301-468-6000, or in the Baltimore, Maryland Metropolitan Area at 1-800-777-7902. Our TTY is 301-879-6380.

Your ID card is for identification only. You will be issued a Health Plan ID card that will serve as evidence of your Membership status. In addition to your Health Plan ID card, you may be asked to show a valid photo ID at your medical appointments. Allowing another person to use your Membership card will result in forfeiture of your card and may result in termination of your membership.

Visiting Other Kaiser Permanente Regions or Group Health Cooperative Service Areas

If you visit a different Kaiser Permanente Region or Group Health Cooperative service area temporarily (not more than 90 days), you can receive visiting member care from designated providers in that area. The covered Services, Copayments, Coinsurance and Deductibles may differ from those in this Service Area, and are governed by the Kaiser Permanente program for visiting members. This program does not cover certain Services, such as transplant Services or infertility Services. Also, except for Out-of-Plan Emergency Services, your right to receive covered Services in the visited service area ends after 90 days unless you receive prior written authorization from us to continue receiving covered Services in the visited service area. The 90-day limit on visiting member care does not apply to Members who attend an accredited college or accredited vocational school.

To receive more information about visiting member Services, including facility locations across the United States, you may call our Member Services Department:

Inside the Washington, D.C. Metropolitan Area
(301) 468-6000
TTY (301) 816-6344

Outside the Washington, D.C. Metropolitan Area
1-800-777-7902

Service areas and facilities where you may obtain visiting member care may change at any time.

The following visiting member care is covered when it is provided or arranged by a Plan Physician in the visited service area. The benefits may not be the same as those you receive in your home Service Area. Except for outpatient prescription drugs, these
benefits are provided at no charge to you.

**Hospital Inpatient Care:**
- Physician Services
- Room and board
- Necessary Services and supplies
- Maternity Services
- Prescription drugs

**Outpatient Care:**
- Office visits
- Outpatient surgery
- Physical, speech and occupational therapy (up to 20 visits for physical therapy per incident; up to two months for occupational and speech therapy)
- Allergy tests and allergy injections
- Dialysis care

**Laboratory and X-Ray:**
- Covered in or out of the hospital

**Outpatient Prescription Drugs:**
- Covered only if you have an outpatient prescription drug benefit (regular home Service Area Copayments, Coinsurance, Deductibles, exclusions and limitations apply)

**Mental Health Services Other than for Emergency or Urgent Care Services:**
- Outpatient visits and inpatient hospital days

**Substance Abuse Treatment Other than for Emergency or Urgent Care Services:**
- Inpatient and outpatient medical detoxification and other outpatient visits

**Skilled Nursing Facility Care:**
- Up to 100 days per calendar year

**Home Health Care:**
- Home health care Services inside the visited service area

**Hospice Care:**
- Home-based hospice care inside the visited service area

**Pre-Authorization Required for Certain Services**
The following Services require preauthorization from your home Service Area while you are visiting another Kaiser Permanente Region or Group Health Cooperative service area:
- Inpatient physical rehabilitation
- Mental health hospital services
- Residential facility admissions for chemical dependency
- Outpatient mental health or chemical dependency benefits

**Visiting Member Service Exclusions**
The following Services are not covered under your visiting member benefits. ("Services" include equipment and supplies.) However, some of these Services, such as Emergency Services, may be covered under your home Service Area benefits, and applicable Copayments, Coinsurance and/or Deductibles will apply. For coverage information, refer to the “Benefits” section of this EOC.

- Services that are not Medically Necessary
- Physical examinations and related Services for insurance, employment, or licensing
- Drugs for the treatment of sexual dysfunction disorders
- Dental care and dental X-rays
- Services to reverse voluntary infertility
- Infertility Services
- Services related to conception by artificial means, such as IVF and GIFT
- Experimental Services and all clinical trials
- Cosmetic surgery or other Services primarily to change appearance
- Custodial care and care provided in an intermediate care facility
- Services related to sexual reassignment
- Transplants and related care
- Complementary and alternative medicine Services, such as chiropractic Services
- Services received as a result of a written referral from a Plan provider in your home Service Area
- Emergency Services, including emergency ambulance Services
- Services that are excluded or limited in your home Service Area

**Moving to Another Kaiser Permanente Region or Group Health Cooperative Service Area**
If you move to another Kaiser Permanente Region or Group Health Cooperative service area, you may be able to transfer your Group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Premium, Copayments, Coinsurance and Deductibles may not be the same in the other service area. You should contact your Group’s employee benefits coordinator before you move.
Value Added Services

Health Plan makes available a variety of value added services to its Members in order to aid Members in their quest for better health by providing access to additional Services, which may not be covered under this plan. Examples may include discounted eyewear; non-covered health education classes and publications discounted fitness club memberships, health promotion and wellness programs and rewards for participating in those programs. Some of these value added services are available to all Members, and others may be available only to Members enrolled in certain groups and/or plans. To take advantage of these Services, a Member need only identify himself/herself as a Health Plan Member by showing his/her ID card and paying the fee, if any, at the time of service. Because these value added services are not covered Services, any fees you pay will not accrue to any coverage calculations, such as deductibles and out-of-pocket maximum calculations.

For information concerning these Services, including which ones are available to you, you may contact our Member Services Department at:

Inside the Washington, D.C., Metropolitan area
(301) 468-6000
TTY (301) 879-6380

Outside the Washington, D.C. Metropolitan area
1-800-777-7902

Our Member Services Representatives are available to assist you Monday through Friday from 7:30 a.m. until 5:30 p.m.

The value added services are neither offered nor guaranteed under your Health Plan coverage. Some of these Services may be provided by entities other than the Health Plan. We may change or discontinue some or all of these Services at any time.

These value added services are not offered as an inducement to purchase a health care plan from Health Plan. Although they are not covered Services, we may include their costs in the calculations of your Premium.

Health Plan does not endorse or make any representations regarding the quality of such Services or their medical efficacy, nor the financial integrity of the entities providing the value added services. The Health Plan expressly disclaims any liability for these Services provided by these entities. If you have a dispute regarding these products or Services, you must resolve it with the entity offering the product or service. Although we have no obligation to assist with such resolution, should a problem arise with any of these products or Services, you may call the Member Services Call Center, and a representative may try to assist in getting the issue resolved.
SECTION 3 – Benefits

The Services described in this “Benefits” section are covered only if all of the following conditions are satisfied:

- You are a Member on the date the Services are rendered;
- You have not met the maximum benefit for the Service, if any. A maximum benefit applies per Member per contract year.
- The Services are provided by a Plan Provider (unless the Service is to be provided by a non-Plan Provider subject to an approved referral as described in Section 2) in accordance with the terms and conditions of this EOC including but not limited to the requirements, if any, for prior approval (authorization);
- The Services are Medically Necessary; and
- You receive the Services from a Plan Provider except as specifically described in this EOC.

You must receive all covered Services from Plan Providers inside our Service Area, except for:

- Emergency Services
- Urgent Care outside our Service Area
- Authorized referrals to non-Plan Providers (as described in Section 2)
- Visiting Member Services as described in Section 2

Exclusions and Limitations: Exclusions and limitations that apply only to a particular benefit are described in this section. Other exclusions, limitations, and reductions that generally affect benefits are described in the “Exclusions, Limitations, and Reductions” section of this EOC.

Note: The “Summary of Services and Cost Shares” section of the Appendix lists the Copayments, Coinsurances and Deductibles that apply to the following covered Services. Your Cost Share will be determined by the type and place of Service.

A. Outpatient Care

We cover the following outpatient care:

- Primary care visits for internal medicine, family practice, pediatrics, and routine preventive obstetrics/gynecology Services (refer to “Preventive Health Care Services” for coverage of preventive care Services);
- Specialty care visits (refer to Section 2 “How to Obtain Services” for information about referrals to Plan specialists);
- Consultations and immunizations for foreign travel (refer to the “Outpatient Prescription Drugs Rider,” attached to this EOC, for coverage of self-administered travel vaccines);
- Diagnostic testing for care or treatment of an illness, or to screen for a disease for which you have been determined to be at high risk for contracting, including, but not limited to:
  - Diagnostic examinations, including digital rectal exams and prostate antigen (PSA) tests provided in accordance with American Cancer Society guidelines to:
    i. persons age fifty and over and
    ii. persons age forty and over who are at high risk for prostate cancer, according to the most recent published guidelines of the American Cancer Society;
  - Colorectal cancer screening, specifically screening with an annual fecal occult blood test, flexible sigmoidoscopy or colonoscopy, or in appropriate circumstances radiologic imaging, in accordance with the most recently published recommendations established by the American College of Gastroenterology, in consultation with the American Cancer Society, for the ages, family histories, and frequencies referenced in such recommendations.
  - Bone mass measurement for the prevention, diagnosis, and treatment of osteoporosis for a qualified individual when a Plan Provider requires the bone mass measurement. A “qualified individual” means
    - an estrogen deficient individual at clinical risk for osteoporosis;
    - an individual with a specific sign suggestive of spinal osteoporosis, including roentgeno-graphic osteopenia or roentgenographic evidence suggestive of collapse, wedging, or ballooning of one or more thoracic or lumbar vertebral bodies, who is a candidate for therapeutic intervention or for an extensive diagnostic evaluation for metabolic bone disease;
    - an individual receiving long-term gluco-corticoid (steroid) therapy;
    - an individual with primary hyper-parathyroidism; or
    - an individual being monitored to assess the response to or efficacy of an approved osteoporosis drug therapy
Your Group Evidence of Coverage

(Refer to “Preventive Health Services” for coverage of preventive care tests and screening Services);

- Outpatient surgery;
- Anesthesia;
- Chemotherapy and radiation therapy;
- Respiratory therapy;
- Medical social Services;
- House calls when care can best be provided in your home as determined by a Plan Provider;
- After hours urgent care received after the regularly scheduled hours of the Plan Provider or Plan Facility. Refer to the Urgent Care provision for covered Services; and
- Equipment, supplies, complex decongestive therapy, and outpatient self-management training and education for the treatment of lymphedema, if prescribed by a health care professional legally authorized to prescribe or provide such items under law.

Additional outpatient Services are covered, but only as specifically described in this “Benefits” section, and subject to all the limits and exclusions for that Service.

B. Hospital Inpatient Care

We cover the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by an acute care general hospital in our Service Area:

- Room and board, including private room when deemed Medically Necessary;
- Specialized care and critical care units;
- General and special nursing care;
- Operating and recovery room;
- Plan Physicians’ and surgeons’ Services, including consultation and treatment by specialists;
- Anesthesia;
- Medical supplies;
- Chemotherapy and radiation therapy;
- Respiratory therapy; and
- Medical social Services and discharge planning.

Additional inpatient Services are covered, but only as specifically described in this “Benefits” section, and subject to all the limits and exclusions for that Service.

C. Accidental Dental Injury Services

We cover Medically Necessary dental Services as a result of accidental injury, regardless of the date of such injury. Coverage is provided when all of the following conditions have been satisfied:

- A Plan Provider provides the restorative dental Services.
- The injury occurred as the result of an external force that is defined as violent contact with an external object, not force incurred while chewing.
- The covered Services must be requested within 60 days of the injury, for injuries occurring on or after the effective date of coverage.

Coverage under this benefit is provided for the most cost-effective procedure available that, in the opinion of the Plan Provider, would produce the most satisfactory result.

Accidental Dental Injury Services Exclusions:

- Services provided by non-Plan Providers.

D. Allergy Services

We cover the following allergy Services:

- Evaluations, and treatment
- Injections and serum

E. Ambulance Services

We cover licensed ambulance Services only if your medical condition requires either: (1) the basic life support, advanced life support, or critical care life support capabilities of an ambulance for inter-facility or home transfer; and (2) the ambulance transportation has been ordered by a Plan Provider. Coverage is also provided for Medically Necessary transportation or Services including Medically Necessary air ambulance transport to the nearest hospital able to provide needed Services, rendered as the result of a 911 call. Your Cost Share will apply to each encounter, whether or not transport was required.

We will not cover ambulance transportation Services in any other circumstances, even if no other transportation is available. We cover ambulance Services only inside our Service Area, except as covered under the “Emergency Services” provision in this section of the EOC.

Ambulance Services Exclusions:

- Transportation by car, taxi, bus, gurney van, wheelchair van, minivan, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan...
F. **Anesthesia for Dental Services**

We cover Services to a Member who is determined by a licensed dentist in consultation with the Member’s treating physician to require general anesthesia and admission to a hospital or ambulatory surgical center to effectively and safely provide dental care and:

- Who are 7 years of age or younger or are severely disabled;
- For whom a successful result cannot be expected from dental care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition; and
- For whom a superior result can be expected from dental care provided under general anesthesia; or
- Who are 17 years of age or younger who is extremely uncooperative, fearful, or uncommunicative with dental needs of such magnitude that treatment should not be delayed or deferred; and
- Whom a lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity; or
- For adults age 17 and older when the Member’s medical condition requires that dental service be performed in a hospital or ambulatory surgical center for the safety of the Member (e.g., heart disease and hemophilia).

General anesthesia and associated hospital and ambulatory surgical center charges will be covered only for dental care that is provided by:

- A fully accredited specialist in pediatric dentistry; or
- A fully accredited specialist in oral and maxillofacial surgery; and
- For whom hospital privileges has been granted.

**Anesthesia for Dental Services Exclusions:**

- The dentist’s or specialist’s professional Services.
- Anesthesia and related facility charges for dental care for temporomandibular joint (TMJ) disorders.

G. **Blood, Blood Products and Their Administration**

We cover blood, blood products, both derivatives and components, including the collection and storage of autologous blood for elective surgery, as well as cord blood procurement and storage for approved Medically Necessary care, when authorized by a Plan Provider. The administration of prescribed whole blood and blood products are also covered.

In addition, benefits shall be provided for the purchase of blood products and blood infusion equipment required for home treatment of routine bleeding episodes associated with hemophilia and other congenital bleeding disorders when the home treatment program is under the supervision of the state-approved hemophilia treatment center.

**Blood, Blood Products and Their Administration Limitations:**

- Member recipients must be designated at the time of procurement of cord blood

**Blood, Blood Products and Their Administration Exclusions:**

- Directed blood donations.

H. **Chemical Dependency and Mental Health Services**

We cover the treatment of mental illnesses including, but not limited to, Biologically Based Mental Illness, emotional disorders, and Drug and Alcohol abuse.

For the purposes of this benefit provision:

- Drug and Alcohol Abuse means a disease that is characterized by a pattern of pathological use of a drug and/or alcohol with repeated attempts to control its use and with significant negative consequences in at least one the following areas of life: medical, legal, financial, or psycho-social;

- Biologically Based Mental Illness means any mental or nervous condition caused by a biological disorder of the brain that results in a clinically significant syndrome that substantially limits the person's ability to function. Specifically, the following diagnoses are defined as Biologically Based Mental Illness as they apply to adults and children: schizophrenia, schizoaffective disorder, bipolar disorder, major depressive disorder, panic disorder, obsessive-compulsive disorder, attention deficit hyperactivity disorder, autism, and drug and alcoholism addiction.

While you are hospitalized, we cover all medical Services of physicians and other health professionals as performed, prescribed or directed by a Physician including:

- Individual therapy
- Group therapy
- Shock therapy
- Drug therapy
Medical Services for detoxification are limited to the removal of the toxic substance or substances from the system.

We cover treatment in a structured multidisciplinary program as an alternative to inpatient psychiatric hospitalization.

Partial hospitalization is defined as the provision of medically directed intensive or intermediate short term treatment for mental illness, emotional disorders, drug and alcohol abuse for a period of less than 24 hours but more than 4 hours in a day in a licensed or certified facility or program.

In an outpatient setting, we cover all necessary Services of physicians and other health care professionals as performed, prescribed, or directed by a physician including, but not limited to:
- Evaluations
- Crisis intervention
- Individual therapy
- Group therapy
- Psychological testing
- Medical treatment for withdrawal symptoms
- Visits for the purpose of monitoring drug therapy

Chemical Dependency and Mental Health Exclusions:
- Services in a facility whose primary purpose is to provide treatment for alcoholism, drug abuse, or drug addiction, except as described above
- Services provided in a psychiatric residential treatment facility, except as described above
- Services for Members who, in the opinion of the Plan Provider, are seeking Services for non-therapeutic purposes
- Cognitive Behavior Therapy (CBT)
- Psychological testing for ability, aptitude, intelligence, or interest
- Services on court order or as a condition of parole or probation, unless determined by the Plan Provider to be necessary and appropriate
- Evaluations that are primarily for legal or administrative purposes, and are not medically indicated

I. Cleft Lip, Cleft Palate or Both
We cover inpatient and outpatient Services arising from orthodontics, oral surgery and otologic, audiological and speech/language treatment as the result of the congenital defect known as cleft lip, cleft palate, or both.

J. Clinical Trials
We cover the patient costs you incur for clinical trials provided on an inpatient and an outpatient basis as the result of treatment studies on cancer. “Patient costs” mean the cost of a Medically Necessary Service that is incurred as a result of the treatment being provided to the member for purposes of the clinical trial. “Patient costs” do not include:
- The cost of an investigational drug or device, except as provided below for off-label use of an FDA approved drug or device;
- The cost of non-health care Services that may be required as a result of treatment in the clinical trial; or
- Costs associated with managing the research for the clinical trial.

We cover the patient costs incurred for clinical trials if:
- The treatment is being provided or the studies are being conducted in a Phase II, Phase III, or Phase IV clinical trial for cancer.
- The treatment is being provided in a clinical trial approved by:
  - the National Cancer Institute (NCI);
  - an NCI cooperative group or an NCI center;
  - the FDA in the form of an investigational new drug application;
  - the federal Department of Veterans Affairs;
  - an institutional review board of an institution in the state which has a multiple project assurance contract approved by the Office of Protection from Research Risks of the National Institutes of Health;
- The facility and personnel providing the treatment are capable of doing so by virtue of their experience, training, and volume of patients treated to maintain expertise;
- There is no clearly superior, noninvestigational treatment alternative; and
- The available clinical or preclinical data provide a reasonable expectation that the treatment will be at least as effective as the noninvestigational alternative.

Note: Coverage will not be restricted solely because the Member received the Service outside the Service Area or the Service was provided by a non-Plan Provider.

Off-Label use of Drugs or Devices. We also cover patient costs incurred for drugs and devices that have...
been approved for sale by the FDA whether or not the FDA has approved the drug or device for use in treating the patient’s particular condition, to the extent that the drugs or devices are not paid for by the manufacturer, distributor or provider of that drug or device.

K. Diabetic Equipment, Supplies, and Self-Management

We cover diabetes equipment, diabetes supplies, and in-person diabetes outpatient self-management training and educational Services, including medical nutrition therapy, when prescribed by a Plan Provider and purchased from a Plan Provider, for the treatment of:

- insulin-using diabetes;
- insulin-dependent diabetes;
- non-insulin using diabetes; or
- elevated blood glucose levels induced by pregnancy, including gestational diabetes.

Note: Insulin is covered under the “Outpatient Prescription Drug Rider” attached to this EOC, if applicable. If the Prescription Drug Rider does not apply, insulin is covered under this benefit.

Diabetic Equipment, and Supplies Limitation:
Diabetic equipment and supplies are limited to Health Plan preferred equipment and supplies unless the equipment or supply: (1) was prescribed by a Plan Provider; and (2) (a) there is no equivalent preferred equipment or supply available, or (b) an equivalent preferred equipment or supply (i) has been ineffective in treating the disease or condition of the Member; or (ii) has caused or is likely to cause an adverse reaction or other harm to the Member. “Health Plan preferred equipment and supplies” are those purchased from a Plan preferred vendor.

L. Dialysis

If the following criteria are met, we cover dialysis Services related to acute renal failure and chronic (end-stage) renal disease:

- You satisfy all medical criteria developed by Medical Group and by the facility providing the dialysis;
- The facility (when not provided in the home) is certified by Medicare; and
- A Plan Physician provides a written referral for care at the facility.

We cover the following renal dialysis Services:
- Outpatient maintenance dialysis treatments in a Plan dialysis facility. Coverage includes the cost of laboratory tests, equipment, supplies and other Services associated with your treatment.
- Inpatient maintenance dialysis if you are admitted to a Plan Hospital because your medical condition requires specialized hospital Services on an inpatient basis.
- Plan Provider Services related to inpatient and outpatient dialysis.

We cover the following self-dialysis Services:
- Training for self-dialysis including the instructions for a person who will assist you with self-dialysis.
- Services of the Plan Provider who is conducting your self-dialysis training.
- Retraining for use of new equipment for self-dialysis.

We cover home dialysis, which includes:
- Hemodialysis;
- Home intermittent peritoneal dialysis (IPD);
- Home continuous cycling peritoneal dialysis (CCPD); and
- Home continuous ambulatory peritoneal dialysis (CAPD).

M. Drugs, Supplies, and Supplements

We cover the following during a covered stay in a Plan Hospital or Skilled Nursing Facility, or if they require administration or observation by medical personnel and are administered to you in a Plan Medical Office or during home visits:

- Oral, infused or injected drugs and radioactive materials used for therapeutic purposes including chemotherapy. This includes off-label use of a drug when the drug is recognized in Standard Reference Compendia or certain medical literature as appropriate in the treatment of the diagnosed condition;
- Injectable devices;
- The equipment and supplies associated with the administration of infused or injected drugs, devices or radioactive materials;
- Dressings and casts; and
- Vaccines and immunizations approved for use by the federal Food and Drug Administration (FDA), that are not considered part of routine preventive care.

Note: Additional Services that require administration or observation by medical personnel are covered. See the “Outpatient Prescription Drugs”, if applicable, for coverage of self-administered outpatient prescription drugs, including self-
administered travel vaccines. “Preventive Health Services” for coverage of vaccines and immunizations that are part of routine preventive care; “Allergy Services” for coverage of allergy test and treatment materials; and “Family Planning Services” for the insertion and removal of contraceptive drugs and devices, if applicable.

**Note:** Dispensing limitations for FDA approved prescription drugs used in the treatment of cancer pain management for patients with intractable cancer pain will be waived.

**Drugs, Supplies and Supplements Exclusions:**
- Drugs, supplies, and supplements which can be self-administered or do not require administration or observation by medical personnel.
- Drugs for which a prescription is not required by law.
- Drugs for the treatment of sexual dysfunction disorders.
- Drugs for the treatment of infertility.
- Contraceptive drugs, unless otherwise covered under a Prescription Drug Rider attached to this EOC.

**N. Durable Medical Equipment**

Durable Medical Equipment is defined as equipment that: (a) is intended for repeated use; (b) is primarily and customarily used to serve a medical purpose; (c) is generally not useful to a person in the absence of illness or injury; and (d) meets Health Plan criteria for medical necessity.

Durable Medical Equipment does not include coverage for prosthetic devices, such as implants, artificial eyes or legs, or orthotic devices, such as braces or therapeutic shoes. Refer to “Prosthetic Devices” for coverage of internal prosthetic devices, ostomy and urological supplies and breast prosthesis. Additional coverage for external prosthesis and orthotic devices is only covered if a Prosthetic and Orthotic Devices Rider is attached to this EOC.

**Basic Durable Medical Equipment**

We cover Durable Medical Equipment as prescribed by a Plan Provider for use in your home (or an institution used as your home). We also cover Durable Medical Equipment used during a covered stay in a Plan Hospital or Skilled Nursing Facility, but only if the Skilled Nursing Facility ordinarily furnishes Durable Medical Equipment.

Coverage is limited to the standard item of equipment that adequately meets your medical needs. 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 loss or misuse. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.

**Note:** Diabetes equipment and supplies are not covered under this section (refer to “Diabetes Equipment, Supplies and Self Management”).

**Supplemental Durable Medical Equipment**

We cover the following Durable Medical Equipment for home use as separate benefits, and as indicated below.

1. **Oxygen and Equipment**

   We cover oxygen and equipment when prescribed by a Plan Provider and your medical condition meets Health Plan’s criteria for medical necessity. A Plan Provider must certify the continued medical need for oxygen and equipment every 30 days.

2. **Positive Airway Pressure Equipment**

   We cover continuous positive airway pressure (CPAP) and bi-level positive airway pressure (BIPAP) equipment when prescribed by a Plan Provider and your medical condition meets Health Plan’s criteria for medical necessity. A Plan Provider must certify the continued medical need every 30 days.

3. **Apnea Monitors**

   We cover apnea monitors for infants who are under age 3, for a period not to exceed 6 months.

4. **Asthma Equipment**

   We cover the following asthma equipment for pediatric and adult asthmatics when purchased through a Plan Provider:
   - Spacers
   - Peak-flow meters
   - Nebulizers

5. **Bilirubin Lights**

   We cover bilirubin lights for infants, who are under age 3, for a period not to exceed 6 months.

**Durable Medical Equipment Exclusions:**
- Comfort, convenience, or luxury equipment or features.
- Exercise or hygiene equipment.
- Non-medical items such as sauna baths or elevators.
- Modifications to your home or car.
- Devices for testing blood or other body substances (except as covered under “Diabetes Equipment, Supplies and Self Management”).
• Electronic monitors of the heart or lungs, except infant apnea monitors.
• Services not preauthorized by Health Plan.

O. Early Intervention Services
We cover Medically Necessary early intervention Services for Dependents from birth to age 3. As used here, “early intervention Services” means speech and language therapy, occupational therapy, physical therapy and assistive technology Services and devices for Dependents who are certified by the Department of Mental Health, Mental Retardation and Substance Abuse Services as eligible for Services under Part H of the Individuals with Disabilities Education Act (20 U.S.C. § 1471 et seq.).

“Medically Necessary early intervention Services” means those Services designed to help an individual attain or retain the capability to function age-appropriately within his or her environment, and shall include Services that enhance functional ability without affecting a cure. These Services are provided in addition to the “Physical, Occupational, Speech Therapy and Multidisciplinary Rehabilitation Services” described in this EOC.

Limitations:
• This benefit is limited to a maximum of $5,000 per year for assistive technology Services and devices.

Early Intervention Services Exclusions
• Care which has been provided under federal, state or local early intervention programs, including school programs, at no cost to the member.

P. Emergency Services
As described below you are covered for Emergency Services if you experience an Emergency Medical Condition anywhere in the world.

If you experience an Emergency Medical Condition you should contact 911 immediately. If you are not sure whether you are experiencing an Emergency Medical Condition, please contact us at the number listed on the reverse side of your ID card for immediate medical advice. You or your representative must notify the Health Plan as soon as possible, not to exceed forty-eight (48) hours or the next business day, whichever is later, if you receive care at a hospital emergency room (ER) to ensure coverage. If the emergency room visit was not due to an "Emergency Medical Condition," as defined in the “Definitions” Appendix of this EOC, and was not authorized by Health Plan, you will be responsible for all charges.

Inside our Service Area:
We cover reasonable charges for Emergency Services provided within our Service Area by a Plan Provider or a non-Plan provider. Coverage provided by a non-Plan Provider is limited to Emergency Services required before you can, without medically harmful consequences, be transported to a Plan Hospital or your primary care Plan Physician’s office.

Outside our Service Area:
We cover reasonable charges for Emergency Services if you are injured or become ill while temporarily outside our Service Area.

We do not cover Services for conditions that, before leaving the Service Area, you should have known might require Services while you are away, such as dialysis for end-stage renal disease, post-operative care following surgery, and treatment for continuing infections, unless we determine that you were temporarily outside our Service Area because of extreme personal emergency.

Continuing Treatment Following Emergency Services

Inside our Service Area
After Emergency Services have been received inside the Service Area, all continuing or follow-up treatment must be provided or coordinated by your primary care Plan Physician.

Inside another Kaiser Permanente Region:
If you have received Emergency Services while you are temporarily in another Kaiser Permanente Region, continuing or follow-up treatment is available from physicians contracting with that Kaiser Permanente plan.

Outside our Service Area:
All other continuing or follow-up care for Emergency Services received outside our Service Area must be authorized by us, until you can safely return to the Service Area.

Transport to a Service Area
If you obtain prior approval from us, or from the nearest Kaiser Foundation Health Plan Region, we will cover necessary ambulance Services or other special transportation arrangements medically required to transport you to a Plan Hospital or Medical Office in our Service Area, or in the nearest Kaiser Foundation Health Plan Region, for continuing or follow-up treatment. Note: All ambulance transportation is covered under the “Ambulatory Services” benefit in this section.

Continued Care in Non-Plan Facility Limitation
If you are admitted to a non-Plan Hospital, you or someone on your behalf must notify us within the later of 48 hours of any hospital admission, or on the first working day following the admission, unless it was not reasonably possible to notify us within that time. We will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you do not notify us, or if you choose not to be transferred, we will not cover any Services you receive after transfer would have been possible.

Filing Claims for Non-Plan Emergency Services
Keep all your receipts for Emergency Services provided by non-Plan Providers and verify that the non-Plan Provider has submitted the claims. All claims must be filed with us within six months of the date of the Service, or as soon as reasonably possible in order to assure payment.

Emergency Services Limitations:

- **Notification**: If you receive care at a hospital emergency room or are admitted to a non-Plan hospital, you, or someone on your behalf, must notify us as soon as possible, but not later than 48 hours after the emergency room visit or hospital admission, or the next business day, whichever is later, unless it was not reasonably possible to notify us. If you are admitted to a hospital, we will decide whether to make arrangements for necessary continued care where you are, or to transfer you to a facility we designate. If you do not notify us as provided herein, we will not cover the emergency room visit, or hospital care you receive after transfer would have been possible.

- **Continuing or Follow-up Treatment**: Except as provided for under “Continuing Treatment Following Emergency Surgery,” we do not cover continuing or follow-up treatment after Emergency Services unless authorized by Health Plan. We cover only the out-of-Plan emergency Services that are required before you could, without medically harmful results, have been moved to a facility we designate either inside or outside our Service Area or in another Kaiser Foundation Health Plan or allied plan service area.

- **Hospital Observation**: Transfer to an observation bed or observation status does not qualify as an admission to a hospital. Your emergency room visit copayment, if applicable, will not be waived.

Q. Family Planning Services
We cover the following:

- Family planning counseling, including pre-abortion and post-abortion counseling and information on birth control
- Insertion and removal, and any Medically Necessary examination associated with the use of contraceptive drugs and devices. Contraceptive devices (other than diaphragms) and implantable contraceptive drugs are supplied by the provider, and are covered under this benefit. Contraceptive drugs and diaphragms are covered only under an “Outpatient Prescription Drug Rider,” if applicable.
- Tubal ligations
- Vasectomies
- Voluntary termination of pregnancy through the 17th week of pregnancy and in the 18th week and thereafter, as permitted under applicable law, if (i) the fetus suffers from a chromosomal, major metabolic or anatomic defect, or (ii) the maintenance of the pregnancy would seriously jeopardize the life or health of the mother.

Voluntary termination of pregnancy limitations:

- We cover up to a maximum of two voluntary terminations of pregnancy during a contract year.

Note: Diagnostic procedures are covered, but not under this section (see “X-ray, Laboratory and Special Procedures”).

R. Hearing Services
We cover hearing tests to determine the need for hearing correction. (Refer to Preventive Health Care Services for coverage for newborn hearing screenings.)

Hearing Services Exclusions:

- Tests to determine an appropriate hearing aid; and
- Hearing aids or tests to determine their efficacy.

S. Home Health Services
Except as provided for Visiting Member Services, we cover the following home health care Services only within our Service Area, only if you are substantially confined to your home, and only if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home:

- Skilled nursing care
- Home health aide Services
- Medical social Services
Home health Services are Medically Necessary health Services that can be safely and effectively provided in your home by health care personnel and are directed by a Plan Provider. They include visits by registered nurses, practical nurses or home health aides who work under the supervision or direction of a registered nurse or medical doctor.

We also cover any other outpatient Services, as described in this "Benefits" section that have been authorized by your Plan Physician as Medically Necessary and appropriately rendered in a home setting.

**Home Health Visits Following Mastectomy or Removal of Testicle**

Members undergoing a mastectomy or removal of a testicle on an outpatient basis, as well as those who receive less than 48 hours of inpatient hospitalization following the surgery, are entitled to the following:

- One home visit scheduled to occur within 24 hours following his or her discharge; and
- One additional home visit, when prescribed by the patient's attending physician.

**Home Health Care Limitations:**

- Home HealthCare visits shall be limited to two (2) hours per visit. Intermittent care shall not exceed three (3) visits in one day.

**Note:** If a visit lasts longer than two hours, then each two-hour increment counts as a separate visit. For example, if a nurse comes to your home for three hours and then leaves, that counts as two visits. Also, each person providing Services counts toward these visit limits. For example, if a home health aide and a nurse are both at your home during the same two hours, that counts as two visits.

- Additional limitations may be stated in the “Summary of Services and Cost Share.”

**Home Health Care Exclusions:**

- Custodial care (see definition under “Exclusions” in the “Exclusions, Limitations, and Reductions” section of this EOC).
- Routine administration of oral medications, eye drops, ointments.
- General maintenance care of colostomy, ileostomy, and ureterostomy.
- Medical supplies or dressings applied by a Member or family caregiver.
- Corrective appliances, artificial aids, and orthopedic devices.
- Homemaker Services.
- Services not preauthorized by Health Plan.

- Care that a Plan Provider determines may be appropriately provided in a Plan Facility or Skilled Nursing Facility, and we provide or offer to provide that care in one of these facilities.
- Transportation and delivery service costs of Durable Medical Equipment, medications, drugs, medical supplies and supplements to the home.

**T. Hospice Care Services**

Hospice Care Services are for terminally ill Members. If a Plan Physician diagnoses you with a terminal illness and determines that your life expectancy is 6 months or less, you can choose Hospice Care Services through home or inpatient care instead of traditional Services otherwise provided for your illness. We cover Hospice Care Services in the home if a Plan Provider determines that it is feasible to maintain effective supervision and control of your care in your home.

We cover Hospice Care Services within our Service Area and only when provided by a Plan Provider. Hospice Care Services include the following:

- Nursing care;
- Physical, occupational, speech, and respiratory therapy;
- Medical social Services;
- Home health aide Services;
- Homemaker Services;
- Medical supplies and appliances;
- Palliative drugs in accord with our drug formulary guidelines;
- Physician care;
- General hospice inpatient Services for acute symptom management including pain management;
- Respite Care that may be limited to 5 consecutive days for any one inpatient stay up to 4 times in any contract year;
- Counseling Services for the Member and his Family Members, including dietary counseling for the Member; and bereavement counseling for the Member’s Family Members, for a period of one year after the Member’s death; and
- Services of hospice volunteers.

**Definitions:**

*Family Member* means a relative by blood, marriage, domestic partnership or adoption who lives with or regularly participates in the care of the terminally ill Member.

*Hospice Care* means a coordinated, inter-disciplinary program of hospice care Services for meeting the
special physical, psychological, spiritual, and social needs of terminally ill individuals and their families, by providing palliative and supportive medical, nursing, and other health Services through home or inpatient care during the illness and bereavement counseling following the death of the Member.

**Respite Care** means temporary care provided to the terminally ill Member to relieve the Member’s Caregiver from the daily care of the Member.

**Caregiver** means an individual primarily responsible for the day to day care of the Member during the period in which the Member receives Hospice Services.

**U. Infertility Services**

We cover the following:

- Services for diagnosis and treatment of involuntary infertility for females and males; and
- Artificial insemination.

**Notes:**

- Involuntary infertility means the inability to conceive after 1 year of unprotected vaginal intercourse.
- Diagnostic procedures and any covered drugs administered by or under the direct supervision of a Plan Provider are covered under this provision. Refer to the Prescription Drug Rider, if applicable, for coverage of outpatient infertility drugs.

**Infertility Services Exclusions:**

- Any charges associated with freezing, storage and thawing of fertilized eggs (embryos), female Member’s eggs and/or male Member’s sperm for future attempts.
- Assisted reproductive procedures and any related testing or service that includes the use of donor sperm, donor eggs or donor embryos.
- Any charges associated with donor eggs, donor sperm or donor embryos.
- Infertility Services when the member does not meet medical guidelines established by the American Society of Reproductive Medicine and the American Society for Reproductive Endocrinology.
- Services not preauthorized by Health Plan.
- Services to reverse voluntary, surgically induced infertility.
- Infertility Services when the infertility is the result of an elective male or female surgical procedure.
- Assisted reproductive technologies and procedures, including, but not limited to: in vitro fertilization; gamete intrafallopian transfers (GIFT); zygote interfallopian transfers (ZIFT); intracytoplasmic sperm injection (ICSI); assisted hatching; preimplantation genetic diagnosis (PGD); and prescription drugs related to such procedures.

**V. Maternity Services**

We cover Services for routine global maternity care and non-routine obstetrical care.

“Routine global maternity” means care provided after the first visit where pregnancy is confirmed, and includes all of the following as a single Service, subject to a single cost share: (a) the normal series of regularly scheduled preventive prenatal care exams; (b) labor and delivery, including cesarean section; and (c) routine postpartum follow-up consultations and exams.

“Non-routine obstetrical care” includes (a) Services provided for a condition not usually associated with pregnancy; (b) Services provided for conditions existing prior to pregnancy; (c) Services related to the development of a high risk condition(s) during pregnancy; and (d) Services provided for the medical complications of pregnancy.

Services for non-routine obstetrical care are covered subject to applicable cost share for specialty, diagnostic, and/or treatment Services.

We cover inpatient hospitalization Services for you and your newborn child for a minimum stay of at least 48 hours following an uncomplicated vaginal delivery; and at least 96 hours following an uncomplicated cesarean section. We also cover postpartum home health visits upon release, when prescribed by the attending provider.

In consultation with your physician, you may request a shorter length of stay. In such cases, we will cover one home health visit scheduled to occur within 24 hours after discharge, and an additional home visit if prescribed by the attending provider.

Up to 4 days of additional hospitalization for the newborn is covered if the enrolled mother is required to remain hospitalized after childbirth for medical reasons.

**W. Medical Foods**

We cover medical foods and low protein modified food products for the treatment of inherited metabolic diseases caused by an inherited abnormality of body chemistry for which the State screens newborns.
babies. Coverage is provided if the medical foods and low protein food products are prescribed as Medically Necessary for the therapeutic treatment of inherited metabolic diseases, and are administered under the direction of a Plan Provider.

Medical foods are intended for the dietary treatment of a disease or condition for which nutritional requirements are established by medical evaluation and are formulated to be consumed or administered enterally (i.e. by tube directly into the stomach or small intestines) under the direction of a Plan Provider.

Low protein modified foods are food products that are (a) specially formulated to have less than one gram of protein per serving, and (b) intended to be used under the direction of a Plan Provider for the dietary treatment of an inherited metabolic disease.

Medical Foods Exclusions:

- Medical food for treatment of any conditions other than an inherited metabolic disease.

X. Morbid Obesity

We cover diagnosis and treatment of morbid obesity including gastric bypass surgery or other surgical method that is recognized by the National Institutes of Health as effective for long-term reversal of morbid obesity, and is consistent with criteria approved by the National Institutes of Health.

Morbid obesity is defined as:

- A weight that is at least 100 pounds over or twice the ideal weight for a patients frame, age, height, and gender, as specified in the 1983 Metropolitan Life Insurance tables; or
- A body mass index (BMI) that is equal to or greater than 35 kilograms per meter squared with a comorbidity or coexisting medical conditions such as hypertension, cardiopulmonary condition, sleep apnea, or diabetes; or
- A BMI of 40 kilograms per meter squared without such comorbidity.

Body Mass index means a practical marker that is used to assess the degree of obesity and is calculated by dividing the weight in kilograms by the height in meters squared.

Morbid Obesity Services Exclusion:

- Services not preauthorized by Health Plan.

Y. Oral Surgery

We cover treatment of tumors where a biopsy is needed for pathological reasons.

We also cover treatment of significant congenital defects, causing functional impairment, found in the oral cavity or jaw area which are similar to disease or which occur in other parts of the body, including Medically Necessary medical or surgical procedures occurring within or adjacent to the oral cavity or sinuses.

For the purposes of this benefit, coverage for diseases and injuries of the jaw include:

- the condition known as TMJ (temporal mandibular joint);
- fractures of the jaw or facial bones;
- removal of cysts of non-dental origin or tumors, including any associated lab fees prior to removal; and
- surgical correction of malformation of the jaw when the malformation creates significant impairment in the Member's speech and nutrition, and when such impairments are demonstrated through examination and consultation with appropriate Plan Providers.

For the purposes of this benefit, coverage of significant congenital defects causing functional impairment must be:

- evidenced through documented medical records showing significant impairment in speech or a nutritional deficit; and
- based on examination of the Member by a Plan Provider.

Functional impairment refers to an anatomical function as opposed to a psychological function.

Health Plan provides coverage for cleft lip and cleft palate under a separate benefit. Please see the “Cleft Lip, Cleft Palate, or Both” section of this EOC for coverage.

Oral Surgery Exclusions:

- Oral surgery Services when the functional aspect is minimal and would not in itself warrant surgery.
- Lab fees associated with cysts that are considered dental under our standards.
- Orthodontic Services.
- Dental appliances.

Z. Preventive Health Care Services

In addition to any other preventive benefits described in the group contract or certificate, Health Plan shall cover the following preventive services and shall not impose any cost-sharing requirements, such as Deductibles, Copayment amounts or Coinsurance amounts to any Member receiving any
of the following benefits for services from Plan Providers:

(a) Evidenced-based items or services that have in effect a rating of "A" or "B" in the current recommendations of the United States Preventive Services Task Force, except that the current recommendations of the United States Preventive Service Task Force regarding breast cancer screening, mammography, and prevention of breast cancer shall be considered the most current other than those issued in or around November 2009;

(b) Immunizations that have in effect a recommendation from the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention with respect to the individual involved;

(c) With respect to infants, children, and adolescents, evidence-informed preventive care and screenings provided for in the comprehensive guidelines supported by the Health Resources and Services Administration; and

(d) With respect to women, such additional preventive care and screenings, not described in paragraph (a) above, as provided for in comprehensive guidelines supported by the Health Resources and Services Administration.

Health Plan shall update new recommendations to the preventive benefits listed above at the schedule established by the Secretary of Health and Human Services.

Preventive Health Care Services Limitations:
While treatment may be provided in the following situations, the following Services are not considered Preventive Health Care Services. Applicable Cost Share will apply:

- Monitoring chronic disease
- Follow-up Services after you have been diagnosed with a disease.
- Testing and diagnosis for specific diseases for which you have been determined to be at high risk for contracting, based on factors determined by national standards
- Services provided when you show signs or symptoms of a specific disease or disease process.
- Non-routine gynecological visits,
- Treatment of a medical condition or problem identified during the course of the preventive screening exam.

Note: Refer to “Outpatient Services” for coverage of non-preventive diagnostic tests and other covered Services.

AA. Prosthetic Devices
We cover the devices listed below 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 ill or injured. Coverage includes fitting and adjustment of these devices, repair or replacement (unless due to loss or misuse), and Services to determine whether you need the prosthetic. If we do not cover the prosthetic, we will try to help you find facilities where you may obtain what you need at a reasonable price. Coverage is limited to the standard device that adequately meets your medical needs.

Internally Implanted Devices
We cover Medically Necessary internal devices implanted during surgery, such as pacemakers, ocular lens implants, artificial hips and joints, breast implants (see “Reconstructive Surgery Benefits” below) and cochlear implants, that are approved by the federal Food and Drug Administration for general use.

Artificial Limbs
We cover Medically Necessary prosthetic devices to replace, in whole or in part, a limb, their repair, fitting, replacement, and components.

As used in this provision:

“Limb” means an arm, a hand, a leg, a foot, or any portion of an arm, a hand, a leg, or a foot.

“Component” means the materials and equipment needed to ensure the comfort and functioning of a prosthetic device.

Ostomy and Urological Supplies
We cover ostomy and urological supplies when prescribed by a Plan Provider and your medical condition meets Health Plan’s criteria for medical necessity.

Breast Prosthetics
We cover breast prostheses and mastectomy bras following a Medically Necessary mastectomy. Coverage includes custom-made internal and external breast prostheses, regardless of when the mastectomy was performed. Coverage also includes breast prostheses for the non-diseased breast to achieve symmetry.

Breast Prosthetics Limitation:
- Coverage for mastectomy bras is limited to a maximum of two (2) per contract year.
Prosthetic Devices Exclusions:
- Internally implanted breast prosthetics for cosmetic purposes.
- External prosthetics, except as provided in this Section, or as provided under a “Prosthetic and Orthotic Devices Rider, if applicable.
- Repair or replacement of prosthetics due to loss, neglect, misuse, or abuse.
- Hair Prostheses.
- Artificial limbs designed primarily for an athletic purpose.
- Microprocessor and robotic controlled external prosthetics and orthotics.

BB. Reconstructive Surgery
We cover reconstructive surgery (a) to correct significant disfigurement resulting from an injury or Medically Necessary surgery, (b) to correct a congenital defect, disease, or anomaly in order to produce significant improvement in physical function, and (c) to treat congenital hemangioma known as port wine stains on the face for Members age 18 or younger.

Following mastectomy, we also cover reconstructive breast surgery and all stages of reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas. Mastectomy is the surgical removal of all or part of a breast. Reconstructive breast surgery is surgery performed as a result of mastectomy to reestablish symmetry between the two breasts. Reconstructive breast surgery includes augmentation mammoplasty, reduction mammoplasty, and mastopexy.

Reconstructive Surgery Exclusions:
Cosmetic surgery, plastic surgery, or other Services, supplies, dermatological preparations and ointments, other than those listed above, that are intended primarily to improve your appearance, are not likely to result in significant improvement in physical function, and are not Medically Necessary. Examples of excluded cosmetic dermatology services are:
- Removal of moles or other benign skin growths for appearance only
- Chemical peels
- Pierced earlobe repairs, except for the repair of an acute bleeding laceration

CC. Skilled Nursing Facility Care
We cover skilled inpatient Services in a licensed Skilled Nursing Facility. The skilled inpatient Services must be those customarily provided by Skilled Nursing Facilities. A prior three-day stay in an acute care hospital is not required.

We cover the following Services:
- Room and board;
- Physician and nursing care;
- Medical social Services;
- Medical and biological supplies; and
- Respiratory therapy.

Note: The following Services are covered, but not under this section:
- Blood (see “Blood, Blood Products and Their Administration);
- Drugs (see “Drugs, Supplies and Supplements”);
- Durable Medical Equipment ordinarily furnished by a Skilled Nursing Facility, including oxygen dispensing equipment and oxygen (see “Durable Medical Equipment”);
- Physical, occupational, and speech therapy (see “Therapy and Rehabilitation Services”); and
- X-ray, laboratory, and special procedures (see “X-ray, Laboratory and Special Procedures”).

Skilled Nursing Facility Care Exclusions:
- Custodial care (see definition under “Exclusions” in the “Exclusions, Limitations, and Reductions” section of this EOC).
- Domiciliary care.

DD. Therapy and Rehabilitation Services

Physical, Occupational, and Speech Therapy Services
If, in the judgment of a Plan Physician, significant improvement is achievable within a 90-day period, we cover physical, occupational and speech therapy:
1. while you are confined in Plan Hospital; and
2. for up to 90 consecutive days of treatment per injury, incident or condition for each therapy in a Plan Medical Center, a Plan Provider’s medical office, or a Skilled Nursing Facility, or as part of home health care. This limit does not apply to necessary treatment of cleft lip or cleft palate.

Physical, Occupational, and Speech Therapy Services Limitations:
- Physical therapy is limited to treatment to restore physical function that was lost due to injury or illness. It is not covered to develop physical function, except as provided for under “Early Intervention Services” in this section.
- Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.
- Speech therapy is limited to treatment for speech impairments due to injury or illness.
**Multidisciplinary Rehabilitation**
If, in the judgment of a Plan Physician, significant improvement is achievable within a two-month period, we cover multidisciplinary rehabilitation Services in a Plan Hospital, Plan Medical Center, Plan Provider’s medical office, or a Skilled Nursing Facility. Coverage is limited to a maximum of two consecutive months of treatment per injury, incident or condition.

Multidisciplinary rehabilitation Service programs mean inpatient or outpatient day programs that incorporate more than one therapy at a time in the rehabilitation treatment.

**Multidisciplinary Rehabilitation Limitations:**
- The limitations listed above for physical, occupation and speech therapy also applies to those Services when provided within a multidisciplinary program.

**Cardiac Rehabilitation Services**
We cover outpatient cardiac rehabilitation Services that is Medically Necessary following coronary surgery or a myocardial infarction, for up to 12 weeks, or 36 sessions, whichever occurs first.

Cardiac rehabilitation Services must be provided or coordinated by a facility approved by Health Plan, and that offers exercise stress testing, rehabilitative exercises and education and counseling.

**Therapy and Rehabilitation Services Exclusions:**
- Long-term rehabilitative therapy.

**EE. Telemedicine Services**
We cover telemedicine Services that would otherwise be covered under this Benefits section when provided by on a face-to-face basis.

**FF. Transplant Services**
If the following criteria are met, we cover stem cell rescue and transplants of organs, tissue, or bone marrow:
- You satisfy all medical criteria developed by Medical Group and by the facility providing the transplant;
- The facility is certified by Medicare; and
- A Plan Provider provides a written referral for care at the facility.

After the referral to a transplant facility, the following applies:
- Unless otherwise authorized by Medical Group, transplants are covered only in our Service Area.
- If either Medical Group or the referral facility determines that you do not satisfy its respective criteria for transplant, we will pay only for covered Services you receive before that determination was made.

- Health Plan, Plan Hospitals, Medical Group and Plan Providers are not responsible for finding, furnishing, or ensuring the availability of a bone marrow or organ donor.
- We cover reasonable medical and hospital expenses as long as these expenses are directly related to a covered transplant for a donor, or an individual identified by Medical Group as a potential donor even if not a Member.

**Transplant Services Exclusions:**
- Services related to non-human or artificial organs and their implantation.

**GG. Urgent Care**
As described below you are covered for Urgent Care Services anywhere in the world. “Urgent Care Services” are defined as Services required as the result of a sudden illness or injury, which requires prompt attention, but is not of an emergent nature.”

Your Copayment or Coinsurance will be determined by the place of Service (i.e., at a Provider’s office or at an after hours urgent care center, as shown in the Summary of Services and Cost Shares section.

**Inside our Service Area**
We will cover reasonable charges for Urgent Care Services received from Plan Providers and Plan Facilities within the Service Area

If you require Urgent Care Services please call your primary care Plan Provider as follows:

1) If your primary care Plan Physician is located at a Plan Medical Office please call:
   - Inside the Washington, D.C. Metropolitan Area
     - (703) 359-7878
     - TTY (703) 359-7616
   - Outside the Washington, D.C. Metropolitan Area
     - 1-800-777-7904
     - TTY 1-800-700-4901

2) If your primary care Plan Physician is located in our network of Plan Providers, please call his or her office directly. You will find his or her telephone number on the front of your identification card.

**Outside our Service Area**
If you are injured or become ill while temporarily outside the Service Area, we will cover reasonable charges for Urgent Care Services as defined in this section. All follow-up care must be provided by a Plan Provider or Plan Facility.
If you obtain prior approval from Health Plan, covered benefits include the cost of necessary ambulance or other special transportation Services medically required to transport you to a Plan Hospital or Plan Medical Office in the Service Area, or in the nearest Kaiser Foundation Health Plan Region for continuing or follow-up treatment.

**Urgent Care Limitations:**
We do not cover Services outside our Service Area for conditions that, before leaving the Service Area, you should have known might require Services while outside our Service Area, such as dialysis for end-stage renal disease, post-operative care following surgery, and treatment for continuing infections, unless we determine that you were temporarily outside our Service Area because of an extreme personal emergency.

**Urgent Care Exclusions:**
- Urgent Care Services within our Service Area that were not provided by a Plan Provider or Plan Facility.

**II. Vision Services**

**Medical Treatment**
We will provide coverage for Medically Necessary treatment for diseases of or injuries to the eye. Such treatment shall be covered to the same extent as for other Medically Necessary treatments for illness or injury.

We cover the following Services:

**Eye Exams**
Refraction exams to determine the need for vision correction and to provide a prescription for corrective lenses. Exams performed in an Optometry Department will be subject to the Primary Care Copayment. Exams performed in an Ophthalmology Department will be subject to the Specialty Care Copayment, if different.

**Eyeglass Lenses**
We provide a discount on the purchase of regular eyeglass lenses, including add-ons, when purchased at a Kaiser Permanente Optical Shop. Regular eyeglass lenses are any lenses with a refractive value. If only one eye needs correction, we also provide a balance lens for the other eye.

**Frames**
We provide a discount on the purchase of eyeglass frames, when purchased at a Kaiser Permanente Optical Shop. The discount includes the mounting of eyeglass lenses in the frame, original fitting of the frames, and subsequent adjustment.

**Contact Lenses**
We provide a discount on the initial fitting for contact lenses, when purchased at a Kaiser Permanente Optical Shop. Initial fitting means the first time you have ever been examined for contact lens wear at a Plan Facility. The discount includes the following services:
- Fitting of contact lenses;
- Initial pair of diagnostic lenses (to assure proper fit);
- Insertion and removal of contact lens training; and
- Three (3) months of follow-up visits.

You will also receive a discount on your initial purchase of contact lenses, if you choose to purchase them at the same time. Note: Additional contact lens Services are available without the discount from any Kaiser Permanente Optical Shop.

**Vision Exclusions:**
- Industrial and athletic safety frames.
- Eyeglass lenses and contact lenses with no refractive value.
  - Sunglasses without corrective lenses unless Medically Necessary.
  - Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as near-sightedness (myopia), farsightedness (hyperopia), and astigmatism (for example, radial keratotomy, photorefractive keratectomy, and similar procedures).
  - Eye exercises.
  - Non-corrective contact lenses;
  - Contact lens Services other than the initial fitting and purchase of contact lenses as provided in this section.
  - Replacement of lost, broken, or damaged lenses frames and contact lenses.
  - Plano lenses.
  - Lens adornment, such as engraving, faceting, or jewelling.
  - Low-vision devices.
  - Non-prescription products, such as eyeglass holders, eyeglass cases, and repair kits.
  - Orthoptic (eye training) therapy.

**II. Visiting Member Services**
We cover the same Medically Necessary Services that are covered under this plan in our Service Area, and your Cost Share will be the same, when you are temporarily (not more than 90 days) a visiting Member in a different Kaiser Permanente Region or Group Health Cooperative service area.
To receive more information about visiting member Services, including facility locations across the United States, you may call our Member Services Department:

Inside the Washington, D.C. Metropolitan Area
(301) 468-6000
TTY (301) 879-6380

Outside the Washington, D.C. Metropolitan Area
1-800-777-7902

Service areas and facilities where you may obtain visiting member care may change at any time.

**Visiting Member Services Limitations:**

- Access to Services in the visited service area will be subject to availability at the time you request the Service. Services may be unavailable due to temporary capacity constraints, inability to provide the Service generally, or other restrictions. If the Service is not available in the visited service area, you must call us for authorization to receive the Service.
- Except for Emergency Services, your right to receive covered Services in the visited service area ends after 90 days unless you receive prior written authorization from us to continue receiving covered Services in the visited service area. The 90-day limit on visiting member care does not apply to any Member who is a student attending an accredited college or accredited vocational school.

**Visiting Member Service Exclusions**

- All the terms and conditions, exclusions and limitations that apply to covered Services in our Service Area, will apply to Services received as a visiting Member in a different Kaiser Permanente Region or Group Health Cooperative service area.

**JJ. X-ray, Laboratory, and Special Procedures**

We cover the following Services only when prescribed as part of care covered in other parts of this “Benefits” section (for example, diagnostic imaging and laboratory tests are covered for outpatient Services only to the extent the outpatient Services are covered under “Outpatient Care”):

- Diagnostic imaging and interventional diagnostic tests;
- Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available;
- Special procedures, such as electrocardiograms and electroencephalograms;
- Sleep lab and sleep studies; and
- Specialty imaging: including CT, MRI, PET Scans, and Nuclear Medicine studies.
SECTION 4 – Exclusions, Limitations, and Reductions

The following section provides you with information on what Services Health Plan will not pay for regardless of whether the Service is medically necessary or not.

It also provides information on how your benefits may be coordinated with other types of coverage.

Exclusions

The Services listed below 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 Service are listed in the description of that Service in the “Benefits” section. When a Service is excluded, all Services related to the excluded Service are also excluded, even if they would otherwise be covered under this EOC.

Alternative Medical Services

Chiropractic and acupuncture Services and the Services of a Chiropractor, Acupuncturist, Naturopath, and Massage Therapist, unless otherwise covered under a Rider attached to this EOC.

Certain Exams and Services

Physical examinations and other Services (a) required for obtaining or maintaining employment or participation in employee programs, or (b) required for insurance, licensing, or disability determinations, or (c) on court-order or required for parole or probation.

Cosmetic Services

Services that are not medically necessary, and are intended primarily to improve your appearance and that are not likely to result in significant improvement in physical function, except for Services covered under “Reconstructive Surgery” or “Cleft Lip, Cleft Palate or Both” in the “Benefits” section.

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.

Dental Care

Dental care and dental x-rays, other than those which are medically necessary as a result of an accidental injury, dental appliances, dental implants, orthodontia, shortening of the mandible or maxillae for cosmetic purposes, correction of malocclusion, dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment, and any dental treatment involved in temporal mandibular joint (TMJ) pain dysfunction syndrome, unless otherwise covered under a Rider attached to this EOC. This exclusion does not apply to medically necessary dental care covered under “Accidental Dental Injury Services”, “Cleft-Lip, Cleft-Palate or Both”, or “Oral Surgery” in the “Benefits” section.

Disposable Supplies

Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances, or devices, not specifically listed as covered in the "Benefits" section.

Durable Medical Equipment

Except for Services covered under “Durable Medical Equipment” in the “Benefits” section.

Employer or Government Responsibility

Financial responsibility for Services that an employer or government agency is required by law to provide.

Experimental or Investigational Services

Except as covered under “Clinical Trials” section of the “Benefits” section, a Service is experimental or investigational for your condition if any of the following statements apply to it as of the time the Service is or will be provided to you:

- It cannot not be legally marketed in the United States without the approval of the Food and Drug Administration ("FDA") and such approval has not been granted; or
- It is the subject of a current new drug or new device application on file with the FDA and FDA approval has not been granted; or
- It is subject to the approval or review of an Institutional Review Board ("IRB") of the treating facility that approves or reviews research concerning the safety, toxicity, or efficacy of services; or
- It is the subject of a written protocol used by the treating facility for research, clinical trials, or other tests or studies to evaluate its safety, effectiveness, toxicity or efficacy, as evidenced in the protocol itself or in the written consent form used by the facility.
In making determinations whether a Service is experimental or investigational, the following sources of information will be relied upon exclusively:

- your medical records,
- the written protocols or other documents pursuant to which the Service has been or will be provided,
- any consent documents you or your representative has executed or will be asked to execute, to receive the Service,
- the files and records of the IRB or similar body that approves or reviews research at the institution where the Service has been or will be provided, and other information concerning the authority or actions of the IRB or similar body,
- the published authoritative medical or scientific literature regarding the service, as applied to your illness or injury, and
- regulations, records, applications, and any other documents or actions issued by, filed with, or taken by, the FDA, the Office of Technology Assessment, or other agencies within the United States Department of Health and Human Services, or any state agency performing similar functions.

Health Plan consults Medical Group and then uses the criteria described above to decide if a particular Service is experimental or investigational.

**External Prosthetic and Orthotic Devices**
Services and supplies for external prosthetic and orthotic devices, except as specifically covered under the “Benefits” section of this EOC, or unless otherwise covered under a Rider attached to this EOC.

**Prohibited Referrals**
Payment of any claim, bill, or other demand or request for payment for covered services determined to be furnished as the result of a referral prohibited by law.

**Routine Foot Care Services**
Routine foot care Services that are not medically necessary. This exclusion does not exclude Services when you are under active treatment for a metabolic or peripheral vascular disease

**Services for Members in the Custody of Law Enforcement Officers**
Non-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers, unless the Services are covered as Out-of-Plan Emergency Services.

**Sexual Reassignment**
All Services related to sexual reassignment (also referred to as “sexual transformation”).

**Surrogacy Arrangements**
Services related to conception, pregnancy or delivery in connection with a 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.

**Travel and Lodging Expenses**
Travel and lodging expenses, except that in some situations, if a Plan Physician refers you to a non-Plan Provider outside our Service Area as described under "Getting a Referral" in the "How to Obtain Services" section, we may pay certain expenses that we pre-authorize in accord with our travel and lodging guidelines.

**Vision Services**
Any eye surgery solely for the purpose of correcting refractive defects of the eye, such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures.

**Workers’ Compensation or Employer’s Liability**
Financial responsibility for Services for any illness, injury, or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as a “Financial Benefit”), is provided under any workers’ compensation or employer’s liability law. We will provide 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:

- Any source providing a Financial Benefit or from whom a Financial Benefit is due; or
- 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 employers’ liability law.

**Limitations**

We will use our best efforts to provide or arrange for covered Services in the event of unusual circumstances that delay or render impractical the provision of Services such as major disaster, epidemic, war, riot, terrorist activity, civil insurrection, disability of a large share of personnel of a Plan Facility, complete or partial destruction of facilities, and labor disputes not involving Health...
Plan, Kaiser Foundation Hospitals, or Medical Group. However, in these circumstances Health Plan, Kaiser Foundation Hospitals, Medical Group, and Medical Group Physicians will not have any liability for any delay or failure in providing covered Services. In the case of a labor dispute involving Health Plan, Kaiser Foundation Hospitals, or Medical Group, we may postpone care until the dispute is resolved if delaying care is safe and will not result in harmful health consequences.

Medicare and TRICARE Benefits
The value of your benefits are coordinated with any benefits to which you are entitled under Medicare, except for Members whose Medicare benefits are secondary by law. TRICARE benefits are usually secondary benefits by law.

Coordination of Benefits (COB)
Member’s with HSA’s: Please note that if you have other health care coverage in addition to the coverage under this EOC, in most instances you will not be eligible to establish or contribute to an HSA unless both plans qualify as High Deductible Health Plans. Consult with your financial or tax advisor for tax advice or more information about your eligibility for an HSA.

If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage. The Plan that pays first (Primary Plan) is determined by using National Association of Insurance Commissioners (NAIC) and Medicare Secondary Payer (MSP) Order of Benefits Guidelines.

1. The Primary Plan then provides benefits as it would in the absence of any other coverage.
2. The Plan that pays benefits second (Secondary Plan) coordinates with the Primary Plan, and pays the difference between what the Primary Plan paid, or the value of any benefit or service provided, and the maximum liability of the Secondary Plan, not to exceed 100 percent of total Allowable Expenses. The Secondary Plan is never liable for more expenses than it would cover if it had been Primary.

If you have any questions about COB, please call our Member Services Call Center.

Inside the Washington, D.C., Metropolitan area
(301) 468-6000

Outside the Washington, D.C. Metropolitan area
1-800-777-7902
TTY (301) 816-6344

Order of Benefit Determination Rules
Coordination of Benefits ("COB") applies when a Member has health care coverage under more than one Plan. "Plan" and "Health Plan" are defined below.

1. The Order of Benefit Determination Rules will be used to determine which Plan is the Primary Plan. The other Plans will be Secondary Plan(s).
2. If the Health Plan is the Primary Plan, it will provide or pay its benefits without considering the other Plan(s) benefits.
3. If the Health Plan is a Secondary Plan, the benefits or services provided under this Agreement will be coordinated with the Primary Plan so the total of benefits paid, or the reasonable cash value of the services provided, between the Primary Plan and the Secondary Plan(s) do not exceed 100% of the total Allowable Expenses.

Definitions
"Plan": Any of the following that provides benefits or services for, or because of, medical care or treatment: Group insurance or group-type coverage, whether insured or uninsured. This includes prepaid group practice or individual practice coverage.

"Health Plan": Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., providing services or benefits for health care. Health Plan is a Plan.

"Allowable Expense" means a health care service or expense, including Deductibles, Coinsurance or Copayments that is covered in full or in part by any of the Plans covering the Member. This means that an expense or healthcare service or a portion of an expense or health care service that is not covered by any of the Plans is not an allowable expense. For example, if a Member is confined in a private hospital room, the difference between the cost of a semi-private room in the hospital and the private room usually is not an Allowable Expense. "Allowable Expense does not include coverage for dental care except as provided under "Accidental Dental Injuries" in the "benefits" section.

"Claim Determination Period": A calendar year. However, it does not include any part of a year during which a person has no Health Plan coverage, or any part of a year before the date this COB provision or a similar provision takes effect.

Order of Benefit Determination Rules
1. If another Plan does not have a COB provision, that Plan is the Primary Plan.
2. If another Plan has a COB provision, the first of the following rules that apply will determine which Plan is the Primary Plan:
a. Subscriber/Dependent. A Plan that covers a person as a Subscriber is Primary to a Plan that covers the person as a dependent.

b. Dependent Child/Parents Not Separated or Divorced. Except as stated in subparagraph (b)(iii) below, when Health Plan and another Plan cover the same child as a dependent of different persons, called "parents":

i. The Plan of the parent whose birthday falls earlier in the year is Primary to the Plan of the parent whose birthday falls later in the year; but

ii. If both parents have the same birthday, the Plan that covered a parent longer is Primary; or

iii. If the rules in (i) or (ii) do not apply to the rules provided in the other Plan, then the rules in the other Plan will be used to determine the order of benefits.

c. Dependent Child/Separated or Divorced Parents. If two or more Plans cover a person as a dependent child of divorced or separated parents, benefits for the child are determined in this order:

i. First, the Plan of the parent with custody of the child;

ii. Then, the Plan of the spouse or Domestic Partner of the parent with custody of the child; and

iii. Finally, the Plan of the parent not having custody of the child.

iv. However, if the specific terms of a court decree state that one of the parents is responsible for the health care expenses of the child, and the Plan obligated to pay or provide the benefits of that parent has actual knowledge of those terms, that Plan is primary. This paragraph (iv) does not apply with respect to any Claim Determination Period or Plan year during which any benefits are actually paid or provided before the payer has that actual knowledge.

d. Active/Inactive Employee. A Plan that covers a person as an employee who is neither laid off nor retired (or as such an employee's dependent) is Primary to a Plan which covers that person as a laid off or retired employee (or as such an employee's dependent).

e. Longer/Shorter Length of Coverage. If none of the above rules determines the order of benefits, the Plan that has covered a Subscriber longer is Primary to the Plan which has covered the Subscriber for the shorter time.

Effect of COB on the Benefits of this Plan

When Health Plan is the Primary Plan, COB has no effect on the benefits or services provided under this Agreement. When Health Plan is a Secondary Plan as to one or more other Plans, its benefits may be coordinated with the Primary Plan carrier using the guidelines below. COB shall in no way restrict or impede the rendering of services provided by Health Plan. At the Member’s request, Health Plan will provide or arrange for covered services and then seek coordination with a Primary Plan.

1. Coordination with This Plan's Benefits. Health Plan may coordinate benefits payable or may recover the reasonable cash value of services it has provided when the sum of:

a. The benefits that would be payable for, or the reasonable cash value of, the services provided as Allowable Expenses by Health Plan in the absence of this COB provision; and

b. The benefits that would be payable for Allowable Expenses under one or more of the other Plans, in the absence of provisions with a purpose like that of this COB provision, whether or not a claim thereon is made; exceeds Allowable Expenses in a Claim Determination Period. In that case, the Health Plan benefits will be coordinated, or the reasonable cash value of any services provided by Health Plan may be recovered, from the Primary Plan, so that they and the benefits payable under the other Plans do not total more than the Allowable Expenses.

2. Right to Reserve and Release Needed Information. Certain information is needed to apply these COB rules. Health Plan will decide the information it needs, and may get that information from, or give it to, any other organization or person. Health Plan need not tell, or get the consent of, any person to do this. Each person claiming benefits under Health Plan must give Health Plan any information it needs.

3. Facility of Payment. If a payment made or service provided under another Plan includes an amount that should have been paid or provided by or through Health Plan, Health Plan may pay that amount to the organization which made that payment. The amount paid will be treated as if it was a benefit paid by Health Plan.

4. Right of Recovery. If the amount of payments by Health Plan is more than it should have paid under this COB provision, or if it has provided services that should have been paid by the
Primary Plan, Health Plan may recover the excess or the reasonable cash value of the services, as applicable, from one or more of:

a. The persons it has paid or for whom it has paid;
b. Insurance companies; or
c. Other organizations.

5. Benefit Reserve Account. When Health Plan does not have to pay full benefits, or recovers the reasonable cash value of the services provided because of COB, the savings will be credited to the Member in a Benefit Reserve Account. These savings can be used by the Member for any unpaid Covered Expense during the calendar year. A Member may request detailed information concerning the Benefits Reserve Account from Health Plan’s Patient Accounting Department.

Military Services
For any Services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs, and when we cover any such Services we may recover the value of the Services from the Department of Veterans Affairs.
SECTION 5 – Getting Assistance; Claims and Appeal Procedures; and Customer Satisfaction Procedure

Getting Assistance
Member Services representatives are available at our Plan Medical Offices and through our Call Center to 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 an ID card. These representatives can also help you file a claim for Emergency Services and Urgent Care Services outside our Service Area (see Post-Service Claims) or to initiate an appeal for any unresolved problem.

We want you to be satisfied with your health care. Please discuss any problems with your primary care plan provider or other health care professionals treating you. If you are not satisfied with your primary care plan provider, you can request a different plan provider by calling our Member Services Department.

Who to Contact

By Telephone
Member Services Department telephone numbers:

Inside the Washington, D.C., Metropolitan area
(301) 468-6000

Outside the Washington, D.C. Metropolitan area
1-800-777-7902

TTY  (301) 879-6380

In Writing
To contact us in writing, mail your correspondence to:

Kaiser Permanente
Member Services Department
2101 East Jefferson Street
Rockville, MD 20852

For an appeal, send it to the attention of:
Member Services Appeals Unit

By Facsimile
To fax us your correspondence, send it to:

301-816-6192

Definitions

Adverse Decision: Any Health Plan determination or decision (a) that a Service is not a covered benefit, or if it is a covered benefit, such Service does not meet Health Plan’s requirements for medical necessity, appropriateness, health care setting, level of care or effectiveness and therefore payment is not provided or made by Health Plan, in whole or in part, for the Service, thereby making the Member responsible for payment of such Service, in whole or in part, or (b) that cancels or terminates a Member’s membership retroactively for a reason other than a failure to pay premiums or contributions toward the cost of coverage.

Appellant: An appellant is a person eligible to file an Independent External Appeal. The Member or the following persons may be considered an Appellant: (1) an Authorized Representative; or (2) the member’s spouse, parent, committee, legal guardian, or other individual authorized by law to act on the Member’s behalf if the Member is not a minor, but is incompetent or incapacitated.

Authorized Representative: An individual appointed by the Member in writing or otherwise authorized by state law to act on the Member’s behalf to file claims and to submit Appeals. Authorized Representative shall also include a Health Care Provider acting on behalf of a Member with the Member’s express written consent, or without the Member’s express consent in an Emergency situation. With respect to claims and appeals, the term “Member” shall include an Authorized Representative.

Complaint: A Complaint is an inquiry to the Member Services Department about Services, Member rights or other issues; or the communication of dissatisfaction about the quality of service or other issue which is not an Adverse Decision. Complaints do not involve utilization review decisions.

Concurrent Care Claim: A request that Health Plan continue to approve an ongoing course of covered treatment to be provided over a period of time or number of treatments, when either (a) the course of treatment prescribed will expire, or (b) the course of treatment prescribed will be shortened.

Expedited (Urgent Care) Appeal: An appeal that must be reviewed under an expedited process because the application of non-expedited appeal time frames could seriously jeopardize a Member's life or health or the Member's ability to regain maximum function. In determining whether an appeal involves Urgent Care, Health Plan must apply the judgment of a prudent layperson that possesses an average
knowledge of health and medicine. An Expedited Appeal is also an appeal involving:
- care that the treating physician deems urgent in nature;
- the treating physician determines that a delay in the care would subject the Member to severe pain that could not adequately be managed without the care or treatment that is being requested; or
- when Health Plan covers prescription drugs and the requested services is a prescription for the alleviation of cancer pain, the Member is a cancer patient and the delay would subject the Member to pain that could not adequately be managed without the care or treatment that is being requested.

Such appeal may be made by telephone, facsimile or other available similarly expeditious method.

**Independent External Review:** If the Member receives an Adverse Decision of an appeal, the Member or the Member’s Authorized Representative, which may include the treating provider, may appeal the Adverse Decision to the Bureau of Insurance for an Independent External Review.

**Pre-Service Claim:** A request that Health Plan provide or pay for a Service that you have not yet received.

**Post-Service Claim:** A request for payment for Services you have already received, including but not limited to, claims for Out-of-Plan emergency services.

**Urgent Medical Condition:** As used in this Section 5, a medical condition for which care has not been rendered and which (a) could seriously jeopardize your life, health or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your medical condition, subject the Member to severe pain that cannot be adequately managed without the Services which are the subject of the claim.

**Procedure for Making a Non-Urgent Pre-Service Claim**

1. Tell the Member Services Department that you want to make a claim for Health Plan to provide or pay for a Service that you have not yet received. Your written or oral request and any related documents you give us constitute your claim. You may write or call us at the address and number listed above.

2. We will review your claim, and if we have all the information we need we will communicate our decision within 2 working days after we receive your claim. If we cannot make a determination because we do not have all the information we need, we will ask you for more information within 15 days of receipt of your claim. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days, we will then make a decision within 15 days of the due date or the receipt date, whichever is earlier, based on the information we have.

3. We will make a good faith attempt to obtain information from the treating provider before we make any Adverse Decision. At any time before we make our decision, the provider shall be entitled to

If you miss a deadline for filing a claim or appeal, we may decline to review it. If your health benefits are provided through an “ERISA” covered employer group, you can file a demand for arbitration or civil action under ERISA §502(a)(1)(B), but you must meet any deadlines and exhaust the claims and appeals procedures as described in this Section before you can do so. If you are not sure if your group is an “ERISA” group, you should contact your employer.

We do not charge you for filing claims or appeals, but you must bear the cost of anyone you hire to represent or help you. You may also contact the Office of the Managed Care Ombudsman (contact information is set forth below) to obtain assistance.

**A. Pre-Service Claims**

Pre-Service claims are requests that Health Plan provide or pay for a Service that you have not yet received. We will decide if your claim involves an Urgent Medical Condition or not. If you receive any of the Services you are requesting before we make our decision, your claim or appeal will become a Post-Service Claim with respect to those Services. If you have any questions about Pre-Service Claims, please contact our Member Services Department at the numbers listed above.

**Procedure for Making a Non-Urgent Pre-Service Claim**

1. Tell the Member Services Department that you want to make a claim for Health Plan to provide or pay for a Service that you have not yet received. Your written or oral request and any related documents you give us constitute your claim. You may write or call us at the address and number listed above.

2. We will review your claim, and if we have all the information we need we will communicate our decision within 2 working days after we receive your claim. If we cannot make a determination because we do not have all the information we need, we will ask you for more information within 15 days of receipt of your claim. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days, we will then make a decision within 15 days of the due date or the receipt date, whichever is earlier, based on the information we have.

3. We will make a good faith attempt to obtain information from the treating provider before we make any Adverse Decision. At any time before we make our decision, the provider shall be entitled to
Your Group Evidence of Coverage

review the issue of medical necessity with a physician advisor or peer of the treating provider. A physician reviewer will review the issue of medical necessity with the provider prior to making any Adverse Decision relating to cancer pain medication.

4. If we make an Adverse Decision regarding your claim, we will notify the treating provider:
   (a) in writing within 2 working days of the decision; or
   (b) orally by telephone within 24 hours of the decision if the claim is for cancer pain medication.

The notice will include instructions for the provider to seek a reconsideration of the Adverse Decision, on behalf of the covered person, including the name, address, and telephone number of the person responsible for making the Adverse Decision.

5. If we deny your claim or if we do not agree to provide or pay for all the Services you requested, we will tell you in writing why we denied your claim, and how you can appeal.

**Expedited Procedure for an Urgent Medical Condition**

1. If you or your treating provider feels that you have an Urgent Medical Condition, you may request an expedited review of your Pre-Service claim.

2. If we determine your claim does not involve an Urgent Medical Condition, we may treat your claim as a non-urgent Pre-Service Claim.

3. We will review your claim, and if we have all the information we need we will notify you of our decision as soon as possible, but no later than 72 hours after receiving your claim. We will send a written or electronic confirmation within 3 days after making our decision. If we cannot make a decision because we do not have all the information we need, we will ask you for more information within 24 hours of receipt of your claim. You will have 48 hours from the time of notification by us to provide the missing information. We will make a decision 48 hours after the earlier of (a) our receipt of the requested information, or (b) the end of the 48-hour period we have given you to provide the specified additional information.

4. If we deny your claim or if we do not agree to provide or pay for all the Services you requested, we will tell you in writing why we denied your claim, and how you can appeal.

5. When you or your Authorized Representative sends an appeal, you or your Authorized Representative may also request simultaneous external review of our initial adverse decision. If you or your Authorized Representative wants simultaneous external review, your or your Authorized Representative’s appeal must tell us this. You will be eligible for the simultaneous external review only if your pre-service appeal qualifies as urgent. If you do not request simultaneous external review in your appeal, than you or your Authorized Representative may be able to request external review after we make our decision regarding the appeal. See Section C Bureau of Insurance Independent External Appeals for additional information about filing an external appeal.

**B. Concurrent Care Claims**

Concurrent Care Claims are requests that Health Plan continue to approve an ongoing course of covered treatment to be provided over a period of time or number of treatments, when either (a) the course of treatment prescribed will expire, or (b) the course of treatment prescribed will be shortened.

1. Determinations regarding a Concurrent Care Claim request will be made, and notice provided to the Member’s provider, by telephone and in writing, within one business day of receipt of all information necessary to make a decision, but no later than 15 calendar days of receipt of the request.

2. If care is authorized, the notice will identify the number of approved services, the new total of approved services, the date of onset of services and the date of the next scheduled concurrent review of the case.

3. If we reduce or terminate coverage for an ongoing course of treatment that we already approved, we will notify the Member sufficiently in advance of the reduction or termination to allow the member to appeal the decision as described below.

**Concurrent Care Claims for an Urgent Medical Condition**

If your Concurrent Care Claim involves an Urgent Medical Condition, and the claim is submitted within 24 hours before the end of the initially approved period, we will decide the claim within 24 hours of receipt.

If you filed a request for additional services at least 24 hours before the end of an approved course of treatment, you may continue to receive those services during the time your claim is under consideration. If your claim is denied, you will be financially responsible for the entire cost of those services. Otherwise, if your request for additional services was not timely filed, Health Plan will decide your request for review within a reasonable period of time.
appropriate to the circumstances but in no event later than 30 calendar days from the date on which your claim was received.

1. If we determine your claim does not involve an Urgent Medical Condition, we may treat your claim as a non-urgent Concurrent Care Claim.

2. We will notify you of our decision orally or in writing within 24 hours after we receive your claim. If we notify you orally, we will send you a written decision within 3 days after that.

3. If we deny your claim or if we do not agree to continue approval of all the Services you requested, we will tell you in writing why we denied your claim and how you can appeal.

4. When you or your Authorized Representative sends the appeal, you or your Authorized Representative may also request simultaneous external review of our adverse decision. If you want simultaneous external review, your or your Authorized Representative’s appeal must tell us this. You or your Authorized Representative will be eligible for the simultaneous external review only if your concurrent care claim qualifies as urgent. If you or your Authorized Representative do not request simultaneous external review in the appeal, then you or your Authorized Representative may be able to request external review after we make our decision regarding the appeal. See Section C Bureau of Insurance Independent External Appeals for additional information about filing an external appeal.

C. Post-Service Claims

Post-service claims are requests for payment for Services you already received, including claims for Emergency Services and Urgent Care Services rendered outside our Service Area. If you have any questions about post-service claims or appeals, please call the Member Services Department at the address and telephone numbers listed above.

Procedure for Making a Post-Service Claim

Claims for Emergency Services or Urgent Care Services rendered outside our Service Area or other Services received from non-Plan Providers must be filed on forms provided by Health Plan; such forms may be obtained by calling or writing to the Member Services Department.

1. You must send the completed claim form to us at the address listed on the claim form within 180 days, or as soon as reasonably possible after the Services are rendered. You should attach itemized bills along with receipts if you have paid the bills. Incomplete claim forms will be returned to you. This will delay any payments which may be owed to you. Also, you must complete and submit to us any documents that we may reasonably need for processing your claim or obtaining payment from insurance companies or other payors.

2. We will review your claim, and if we have all the information we need we will send you a written decision within 30 days after we receive your claim. If we tell you we need more time because of circumstances beyond our control, we may take an additional 15 days to send you our written decision. If we tell you we need more time and ask you for more information, you will have 45 days to provide the requested information. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days, we will make a decision based on the information we have. We will issue our decision within 15 days of the deadline for receiving the information.

3. If we deny your claim or if we do not pay for all the Services you requested, our written decision will tell you why we denied your claim and how you can appeal.

Reconsideration of an Adverse Decision

Reconsideration of an Adverse Decision is available only to the treating health care provider, to request a review, on behalf of a Member, of an Adverse Decision by Health Plan. A request for reconsideration is optional. The treating provider may choose to skip this step and the Member or the Authorized Representative may file an appeal as described below. If the provider does request reconsideration, the Member still has a right to appeal.

Health Plan will render its decision regarding the reconsideration request and provide the decision to the treating provider and the Member, in writing, within 10 working days of the date of receipt of the request. If we deny the claim, the notice will include the criteria used and the clinical reason for the Adverse Decision, the alternate length of treatment of any alternate treatment recommended, and the Member’s right to appeal the decision as described below.

Appeals of Claim Decisions

The Appeal Procedures are designed by Health Plan to assure that Member concerns are fairly and properly heard and resolved. By following the steps outlined below, Member concerns can be quickly and responsively addressed.
A. Standard Appeal

This procedure applies to decisions regarding non-urgent Pre-Service Claims and Concurrent Claims as well as for Post-Service Claims. Please note that the timeframe for our response differs for Post-Service Claims (it is longer).

1. You or your Authorized Representative may initiate a standard appeal by submitting a written request, including all supporting documentation that relates to the appeal to:

   Kaiser Permanente
   2101 East Jefferson Street
   Rockville, MD 20849
   Member Services Appeals and Correspondence
   301-816-6192 (FAX)

You or your Authorized Representative may request a standard appeal by contacting the Member Services Department. In addition, you or your Authorized Representative, as applicable, may review the Health Plan’s appeal file and provide evidence and testimony to support the appeal request.

Member Service Representatives are available by telephone each day during business hours to describe to Members how appeals are processed and resolved and to assist the Member with filing an appeal. The Member Service Representative can be contacted Monday through Friday from 7:30 AM to 5:30 PM at 301-468-6000, if calling within the local area, or 301-816-6344 TTY (Telephonic Device for the Deaf).

The appeal must be filed in writing within 180 days from the date of receipt of the original denial notice. If the appeal is filed after the 180 days, Health Plan will send a letter denying any further review due to lack of timely filing.

If within 5 working days after a Member files an appeal, the Health Plan does not have sufficient information to initiate its internal appeal process, the Health Plan shall:

a) notify the Member that it cannot proceed with reviewing the appeal unless additional information is provided; and
b) assist in gathering the necessary information without further delay.

2. Standard appeals will either be acknowledged within 5 working days of the filing date of the written appeal request. An acknowledgement letter will be sent as follows:

   Appeal of a Non-urgent Pre-Service or Non-urgent Concurrent Care Claim

   If the appeal is for a Service that the Member is requesting, the acknowledgment letter will: i) request additional information, if necessary; ii) inform the Member when there will be a decision on their appeal; and iii) state that written notice of the appeal decision will be sent within 30 days of the date the appeal was received.

   Appeal of a Post-Service Claim

   If the appeal is asking for payment for completed services, an acknowledgment letter is sent: i) requesting additional information, if necessary; ii) informing the Member when a decision will be made; and iii) that the Member will be notified of the decision within 60 days of the date the appeal was received.

3. If there will be a delay in concluding the appeal process in the designated time, the Member will be sent a letter requesting an extension of time during the original time frame for a decision. If the Member does not agree to this extension, the appeal will move forward to be completed by end of the original time frame. Any agreement to extend the appeal decision shall be documented in writing.

4. If the appeal is approved, a letter will be sent to the Member stating the approval. If the appeal is by an Authorized Representative, the letter will be sent to both the Member and the Authorized Representative.

In addition, you or your Authorized Representative, as applicable, may review (without charge) the information on which Health Plan made its decision. You or your Authorized Representative may also send additional information, including comments, documents, or additional medical records supporting the claim, to:

   Member Services
   Appeals and Correspondence
   Kaiser Permanente
   2101 East Jefferson Street
   Rockville, MD 20852
   By Facsimile:
   (301) 816-6192
If the Health Plan asked for additional information before and you or your Authorized Representative did not provide it, you or your Authorized Representative may still submit the additional information with the appeal. In addition, you or your Authorized Representative may also provide testimony by writing or by telephone. Written testimony may be sent along with the appeal to the address above. To arrange to give testimony by telephone, you or your Authorized Representative may contact the Member Services Appeals Unit. Health Plan will add all additional information to the claim file and review all new information without regard to whether this information was submitted or considered in the initial decision.

Prior to Health Plan rendering its final decision, it must provide you or your Authorized Representative, without charge, any new or additional evidence considered, relied upon, or generated (or at the direction of ) by Health Plan in connection with the informal appeal.

If during the Health Plan’s review of the standard appeal, it determines that an adverse decision can be made based on a new or additional rationale, the Health Plan must provide you or your Authorized Representative with this new information prior to issuing its final adverse decision. The additional information must be provided to you or your Authorized Representative as soon as possible and sufficiently before the deadline to give you or your Authorized Representative a reasonable opportunity to respond to the new information.

If the review results in a denial, Health Plan will notify the Member or the member’s Authorized Representative. The notification shall include:

(a) the specific factual basis for the decision in clear understandable language;
(b) references to any specific criteria or standards on including interpretive guidelines, on which the appeal decision was based (including reference to the specific plan provisions on which determination was based);
(c) a statement that the Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. If specific criterion was relied upon, either a copy of the criterion or a statement that such criterion will be provided free of charge upon request. If the determination was based on medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the plan to the Member’s medical circumstances, or provide a statement that such explanation will be supplied free of charge upon request. In addition, you or your Authorized representative has the right to request any diagnostic and treatment codes and their meanings that may be the subject of your or your Authorized representative’s claim.
(d) a description of the right of the Member to file an external appeal with the Bureau of Insurance, along with the forms for filing and a detailed explanation of how to file such an appeal. An external appeal must be filed within 30 days of the date of Health Plan’s final Adverse Decision, as described below; and
(e) A statement of your rights under section 502(a) of ERISA.
(f) If we send you a notice of an adverse decision to an address in a county where a federally mandated threshold language applies, then you or your Authorized Representative may request translation of that notice into the applicable threshold language. A threshold language applies to a county if at least 10% of the population is literate only in the same federally mandated non-English language. You or your Authorized Representative may request translation of the notice by contacting Member Services.

If Health Plan fails to make an appeal decision for a non-urgent Pre-Service Appeal within 30 days or within 60 days for a Post-Service Appeal, the Member may file a complaint with the Bureau of Insurance.

B. Expedited Appeal

When an Adverse Decision or adverse reconsideration is made, and you, your Authorized Representative, or treating health care provider believes that such Adverse Decision or adverse reconsideration warrants an immediate Expedited Appeal, you, your Authorized Representative, or your treating health care provider shall have the opportunity to appeal the Adverse Decision or adverse reconsideration by telephone on an expedited basis.

An Expedited Appeal may be requested only when the regular reconsideration and appeal process will delay the rendering of Covered Services in a manner that would be detrimental to the Member’s health.

1. You, your Authorized Representative, or your treating health care provider may initiate an Expedited Appeal by contacting Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
(a) During Regular Business Hours
Monday though Friday from 7:30am – 5:30pm – The Member should contact the Member Services Department.

Inside the Washington, D.C. Metropolitan area
(301) 468-6000

Outside the Washington, D.C. Metropolitan area
(800) 777-7902.

(b) During Non-Business Hours
The Member should call the Advice/Appointment Line.

Inside the Washington, D.C. Metropolitan area
(703) 359-7878

Outside the Washington, D.C. Metropolitan area
(800) 777-7904

2. Once an Expedited Appeal is initiated, clinical review will determine if the appeal involves an urgent Pre-Service or Concurrent Care Claim. If the appeal does not meet the criteria for an expedited appeal, the request will be managed as a standard appeal, as described above. If such a decision is made, Health Plan will verbally notify the Member within 24 hours.

3. If the request for appeal meets the criteria for an expedited appeal, the appeal will be reviewed by a Plan physician who is board certified or eligible in the same specialty as the treatment under review, and who is not the individual (or the individual’s subordinate) who made the initial adverse decision.

If additional information is needed to proceed with the expedited review, Health Plan and the provider shall attempt to share the maximum information by telephone, facsimile, or otherwise to resolve the expedited appeal in a satisfactory manner.

4. A decision with respect to such Expedited Appeal shall be rendered no later than:
(a) 72 hours after receipt of the claim, if we have all of the necessary information; or
(b) if the claim is for cancer pain medication, no later than 24 hours after receipt of the claim.

5. If approval is recommended, Health Plan will immediately provide assistance in arranging the authorized treatment or benefit.

6. If Health Plan declines to review an appeal as an Expedited Appeal; or if the Expedited Appeal results in a denial, Health Plan shall immediately take the following actions:
(a) Notify you, your Authorized Representative, or the provider who requested the expedited review, by telephone, fax, or electronic mail that the Member is eligible for an Expedited Appeal to the Bureau of Insurance without the necessity of providing the justification required for a standard appeal; and
(b) Within 24 hours after the initial notice, provide a written notice to the provider and the Member clearly informing them of the right to appeal this decision to the Bureau of Insurance. The written notice will include the appropriate forms and instructions to file an appeal with the Bureau of Insurance, as described below.

The notification shall also include:
(a) the specific factual basis for the decision in clear understandable language;
(b) references to any specific criteria or standards, including interpretive guidelines, on which the decision was based (including reference to the specific plan provisions on which determination was based);
(c) a statement that the Member is entitled to receive upon request and free of charge, reasonable access to, and copies of, all documents, records and other information relevant to the claim. If specific criterion was relied upon, either a copy of the criterion or a statement that such criterion will be provided free of charge upon request. If the determination was based on medical necessity, experimental treatment or similar exclusion or limit, either an explanation of the scientific or clinical judgment, applying the terms of the plan to the Member’s medical circumstances, or provide a statement that such explanation will be supplied free of charge upon request; and
(d) A statement of your rights under section 502(a) of ERISA.

7. An Expedited Appeal may be further appealed through the standard appeal process described above unless all material information was reasonably available to the provider and to Health Plan at the time of the expedited appeal, and the physician advisor reviewing the Expedited Appeal was a peer of the treating health care provider, was board certified or board eligible, and specialized in a discipline related to the issues of the Expedited Appeal.
C. Bureau of Insurance
Independent External Appeals

A Member may file for an Independent External Appeal with the State Corporation Commission’s Bureau of Insurance (Bureau) if:

a) all of the Health Plan’s appeal procedures described above have been exhausted;
b) the Member requested an Expedited Appeal and the Health Plan determined that the standard appeal timeframes should apply; or
c) when an Expedited Appeal is reviewed and is denied.

However a member may request an ER prior to exhausting our internal appeal process if:

a) an Adverse determination was based on a determination that services are experimental/investigational may be expedited with written certification by the treating physician that services would be less effective if not initiated promptly;
b) an Expedited emergency review (ER) for medical necessity, appropriateness, healthcare setting, level of care, or effectiveness denials may be requested simultaneously with an expedited internal review; the Independent Review Organization (IRO) will review and determine if internal appeal should be completed prior to ER;
c) the Health Plan fails to render a standard internal appeal determination within thirty (30) or sixty (60) days and you, your Authorized Representative or Health Care provider has not requested or agreed to a delay; or
d) the Health Plan waives the exhaustion requirement.

The forms and instructions for filing an ER are provided to the Member along with the notice of a final Adverse Decision.

To file an appeal with the Bureau it must be filed in writing within 120 days of the decision using the forms required by the Bureau. The request is mailed to the following address:

Virginia State Corporation Commission
Bureau of Insurance
Life and Health Consumer Services Division
P. O. Box 1157
Richmond, VA 23218
(804) 371-9691
Website: www.scc.virginia.gov

The decision resulting from the external review will be binding on both the member and Health Plan to the same extent to which we would have been bound by a judgment entered in an action of law or in equity, with respect to those issues which the external review entity may review regarding a final Adverse Decision of Health Plan.

Office of the Managed Care Ombudsman

The Office of the Managed Care Ombudsman is available to assist Health Plan Members to file an appeal.

If a Member has questions regarding an appeal or grievance concerning the health care services that he or she has provided which have not been satisfactorily addressed by the Health Plan, he or she may contact the Office of the Managed Care Ombudsman for assistance at:

Office of the Managed Care Ombudsman
Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
Local: 1-804-371-9032
Toll Free: 1-877-310-6560
E-Mail: ombudsman@scc.virginia.gov

The Office of Licensure and Certification

If a Member has concerns regarding the quality of care he or she has received, he or she may contact The Office of Licensure and Certification at:

Complaint Intake
Office of Licensure and Certification
Virginia Department of Health
9960 Mayland Drive, Suite 401
Richmond, VA 23233-1463

Complaint Hotline:
Local: 1-804-367-2106
Toll Free: 1-800-955-1819
Fax No.: 1-804-527-4503

Customer Satisfaction Procedure

In addition, Health Plan has established a procedure for hearing and resolving Complaints by Members. An oral Complaint may be made to any Health Plan employee or to any person who regularly provides health care services to Members. A written Complaint must be given or sent to a Membership Services Representative located at a Medical Office or by sending a letter to our Member Services Department at the following address:
Kaiser Permanente
Member Services Department
Appeals and Correspondence
2101 East Jefferson St.
Rockville, MD 20852

You or your Authorized Representative will receive a written response to your complaints within 30 days unless you or your Authorized Representative is notified that additional time is required.

If you are dissatisfied with our response, you may file a complaint with the Bureau of Insurance (Bureau) at any time.

For information visit the Bureau’s website at www.scc.virginia.gov or call the Life and Health Consumer Services Section at (804) 371-9691 or toll-free (877) 310-6560, to discuss your complaint or receive assistance on how to file a complaint. Written complaints may be mailed to:

State Corporation Commission
Bureau of Insurance
P O Box 1157
Richmond, VA 23218
Fax: (804) 371-9944
SECTION 6 – Termination of Membership

Your group is required to inform the Subscriber of the date your coverage terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. In addition, Dependents’ membership end at the same time as the Subscriber’s membership ends.

You will be billed at Non-Member Rates for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further responsibility under this EOC after your membership terminates, except as provided under “Extension of Benefits” in this “Termination of Membership” section.

This “Termination of Membership” section describes how your membership may end and explains how you will be able to maintain Health Plan coverage without a break in coverage if your membership under this EOC ends.

Termination Due to Loss of Eligibility

If you meet the eligibility requirements described under “Who is Eligible” in the “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 terminates on the last day of that month unless your Group has an arrangement with us to terminate at a time other than the last day of the month. Please check with your Group’s benefits administrator to confirm your termination date.

Termination of Group Agreement

If your Group’s Agreement with us terminates for any reason, your membership ends on the same date.

Termination for Cause

We may terminate the memberships of the Subscriber and all Dependents in your Family Unit by sending written notice to the Subscriber at least 31 days before the termination date if you anyone in your Family Unit commits any of the following acts:

- You knowingly furnish incorrect or incomplete information to us or fail to notify us of changes in your family status or Medicare coverage that may affect your eligibility or benefits; or
- You no longer live or work within Health Plan’s Service Area.
- Your behavior with respect to Health Plan staff or Medical Group providers is disruptive, unruly, abusive or uncooperative to the extent that your continued enrollment under this EOC seriously impairs Health Plan’s ability to furnish services to you or to other Health Plan members.

We may report any Member fraud to the authorities for prosecution.

Termination for Nonpayment

Nonpayment of Premium

You are entitled to coverage only for the period for which we have received the appropriate Premium from your Group. If your Group fails to pay us the appropriate Premium for your Family Unit, we will terminate the memberships of everyone in your Family Unit.

Nonpayment of any other charges

We may terminate the memberships of a Subscriber and all Dependents in your Family Unit if any one of you fails to pay any amount he or she owes to Health Plan or Medical Group, or fails to pay the applicable Cost Share to any Plan Provider. We will send written notice of the termination to the Subscriber at least 31 days before the termination date.

Extension of Benefits

In those instances when your coverage with us has terminated, we will extend benefits for covered services, subject to Premium payment, in the following instance:

- If you become Totally Disabled while enrolled under this Agreement and remain so at the time your coverage ends, we will continue to provide benefits for covered services. Coverage will continue for 180 days from the date of termination or until you no longer qualify as being Totally Disabled, or until such time as a succeeding health plan elects to provide coverage to you without limitations as to the disabling condition, whichever comes first.
To assist us, if you believe you qualify under this “Extension of Benefits” provision, you must notify us in writing.

Upon termination of the Extension of Benefits, the Member will have the right to convert his or her coverage as described below.

Limitation(s):
The “Extension of Benefits” section listed above does not apply to the following:

- Members’ whose coverage ends because of failure to pay Premium; or
- Members’ whose coverage ends because of fraud or material misrepresentation by the Member.

Continuation of Group Coverage under Federal Law

(COBRA)
You or your Dependents may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility. Members are eligible for COBRA continuation coverage even if they live in another Kaiser Foundation Health Plan or allied plan service area. Please contact your Group if you want to know whether you or your Dependents are eligible for COBRA coverage, how to elect COBRA coverage, or how much you will have to pay your Group for it.

USERRA
If you are called to active duty in the uniformed services, 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 USERRA law. Members are not ineligible for USERRA continuation coverage solely because they live in another Kaiser Foundation Health Plan or allied plan service area. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

Conversion of Membership
You may be eligible to convert to a non-group plan if you no longer meet the eligibility requirements described under “Who is Eligible” in the “Eligibility and Enrollment” section, or if you enroll in COBRA or USERRA continuation of coverage and then lose eligibility for that state continuation of coverage. However, you may not convert to this non-group plan if:

- You continue to be eligible for coverage through your Group;
- You live in another Kaiser Foundation Health Plan or allied plan service area, except that the Subscriber’s or the Subscriber’s Spouse’s otherwise eligible children are not ineligible to be covered dependents solely because they live in another Kaiser Foundation Health Plan or allied plan service area if: (1) they are attending an accredited college or accredited vocational school; or (2) you are required to cover them pursuant to a Qualified Medical Child Support Order (QMCSO);
- Your membership ends because our Agreement with your Group terminates; or
- We terminated your membership under “Termination for Cause” or “Nonpayment of other charges” in this “Termination of Membership” section.

You must apply to convert your membership within the later of 31 days after your Group coverage ends or the date we notify you of your conversion rights. During this period, no medical review is required, and your non-group coverage begins when your Group coverage ends. You will have to pay Premium, and the benefits and copayments under the non-group coverage may differ from those under this EOC.

For information about converting your membership or about other non-group plans, call our Member Services Call Center.
Inside the Washington, D.C., Metropolitan area (301) 468-6000
TTY (301) 816-6344
Outside the Washington, D.C. Metropolitan area 1-800-777-7902
SECTION 7 – Miscellaneous Provisions

Administration of Agreement
We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of the Group Agreement and this EOC.

Advance Directives
The following legal forms help you control the kind of health care you will receive if you become very ill or unconscious:

- **Durable 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 views on life support and other treatments.

- **A Living Will and the Natural Death Act Declaration to Physicians** lets you write down your wishes about receiving life support and other treatment.

For additional information about Advance Directives, including how to obtain forms and instructions, contract our Member Services Call Center.

Inside Washington, D.C., Metropolitan area (301) 468-6000, or in the Baltimore, Maryland TTY (301) 816-6344

Outside the Washington, D.C. Metropolitan area 1-800-777-7902

Amendment of Agreement
Your Group’s Agreement with us will change periodically. If these changes affect this EOC, a revised EOC will be issued to you.

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 Fees and Expenses
In any dispute between a Member and Health Plan or Plan Providers, each party will bear its own attorneys’ fees and other expenses.

Contracts with Plan Providers
Health Plan and Plan Providers are independent contractors. Your Plan Providers are paid in a number of ways, including salary, capitation, per diem rates, case rates, fee for service, and incentive payments. If you would like further information about the way Plan Providers are paid to provide or arrange medical and hospital care for Members, please refer to your **Provider Directory** or call our Member Services Call Center in the Washington, D.C., Metropolitan area at (301) 468-6000, or in the Baltimore, Maryland Metropolitan Area at 1-800-777-7902. Our TTY is (301) 816-6344.

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 non-covered Services or Services you obtain from Non-Plan Providers, except for Emergency Services or authorized referrals.

If our contract with any Plan Provider terminates, for reasons unrelated to fraud, patient abuse, incompetence, or loss of licensure status, while you are under the care of that Plan Provider, you may continue to see that provider and we will retain financial responsibility for covered Services you receive, in excess of any applicable Copayments, Coinsurance or Deductibles for a period not to exceed 90 days from the date we have notified you of the Plan Provider’s termination.

Governing Law
Except as preempted by federal law, this EOC will be covered in accord with the law of the Commonwealth of Virginia 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.

Notice of Non-Grandfathered Coverage
Health Plan believes this coverage is a “non-grandfathered health plan” under the Patient Protection and Affordable Care Act (PPACA).

Groups and Members not Health Plan’s Agents
Neither your Group nor any Member is the agent or representative of Health Plan.
**Member Rights and Responsibilities**

Kaiser Permanente is committed to providing you and your family with quality health care Services. In a spirit of partnership with you, here are the rights and responsibilities we share in the delivery of your health care Services.

**MEMBER RIGHTS**

As a member of Kaiser Permanente, you have the right to:

1. **Receive information that empowers you to be involved in health care decision making. This includes your right to:**
   a. Actively participate in discussions and decisions regarding your health care options.
   b. Receive and be helped to understand information related to the nature of your health status or condition, including all appropriate treatment and non-treatment options for your condition and the risks involved - no matter what the cost is or what your benefits are.
   c. Receive relevant information and education that helps promote your safety in the course of treatment.
   d. Receive information about the outcomes of health care you have received, including unanticipated outcomes. When appropriate, family members or others you have designated will receive such information.
   e. Refuse treatment, providing you accept the responsibility and consequences of your decision.
   f. Give someone you trust the legal authority to make decisions for you if you ever become unable to make decisions for yourself by completing and giving us an Advance Directive, a durable power of attorney for health, living will, or other health care treatment directive. You can rescind or modify these documents at any time.
   g. Receive information about research projects that may affect your health care or treatment. You have the right to choose to participate in research projects.
   h. Receive access to your medical records and any information that pertains to you, except as prohibited by law. This includes the right to ask us to make additions or corrections to your medical record. We will review your request based on HIPAA criteria to determine if the requested additions are appropriate. If we approve your request, we will make the correction or addition to your protected health information. If we deny your request, we will tell you why and explain your right to file a written statement of disagreement. You, or your authorized representative, will be asked to provide written permission before your records are released, unless otherwise permitted by law.

2. **Receive information about Kaiser Permanente and your plan. This includes your right to:**
   a. Receive the information you need to choose or change your Primary Care Physician, including the name, professional level, and credentials of the doctors assisting or treating you.
   b. Receive information about Kaiser Permanente, our Services, our practitioners and providers, and the rights and responsibilities you have as a Member. You also can make recommendations regarding Kaiser Permanente’s member rights and responsibility policies.
   c. Receive information about financial arrangements with physicians that could affect the use of Services you might need.
   d. Receive Emergency Services when you, as a prudent layperson, acting reasonably, would have believed that an emergency medical condition existed.
   e. Receive covered urgently needed services when traveling outside Kaiser Permanente’s Service Area.
   f. Receive information about what Services are covered and what you will have to pay and to examine an explanation of any bills for Services that are not covered.
   g. File a complaint, grievance or appeal about Kaiser Permanente or the care you received without fear of retribution or discrimination, expect problems to be fairly examined, and receive an acknowledgement and a resolution in a timely manner.

3. **Receive professional care and service. This includes your right to:**
   a. See Plan Providers, get covered health care Services and get your prescriptions filled within a reasonable period of time and in an efficient, prompt, caring, and professional manner.
   b. Have your medical care, medical records and protected health information handled confidentially and in a way that respects your privacy.
Your Group Evidence of Coverage

MEMBER RESPONSIBILITIES
As a Member of Kaiser Permanente, you have the responsibility to:

1. Promote your own good health:
   a. Be active in your health care and engage in healthy habits.
   b. Select a Primary Care Physician. You may choose a doctor who practices in the specialty of Internal Medicine, Pediatrics, or Family Practice as your Primary Care Physician.
   c. To the best of your ability, give accurate and complete information about your health history and health condition to your doctor or other health care professionals treating you.
   d. Work with us to help you understand your health problems and develop mutually agreed upon treatment goals.
   e. Talk with your doctor or health care professional if you have questions or do not understand or agree with any aspect of your medical treatment.
   f. Do your best to improve your health by following the treatment plan and instructions your physician or health care professional recommends.
   g. Schedule the health care appointments your physician or health care professional recommends.
   h. Keep scheduled appointments or cancel appointments with as much notice as possible.

2. Know and understand your plan and benefits:
   a. Read about your health care benefits in this EOC and become familiar with them. Call us when you have questions or concerns.
   b. Pay your plan premiums and bring payment with you when your visit requires a Copayment, Coinsurance or Deductible.

3. Promote respect and safety for others:
   a. Extend the same courtesy and respect to others that you expect when seeking health care Services.
   b. Assume a safe environment for other Members, staff, and physicians by not threatening or harming others.
   c. Let us know if you have any questions, concerns, problems or suggestions.

Named Fiduciary
Under our Agreement with your Group, we have assumed the role of a “named fiduciary,” a party responsible for determining whether you are entitled to benefits under this EOC. Also, as a named fiduciary, we have the authority to review and evaluate claims that arise under this EOC. We conduct this evaluation independently by interpreting the provisions of this EOC.

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 on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability.

Notices
Our notices to you will be sent to the most recent address we have on file for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call our Member Services Call Center in the Washington, D.C., Metropolitan area at (301) 468-6000, or in the Baltimore, Maryland Metropolitan Area at 1-800-777-7902 as soon as possible to give us their new address. Our TTY is (301) 816-6344.
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, to the extent that if we have made payment to a health care provider, we may only retroactively deny reimbursement to the health care provider during the 6-month period after the date we paid the claim submitted by the health care provider.

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. Your PHI is individually identifiable information about your health care services you receive, or payment for your health care. 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, health research and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give PHI to others, such as government agencies or in judicial actions. In addition, Member-identifiable health 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, which provides additional information about our privacy practices and your rights regarding your PHI, is available and will be furnished to you upon request. To request a copy, please call our Member Service Call Center (see below). You can also find the notice at your local Plan Facility or on our Web site at www.kp.org.

Inside Washington, D.C., Metropolitan area (301) 468-6000, or in the Baltimore, Maryland TTY (301) 816-6344

Outside the Washington, D.C. Metropolitan area 1-800-777-7902
APPENDICES

Definitions
The following terms, when capitalized and used in any part of this EOC, mean:

Allowable Charges (AC): means either:
- For Services provided by Health Plan or Medical Group, the amount in the Health Plan's schedule of Medical Group and Health Plan charges for Services provided to Members;
- For items obtained at a Plan Pharmacy, the “Member Standard Value” which means the cost of the item calculated on a discounted wholesale price plus a dispensing fee;
- For all other Services, the contracted amount; the negotiated amount; the amount stated in the fee schedule that providers have agreed to accept as payment for those Services; or, the amount that the Health Plan pays for those Services.

Basic Health Services
Basic Health Services include:
- Inpatient and outpatient physician Services
- Inpatient hospital Services
- Outpatient medical Services
- Diagnostic laboratory and radiology Services
- Preventive health Services
- Emergency health care Services
- Prosthetic devices that are artificial devices to replace, in whole or in part, a limb
- Inpatient and outpatient chemical dependency and mental health Services.

Copayment: A specific dollar amount that you must pay when you receive a covered Service as listed under “Copayments and Coinsurance” in the Summary of Services and Cost Shares section of the Appendix.

Cost Share: The amount of the Allowable Charge that you must pay for covered Services through Copayments, and Coinsurance.

Dependent: A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements see “Who Is Eligible” in the “Eligibility and Enrollment” section.)

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in any of the following:
- Placing the person’s health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

Emergency Services: All of the following with respect to an Emergency Medical Condition:
- A medical screening examination (as required under the Emergency Medical Treatment and Active Labor Act) that is within the capability of the emergency department of a hospital, including ancillary services routinely available to the emergency department to evaluate the Emergency Medical Condition.
- Within the capabilities of the staff and facilities available at the hospital, the further medical examination and treatment that the Emergency Medical Treatment and Active Labor Act requires to Stabilize the patient.

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

Fee Schedule: A listing of procedure-specific fees developed by Health Plan and for which the Plan Provider agrees to accept as payment in full for covered Services rendered.

Health Plan: Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. This EOC sometimes refers to Health Plan as “we” or “us”.

Health Plan Region: Each of the specific geographic areas where Kaiser Foundation Health Plan, Inc., or an affiliated organization conducts a direct service health care program.


Medical Group: The Mid-Atlantic Permanente Medical Group, P.C.
**Medically Necessary**: Medically Necessary means that the Service is all of the following: (i) medically required to prevent, diagnose or treat your condition or clinical symptoms; (ii) in accordance with generally accepted standards of medical practice; (iii) not solely for the convenience of you, your family and/or you provider; and (iv) the most appropriate level of Service which can safely be provided to you. For purposes of this definition, “generally accepted standards of medical practice” means (a) standards that are based on credible scientific evidence published in peer-reviewed medical literature generally recognized by the relevant medical community; (b) physician specialty society recommendations; (c) the view of physicians practicing in the Kaiser Permanente Medical Care Program; and/or (d) any other relevant factors reasonably determined by us. Unless otherwise required by law, we decide if a Service (described in this Section 3) is Medically Necessary and our decision is final and conclusive subject to your right to appeal as set forth in Section 5.

**Medicare**: A federal health insurance program for people 65 and older, certain disabled people, and those with end-stage renal disease (ESRD).

**Member**: A person who is eligible and enrolled under this EOC, and for whom we have received applicable Premium. This EOC sometimes refers to Member as “you” or “your.”

**Plan**: Kaiser Permanente.

**Plan Facility**: A Plan Medical Center, a Plan Hospital or another freestanding facility that (i) is operated by us or contracts to provide Services and supplies to Members, and (ii) is included in your Signature provider network.

**Plan Hospital**: A hospital that (i) contracts to provide inpatient and/or outpatient Services to Members and (ii) is included in your Signature provider network.

**Plan Medical Center**: Medical office and specialty care facilities such as imaging centers operated by us in which Medical Group and other health care providers including Non-Physician Specialists employed by us provide primary care, specialty care, and ancillary care Services to Members.

**Plan Pharmacy**: Any pharmacy located at a Plan Medical Center.

**Plan Physician**: Any licensed physician who is an employee of Medical Group, or any licensed physician (except for those physicians who contract only to provide Services upon referral) who (1) contracts to provide Services and supplies to Members and (ii) is included in your Signature provider network.

**Plan Provider**: A Plan Physician, or other health care provider including but not limited to a non-physician specialist, and Plan Facility that (i) is employed by or operated by an entity that participates in the Kaiser Permanente Medical Care Program, or (ii) contracts with an entity that participates in the Kaiser Permanente Medical Care Program.

**Premium**: Periodic membership charges paid by Group.

**Service Area**: The areas of the District of Columbia; the following Virginia counties – Arlington, Fairfax, King George, Spotsylvania, Stafford, Loudoun, Prince William, and specific ZIP codes within Caroline, Culpeper, Fauquier, Hanover, Louisa, Orange and Westmoreland; the following Virginia cities – Alexandria, Falls Church, Fairfax, Fredericksburg, Manassas and Manassas Park; the following Maryland counties: Anne Arundel, Baltimore, Carroll, Harford, Howard, Montgomery, and Prince George’s, and specific ZIP codes within Calvert, Charles, and Frederick counties. A listing of these ZIP codes may be obtained from any Health Plan office.

**Services**: Health care services or items.

**Skilled Nursing Facility**: A facility that provides inpatient skilled nursing care, rehabilitation Services, or other related health care Services and is certified by Medicare. 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 a convalescent nursing home, rest facility, or facility for the aged that furnishes primarily custodial care, including training in routines of daily living.

**Spouse**: Your legal husband or wife.

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

**Subscriber**: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status (unless coverage is
Evidence of Coverage

Your Medicare Health Benefits and Services and Prescription Drug Coverage as a Member of Kaiser Permanente Medicare Plus Group Plan (Cost)

This booklet gives you the details about your Medicare health care and prescription drug coverage from January 1 to December 31, 2015. It explains how to get coverage for the health care services and prescription drugs you need.

This is an important legal document. Please keep it in a safe place.

This plan, Kaiser Permanente Medicare Plus, is offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., (Health Plan). When this Evidence of Coverage says "we," "us," or "our," it means Health Plan. When it says "plan" or "our plan," it means Kaiser Permanente Medicare Plus (Medicare Plus).

Kaiser Permanente is a Cost plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

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

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

Benefits, formulary, pharmacy network, premium, deductible, and/or copayments/coinsurance may change on January 1, 2016.
# Table of Contents

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

## CHAPTER 1. Getting started as a member

Explains what it means to be in a Medicare health plan and how to use this booklet. Tells about materials we will send you, premiums, your plan membership card, and keeping your membership record up-to-date.

## CHAPTER 2. Important phone numbers and resources

Tells you how to get in touch with our plan (Medicare Plus) and with other organizations including Medicare, the State Health Insurance Assistance Program (SHIP), the Quality Improvement Organization, Social Security, Medicaid (the state health insurance program for people with low incomes), programs that help people pay for their prescription drugs, and the Railroad Retirement Board.

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

Explains important things you need to know about getting your medical care as a member of our plan. Topics include using the providers in our plan's network and how to get care when you have an emergency.

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

Gives the details about which types of medical care are covered and *not* covered for you as a member of our plan. Explains how much you will pay as your share of the cost for your covered medical care.

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

Explains rules you need to follow when you get your Part D drugs. Tells how to use our *Kaiser Permanente 2015 Abridged Formulary* and *Kaiser Permanente 2015 Comprehensive Formulary* to find out which drugs are covered. Tells which kinds of drugs are *not* covered. Explains several kinds of restrictions that apply to your coverage for certain drugs. Explains where to get your prescriptions filled. Tells about our plan's programs for drug safety and managing medications.
CHAPTER 6. What you pay for your Part D prescription drugs ................................. 116

Tells about the two stages of drug coverage (Initial Coverage Stage and Catastrophic Coverage Stage) and how these stages affect what you pay for your drugs. Explains the three cost-sharing tiers for your Part D drugs and tells what you must pay for a drug in each costs-sharing tier. Tells about the late enrollment penalty.

CHAPTER 7. Asking us to pay our share of a bill you have received for covered medical services or drugs .................................................... 136

Explains when and how to send a bill to us when you want to ask us to pay you back for our share of the cost for your covered services or drugs.

CHAPTER 8. Your rights and responsibilities .................................................... 142

Explains the rights and responsibilities you have as a member of our plan. Tells what you can do if you think your rights are not being respected.

CHAPTER 9. What to do if you have a problem or complaint (coverage decisions, appeals, and complaints) ........................................ 152

Tells you step-by-step what to do if you are having problems or concerns as a member of our plan.

• Explains how to ask for coverage decisions and make appeals if you are having trouble getting the medical care or prescription drugs you think are covered by our plan. This includes asking us to make exceptions to the rules or extra restrictions on your coverage for prescription drugs, and asking us to keep covering hospital care and certain types of medical services if you think your coverage is ending too soon.

• Explains how to make complaints about quality of care, waiting times, customer service, and other concerns.

CHAPTER 10. Ending your membership in our plan ........................................ 204

Explains when and how you can end your membership in our plan. Explains situations in which our plan is required to end your membership.

CHAPTER 11. Legal notices ................................................................................. 210

Includes notices about governing law and about nondiscrimination.

CHAPTER 12. Definitions of important words .................................................... 216

Explains key terms used in this booklet.

AMENDMENT. "What You Need To Know" – Your Important State-mandated Health Care Benefits and Rights and Other Legal Notices
CHAPTER 1. Getting started as a member

SECTION 1. Introduction ........................................................................................................ 3
Section 1.1 You are enrolled in Medicare Plus, which is a Medicare Cost Plan ..................3
Section 1.2 What is the Evidence of Coverage booklet about? ..........................................3
Section 1.3 What does this chapter tell you? ......................................................................3
Section 1.4 What if you are new to Medicare Plus? ..........................................................4
Section 1.5 Legal information about the Evidence of Coverage ........................................4

SECTION 2. What makes you eligible to be a plan member? ........................................ 4
Section 2.1 Your eligibility requirements .........................................................................4
Section 2.2 What are Medicare Part A and Medicare Part B? .............................................5
Section 2.3 Here is our plan service area for Medicare Plus ..............................................5

SECTION 3. What other materials will you get from us? ............................................ 6
Section 3.1 Your plan membership card—use it to get all the care and prescription drugs covered by our plan..........................................................6
Section 3.2 The Provider Directory: Your guide to all providers in our network...............6
Section 3.3 The Pharmacy Directory: Your guide to pharmacies in our network ..........7
Section 3.4 Our plan's Kaiser Permanente 2015 Abridged Formulary .........................7
Section 3.5 The Explanation of Benefits (the "EOB"): Reports with a summary of payments made for your Part D prescription drugs..........................8

SECTION 4. Your monthly premium for Medicare Plus ............................................... 8
Section 4.1 How much is your plan premium? .................................................................8

SECTION 5. Please keep your plan membership record up-to-date ......................... 10
Section 5.1 How to help make sure that we have accurate information about you ..........10

SECTION 6. We protect the privacy of your personal health information ............ 11
Section 6.1 We make sure that your health information is protected ..........................11

SECTION 7. How other insurance works with our plan ........................................ 11
Section 7.1 Which plan pays first when you have other insurance? ..........................11
SECTION 1. Introduction

Section 1.1 You are enrolled in Medicare Plus, which is a Medicare Cost Plan

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

There are different types of Medicare health plans. Medicare Plus is a Medicare Cost Plan. Like all Medicare health plans, this Medicare Cost Plan is approved by Medicare and run by a private company.

Section 1.2 What is the Evidence of Coverage booklet about?

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

This plan, Kaiser Permanente Medicare Plus, is offered by Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc., (When this Evidence of Coverage says "we," "us," or "our," it means Health Plan. When it says "plan" or "our plan," it means Kaiser Permanente Medicare Plus (Medicare Plus).

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

Section 1.3 What does this chapter tell you?

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

- What makes you eligible to be a plan member?
- What is our service area?
- What materials will you get from us?
- What is your plan premium and how can you pay it?
- How do you keep the information in your membership record up-to-date?
Section 1.4  What if you are new to Medicare Plus?

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

If you are confused or concerned or just have a question, please contact Member Services (phone numbers are printed on the back cover of this booklet).

Section 1.5  Legal information about the Evidence of Coverage

This Evidence of Coverage explains what our plan covers in addition to your enrollment form, our Kaiser Permanente 2015 Abridged Formulary and Kaiser Permanente 2015 Comprehensive Formulary, and any notices you receive from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called "riders" or "amendments."

The Evidence of Coverage is in effect for the months in which you are enrolled in Medicare Plus between January 1, 2015, and December 31, 2015, unless amended.

Each calendar year, Medicare allows us to make changes to the plans that we offer. This means we can change the costs and benefits of our plan after December 31, 2015. We can also choose to stop offering the plan, or to offer it in a different service area, after December 31, 2015.

Medicare must approve our plan each year

Medicare (the Centers for Medicare & Medicaid Services) must approve our plan each year. You can continue to get Medicare coverage as a member of our plan as long as we choose to continue to offer Medicare Plus and Medicare renews its approval of our plan.

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

Section 2.1  Your eligibility requirements

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

• You live in our geographic service area (Section 2.3 below describes our service area).
• – and – you have Medicare Part B (or you have both Part A and Part B).
• – and – you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer.
Section 2.2 What are Medicare Part A and Medicare Part B?

When you first signed up for Medicare, you received information about what services are covered under Medicare Part A and Medicare Part B. Remember:

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

Section 2.3 Here is our plan service area for Medicare Plus

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

Our service area includes the city of Washington D.C. and these cities and counties in Maryland and Virginia: Alexandria City, Anne Arundel, Arlington, Baltimore County, Baltimore City, Carroll County, Fairfax City, Fairfax County, Falls Church City, Harford County, Howard County, Loudoun County, Manassas City, Manassas Park City, Montgomery County, Prince George's County, and Prince William County.

Also, our service area includes these parts of counties in Maryland, in the following ZIP codes only:

- **Calvert County:** 20639, 20678, 20689, 20714, 20732, 20736, 20754.
- **Charles County:** 20601, 20602, 20603, 20604, 20612, 20616, 20617, 20637, 20640, 20643, 20646, 20658, 20675, 20677, 20695.
- **Frederick County:** 21701, 21702, 21703, 21704, 21705, 21709, 21710, 21714, 21716, 21717, 21718, 21754, 21755, 21758, 21759, 21762, 21769, 21770, 21771, 21774, 21775, 21777, 21790, 21792, 21793.

In addition, we offer coverage in several states. However, there may be cost or other differences between the plans we offer in each state. If you move out of the state where you live into a state that is still within our service area, you must call Member Services in order to update your information. If you move into a state outside of our service area, you cannot remain a member of our plan. Please call Member Services to find out if we have a plan in your new state.

**If you plan to move out of the service area, please contact Member Services** (phone numbers are printed on the back cover of this booklet).

It is also important to notify your group's benefits administrator and call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.
SECTION 3. What other materials will you get from us?

Section 3.1 Your plan membership card—use it to get all the care and prescription drugs covered by our plan

We will send you a plan membership card. You should use this card whenever you get covered services or drugs from a Medicare Plus network provider. Here's a sample membership card to show you what yours will look like:

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. Phone numbers for Member Services are printed on the back cover of this booklet.

Because Medicare Plus is a Medicare Cost Plan, you should also keep your red, white, and blue Medicare card with you. As a Cost Plan member, if you receive Medicare-covered services (except for emergency or urgent care) from an out-of-network provider or when you are outside of our service area, these services will be paid for by Original Medicare, not our plan. In these cases, you will be responsible for Original Medicare deductibles and coinsurance. (If you receive emergency or urgent care from an out-of-network provider or when you are outside of our service area, our plan will pay for these services.) It is important that you keep your red, white, and blue Medicare card with you for when you receive services paid for under Original Medicare.

Section 3.2 The Provider Directory: Your guide to all providers in our network

The Provider Directory lists our network providers.
What are "network providers"?

Network providers are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. However, members of our plan may also get services from out-of-network providers. If you get care from out-of-network providers, you will pay the cost-sharing amounts under Original Medicare.

If you don't have your copy of the Provider Directory, you can request a copy from Member Services (phone numbers are printed on the back cover of this booklet). You may ask Member Services for more information about our network providers, including their qualifications. You can view or download the Provider Directory at kp.org. Both Member Services and our website can give you the most up-to-date information about our network providers.

Section 3.3 The Pharmacy Directory: Your guide to pharmacies in our network

What are "network pharmacies"?

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

Why do you need to know about network pharmacies?

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

The Pharmacy Directory will also tell you which of the pharmacies in our network have preferred cost-sharing, which may be lower than the standard cost-sharing offered by other network pharmacies.

If you don't have the Pharmacy Directory, you can get a copy from Member Services (phone numbers are printed on the back cover of this booklet). At any time, you can call Member Services to get up-to-date information about changes in the pharmacy network. You can also find this information on our Website at kp.org/seniormedrx.

Section 3.4 Our plan's Kaiser Permanente 2015 Abridged Formulary

Our plan has a Kaiser Permanente 2015 Abridged Formulary. We call it the "Drug List" for short. It tells which Part D prescription drugs are covered by our plan. The drugs on this list are selected by our plan with the help of a team of doctors and pharmacists. The list must meet requirements set by Medicare. Medicare has approved our Drug List. The Drug List also tells you if there are any rules that restrict coverage for your drugs.

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

Section 3.5 The Explanation of Benefits (the "EOB"): Reports with a summary of payments made for your Part D prescription drugs

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

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

A Part D EOB summary is also available upon request. To get a copy, please contact Member Services (phone numbers are printed on the back cover of this booklet).

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

SECTION 4. Your monthly premium for Medicare Plus

Section 4.1 How much is your plan premium?

You do not pay a separate monthly plan premium for Medicare Plus. You must continue to pay your Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Your coverage is provided through contract with your current employer or former employer or union. Please contact the employer's or union's benefits administrator for information about your plan premium.

In some situations, your plan premium could be more

In some situations, your plan premium could be more than the amount listed above in Section 4.1. These situations are described below.

- Some members are required to pay a late enrollment penalty because they did not join a Medicare drug plan when they first became eligible or because they had a continuous
period of 63 days or more when they didn’t have “creditable” prescription drug coverage. (“Creditable” means the drug coverage is at least as good as Medicare’s standard drug coverage.) For these members, the late enrollment penalty is added to the plan’s monthly premium. Their premium amount will be the monthly plan premium plus the amount of their late enrollment penalty.

- If you are required to pay the late enrollment penalty, the amount of your penalty depends on how long you waited before you enrolled in drug coverage or how many months you were without drug coverage after you became eligible. Chapter 6, Section 10 explains the late enrollment penalty.

- If you have a late enrollment penalty and do not pay it, you could lose your prescription drug coverage.

Many members are required to pay other Medicare premiums

Many members are required to pay other Medicare premiums. Some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A. And most plan members pay a premium for Medicare Part B. You must continue paying your Medicare Part B premium to remain a member of our plan.

Some people pay an extra amount for Part D because of their yearly income; this is known Income Related Adjustment Amounts, also known as IRMAA. If your income is $85,000 or above for an individual (or married individuals filing separately) or $170,000 or above for married couples, you must pay an extra amount directly to the government (not the Medicare plan) for your Medicare Part D coverage.

- If you are required to pay the extra amount and you do not pay it, you will lose your prescription drug coverage.

- If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be.

- For more information about Part D premiums based on income, go to Chapter 6, Section 10, in this booklet. You can also visit http://www.medicare.gov on the Web or call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. Or you may call Social Security at 1-800-772-1213. TTY users should call 1-800-325-0778.

Your copy of Medicare & You 2015 gives information about Medicare premiums in the section called “2015 Medicare Costs.” This explains how the Medicare Part B and Part D premium differs for people with different incomes. Everyone with Medicare receives a copy of Medicare & You each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of Medicare & You 2015 from the Medicare website (http://www.medicare.gov). Or, you can order a printed copy by phone at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users call 1-877-486-2048.
SECTION 5. Please keep your plan membership record up-to-date

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

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

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

Let us know about these changes:

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

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

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

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

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

Once each year, we will send you a letter that lists any other medical or drug insurance coverage that we know about. Please read over this information carefully. If it is correct, you don't need to do anything. If the information is incorrect, or if you have other coverage that is not listed, please call Member Services (phone numbers are printed on the back cover of this booklet).
SECTION 6. We protect the privacy of your personal health information

Section 6.1 We make sure that your health information is protected

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

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

SECTION 7. How other insurance works with our plan

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

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

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

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

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

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

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

If you have other insurance, tell your doctor, hospital, and pharmacy. If you have questions about who pays first, or you need to update your other insurance information, call Member Services (phone numbers are printed on the back cover of this booklet). You may need to give your plan member ID number to your other insurers (once you have confirmed their identity) so your bills are paid correctly and on time.
CHAPTER 2. Important phone numbers and resources

SECTION 1. Kaiser Permanente Medicare Plus contacts (how to contact us, including how to reach Member Services at our plan) ..................... 14

SECTION 2. Medicare (how to get help and information directly from the federal Medicare program) ................................................................. 16

SECTION 3. State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare) .................. 18

SECTION 4. Quality Improvement Organization (paid by Medicare to check on the quality of care for people with Medicare) ......................... 19

SECTION 5. Social Security ........................................................................................................................................................................ 20

SECTION 6. Medicaid (a joint federal and state program that helps with medical costs for some people with limited income and resources) ........................................................................................................... 21

SECTION 7. Information about programs to help people pay for their prescription drugs .................................................................................................................. 22

SECTION 8. How to contact the Railroad Retirement Board .................................................. 26

SECTION 9. Do you have “group insurance” or other health insurance from an employer? ........................................................................................................... 27
SECTION 1. Kaiser Permanente Medicare Plus contacts (how to contact us, including how to reach Member Services at our plan)

How to contact our plan's Member Services

For assistance with claims, billing, or membership card questions, please call or write to Medicare Plus Member Services. We will be happy to help you.

<table>
<thead>
<tr>
<th>Method</th>
<th>Member Services – contact information</th>
</tr>
</thead>
</table>
| CALL   | 1-888-777-5536  Calls to this number are free.  
          Seven days a week, 8 a.m. to 8 p.m.  
          Member Services also has free language interpreter services available for non-English speakers. |
| TTY    | 711  Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m. |
| FAX    | 301-816-6192 |
| WRITE  | Kaiser Permanente, Member Services  
          2101 East Jefferson Street  
          Rockville, Maryland 20852 |
| WEBSITE| kp.org |

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

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or Part D prescription drugs. An appeal is a formal way of asking us to review and change a coverage decision we have made. You can make a complaint about us or one of our network providers or pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes.

For more information about asking for coverage decisions or making an appeal or a complaint about your medical care or Part D prescription drugs, see Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)." You may call us if you have questions about our coverage decision process.
### Coverage decisions, appeals, or complaints for medical care or Part D prescription drugs – contact information

**CALL**  1-888-777-5536  Calls to this number are free.  
Seven days a week, 8 a.m. to 8 p.m.

**TTY**  711  
Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.

**FAX**  301-816-6192

**WRITE**  Kaiser Permanente, Member Services  
2101 East Jefferson Street  
Rockville, Maryland 20852

**WEBSITE**  kp.org

**MEDICARE WEBSITE**  You can submit a complaint about our plan directly to Medicare.  
To submit an online complaint to Medicare, go to  
www.medicare.gov/MedicareComplaintForm/home.aspx.

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

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

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

### Payment requests – contact information

**CALL**  1-888-777-5536  Calls to this number are free.  
Seven days a week, 8 a.m. to 8 p.m.

**TTY**  711  
Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.
<table>
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<tr>
<th>Method</th>
<th>Payment requests – contact information</th>
</tr>
</thead>
<tbody>
<tr>
<td>FAX</td>
<td>301-816-6192</td>
</tr>
<tr>
<td>WRITE</td>
<td>Kaiser Permanente, Member Services</td>
</tr>
<tr>
<td></td>
<td>2101 East Jefferson Street</td>
</tr>
<tr>
<td></td>
<td>Rockville, Maryland 20852</td>
</tr>
<tr>
<td>WEBSITE</td>
<td>kp.org</td>
</tr>
</tbody>
</table>

**SECTION 2. Medicare (how to get help and information directly from the federal Medicare program)**

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage and Medicare Cost Plan organizations, including our plan.

<table>
<thead>
<tr>
<th>Method</th>
<th>Medicare – contact information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>1-800-MEDICARE or 1-800-633-4227</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free. 24 hours a day, 7 days a week.</td>
</tr>
<tr>
<td>TTY</td>
<td>1-877-486-2048</td>
</tr>
<tr>
<td></td>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.</td>
</tr>
</tbody>
</table>
This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.

The Medicare website also has detailed information about your Medicare eligibility and enrollment options, with the following tools:

- **Medicare Eligibility Tool**: Provides Medicare eligibility status information.

- **Medicare Plan Finder**: Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans.

You can also use the website to tell Medicare about any complaints you have about our plan:

- **Tell Medicare about your complaint**: You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to [www.medicare.gov/MedicareComplaintForm/home.aspx](http://www.medicare.gov/MedicareComplaintForm/home.aspx). Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)
SECTION 3. State Health Insurance Assistance Program (free help, information, and answers to your questions about Medicare)

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

- In the District of Columbia, the SHIP is called Health Insurance Counseling Project.
- In Maryland, the SHIP is called Maryland Department of Aging.
- In Virginia, the SHIP is called Virginia Insurance Counseling and Assistance Program.

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

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

<table>
<thead>
<tr>
<th>Method</th>
<th>Health Insurance Counseling Project (District of Columbia's SHIP) – contact information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>202-994-6272</td>
</tr>
<tr>
<td>TTY</td>
<td>202-994-6656</td>
</tr>
<tr>
<td></td>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
</tr>
<tr>
<td>WRITE</td>
<td>2136 Pennsylvania Avenue, N.W., Washington, DC 20052</td>
</tr>
<tr>
<td>WEBSITE</td>
<td><a href="http://www.law.gwu.edu/academics/el/clinics/insurance/">www.law.gwu.edu/academics/el/clinics/insurance/</a></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Method</th>
<th>Maryland Department of Aging – contact information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>410-767-1100 or toll free 1-800-243-3425</td>
</tr>
<tr>
<td>TTY</td>
<td>711</td>
</tr>
<tr>
<td>WRITE</td>
<td>301 West Preston St., Suite 1007, Baltimore, MD 21201</td>
</tr>
</tbody>
</table>
### Maryland Department of Aging – contact information

Method: WEBSITE  
mdoa.state.md.us/

### Virginia Insurance Counseling and Assistance Program – contact information

Method: CALL  
804-662-9333 or toll free 1-800-552-3402

Method: TTY  
711

Method: WRITE  
1610 Forest Avenue, Suite 100, Henrico, VA 23229

Method: WEBSITE  
vda.virginia.gov

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

There is a Quality Improvement Organization for each state. For District of Columbia, Maryland, and Virginia, the Quality Improvement Organization is called KEPRO.

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

You should contact KEPRO in any of these situations:

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

### KEPRO (District of Columbia’s, Maryland’s, and Virginia’s QIO) – contact information

Method: CALL  
1-844-455-8708

Method: TTY  
1-855-843-4776

This number requires special telephone equipment and is only for people...
Method | KEPRO (District of Columbia’s, Maryland’s, and Virginia’s QIO) – contact information

| WRITE | KEPRO  
| | 5201 W. Kennedy Blvd., Suite 900  
| | Tampa, FL  33609

| WEBSITE | www.KEPROqio.com

**SECTION 5. Social Security**

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for a reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

**Method | Social Security – contact information**

| CALL | 1-800-772-1213 Calls to this number are free.  
| | Available 7 a.m. to 7 p.m., Monday through Friday.  
| | You can use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.

| TTY | 1-800-325-0778  
| | This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.  
| |
SECTION 6. Medicaid (a joint federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). Some people with QMB are also eligible for full Medicaid benefits (QMB+).
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).
- **Qualified Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact the Medicaid agency for your state listed below.

<table>
<thead>
<tr>
<th>Method</th>
<th>Department of Healthcare Finance (District of Columbia's Medicaid program) – contact information</th>
</tr>
</thead>
<tbody>
<tr>
<td>CALL</td>
<td>202-442-5988</td>
</tr>
<tr>
<td>TTY</td>
<td>711</td>
</tr>
<tr>
<td>WRITE</td>
<td>441 4th Street NW, 900S, Washington, DC 20001</td>
</tr>
<tr>
<td>WEBSITE</td>
<td>dhcf.dc.gov</td>
</tr>
<tr>
<td>Method</td>
<td>Maryland Medical Assistance Program/HealthChoice – contact information</td>
</tr>
<tr>
<td>--------------------------------</td>
<td>------------------------------------------------------------------------------------------</td>
</tr>
<tr>
<td>CALL</td>
<td>410-767-5800 or toll free 1-800-492-5231</td>
</tr>
<tr>
<td>TTY</td>
<td>1-800-735-2258</td>
</tr>
<tr>
<td></td>
<td>This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.</td>
</tr>
<tr>
<td>WRITE</td>
<td>Contact the Department of Social Services (DSS) in the city or county where you live.</td>
</tr>
<tr>
<td>WEBSITE</td>
<td>dhmh.state.md.us/mma/healthchoice/index.html</td>
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<tr>
<th>Method</th>
<th>Virginia Department of Medical Assistance Services – contact information</th>
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</thead>
<tbody>
<tr>
<td>CALL</td>
<td>804-786-6145 or toll free 1-800-643-2273</td>
</tr>
<tr>
<td>TTY</td>
<td>711</td>
</tr>
<tr>
<td>WRITE</td>
<td>Contact the Department of Social Services (DSS) in the city or county where you live.</td>
</tr>
<tr>
<td>WEBSITE</td>
<td>dmasva.dmas.virginia.gov</td>
</tr>
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**SECTION 7. Information about programs to help people pay for their prescription drugs**

**Medicare's "Extra Help" Program**

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

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

- **1-800-MEDICARE (1-800-633-4227).** TTY users should call 1-877-486-2048, 24 hours a day, 7 days a week;
- The Social Security Office at **1-800-772-1213,** between 7 a.m. to 7 p.m., Monday through Friday. TTY users should call **1-800-325-0778;** or
- Your state Medicaid office (see Section 6 in this chapter for contact information).

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect cost-sharing amount when you get your prescription at a pharmacy, our plan has established a process that allows you either to request assistance in obtaining evidence of your proper copayment level, or, if you already have the evidence, to provide this evidence to us.

If you aren't sure what evidence to provide us, please contact a network pharmacy or Member Services. The evidence is often a letter from either the state Medicaid or Social Security office that confirms you are qualified for "Extra Help.

You or your appointed representative may need to provide the evidence to a network pharmacy when obtaining covered Part D prescriptions so that we may charge you the appropriate cost-sharing amount until 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 the pharmacy. Please provide your evidence in one of the following ways so we can forward it to CMS for updating:

- Write to Kaiser Permanente at:
  California Service Center
  Attn: Best Available Evidence
  P.O. Box 232407
  San Diego, CA 92193-2407
- Fax it to **1-877-528-8579.**

Take it to a network pharmacy or your local Member Services office at a plan facility.

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

The Medicare Coverage Gap Discount Program is available nationwide. Because our plan does not have a coverage gap, the discounts described here do not apply to you.

Instead, our plan continues to cover your drugs at your regular cost-sharing amount until you qualify for the Catastrophic Coverage Stage. Please go to Chapter 6, Section 5, for more information about your coverage during the Initial Coverage Stage.

The Medicare Coverage Gap Discount Program provides manufacturer discounts on brand-name drugs to Part D enrollees who have reached the coverage gap and are not already receiving "Extra Help." A 50% discount on the negotiated price (excluding the dispensing fee and vaccine administration fee, if any) is available for those brand-name drugs from manufacturers that have agreed to pay the discount. The plan pays an additional 5% and you pay the remaining 45% for your brand-name drugs.

If you reach the coverage gap, we automatically apply the discount when your pharmacy bills you for your prescription. Your Part D Explanation of Benefits (EOB) will show any discount provided. Both the amount you pay and the amount discounted by the manufacturer count toward your out-of-pocket costs as if you had paid them, and move you through the coverage gap. The amount paid by the plan (5%) does not count toward your out-of-pocket costs.

You also receive some coverage for generic drugs. If you reach the coverage gap, our plan pays 35% of the price for generic drugs and you pay the remaining 65% of the price. For generic drugs, the amount paid by our plan (35%) does not count toward your out-of-pocket costs. Only the amount you pay counts and moves you through the coverage gap. Also, the dispensing fee is included as part of the cost of the drug.

If you have any questions about the availability of discounts for the drugs you are taking or about the Medicare Coverage Gap Discount Program in general, please contact Member Services (phone numbers are printed on the back cover of this booklet).

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

If you are enrolled in a State Pharmaceutical Assistance Program (SPAP), or any other program that provides coverage for Part D drugs (other than "Extra Help"), you still get the 50% discount on covered brand-name drugs. Also, the plan pays 5% of the costs of brand-name drugs in the coverage gap. The 50% discount and the 5% paid by the plan are applied to the price of the drug before any SPAP or other coverage.

What if you have coverage from an AIDS Drug Assistance Program (ADAP)?

What is the AIDS Drug Assistance Program (ADAP)?

The AIDS Drug Assistance Program (ADAP) helps ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through the District of Columbia ADAP, Maryland ADAP, or Virginia ADAP depending upon where you live. Note: To be eligible for the ADAP operating in your state, individuals must meet certain criteria,
including proof of state residence and HIV status, low income as defined by the state, and uninsured/underinsured status.

If you are currently enrolled in an ADAP, it can continue to provide you with Medicare Part D prescription cost-sharing assistance for drugs on the ADAP formulary. In order to be sure you continue receiving this assistance, please notify your local ADAP enrollment worker of any changes in your Medicare Part D plan name or policy number. Please call 202-671-4900 for DC residents, 410-767-6535 for Maryland residents, or 855-362-0658 for Virginia residents.

For information on eligibility criteria, covered drugs, or how to enroll in the program, please call 202-671-4900 for DC residents, 410-767-6535 for Maryland residents, or 855-362-0658 for Virginia residents.

**What if you get "Extra Help" from Medicare to help pay your prescription drug costs?**

**Can you get the discounts?**

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

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

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

**State Pharmaceutical Assistance Programs**

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

These programs provide financial help for prescription drugs to limited income and medically needy seniors and individuals with disabilities. In Maryland, the name of the State Pharmaceutical Assistance Program is Maryland Senior Prescription Drug Assistance Program (SPDAP). Maryland also has other programs that assist Maryland residents with drug expenses, which are the Kidney Disease Program and the AIDS Drug Assistance Program.

<table>
<thead>
<tr>
<th>Method</th>
<th>Maryland Senior Prescription Drug Assistance Program (SPDAP) – contact information</th>
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<tbody>
<tr>
<td>CALL</td>
<td>1-800-551-5995</td>
</tr>
<tr>
<td>TTY</td>
<td>1-800-877-5156</td>
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This number requires special telephone equipment and is only for people.
who have difficulties with hearing or speaking.

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<tr>
<th>Method</th>
<th>Maryland Kidney Disease Program – contact information</th>
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<tbody>
<tr>
<td>CALL</td>
<td>1-410-767-5000</td>
</tr>
</tbody>
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<table>
<thead>
<tr>
<th>Method</th>
<th>Maryland AIDS Drug Assistance Program – contact information</th>
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<tbody>
<tr>
<td>CALL</td>
<td>1-410-767-6535</td>
</tr>
</tbody>
</table>

**SECTION 8. How to contact the Railroad Retirement Board**

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

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

<table>
<thead>
<tr>
<th>Method</th>
<th>Railroad Retirement Board – contact information</th>
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<tbody>
<tr>
<td>CALL</td>
<td>1-877-772-5772</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free. Available 9:00 a.m. to 3:30 p.m., Monday through Friday. If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.</td>
</tr>
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| TTY    | 1-312-751-4701                                   |
|        | This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are **not** free. |

<table>
<thead>
<tr>
<th>WEBSITE</th>
<th><a href="http://www.rrb.gov">http://www.rrb.gov</a></th>
</tr>
</thead>
</table>
If you (or your spouse) get benefits from your (or your spouse’s) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse’s) employer or retiree health benefits, premiums, or the enrollment period. Phone numbers for Member Services are printed on the back cover of this booklet. You may also call 1-800-MEDICARE (1-800-633-4227; TTY: 1-877-486-2048) with questions related to your Medicare coverage under this plan.

If you have other prescription drug coverage through your (or your spouse’s) employer or retiree group, please contact that group’s benefits administrator. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.
CHAPTER 3. Using our plan’s coverage for your medical services

SECTION 1. Things to know about getting your medical care covered as a member of our plan .......................................................... 29
  Section 1.1 What are "network providers" and "covered services"? ................................................................. 29
  Section 1.2 Basic rules for getting your medical care covered by our plan........................................ 29

SECTION 2. Use providers in our network to get your medical care .......... 30
  Section 2.1 You must choose a Primary Care Provider (PCP) to provide and oversee your medical care ........................................................................................................ 30
  Section 2.2 What kinds of medical care can you get without getting approval in advance from your PCP? .......................................................................................... 31
  Section 2.3 How to get care from specialists and other network providers.............................. 32

SECTION 3. How to get covered services when you have an emergency or urgent need for care ........................................................................ 34
  Section 3.1 Getting care if you have a medical emergency ................................................................. 34
  Section 3.2 Getting care when you have an urgent need for care ...................................................... 35

SECTION 4. What if you are billed directly for the full cost of your covered services? ................................................................. 36
  Section 4.1 You can ask us to pay our share of the cost for covered services ......................... 36
  Section 4.2 If services are not covered by our plan or Original Medicare, you must pay the full cost ........................................................................................................ 36

SECTION 5. How are your medical services covered when you are in a "clinical research study"? .................................................................. 37
  Section 5.1 What is a "clinical research study"? .................................................................................. 37
  Section 5.2 When you participate in a clinical research study, who pays for what?..................... 38

SECTION 6. Rules for getting care covered in a "religious nonmedical health care institution" ........................................................................ 39
  Section 6.1 What is a religious nonmedical health care institution? .................................................. 39
  Section 6.2 What care from a religious nonmedical health care institution is covered by our plan? .................................................................................................................. 39

SECTION 7. Rules for ownership of durable medical equipment ...................... 40
  Section 7.1 Will you own the durable medical equipment after making a certain number of payments under our plan? ................................................................. 40
SECTION 1. Things to know about getting your medical care covered as a member of our plan

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

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the Medical Benefits Chart in the next chapter, Chapter 4, "Medical Benefits Chart (what is covered and what you pay)."

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

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

- "Providers" are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.

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

- "Covered services" include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4.

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

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

We will generally cover your medical care as long as:

- The care you receive is included in our plan's Medical Benefits Chart (this chart is in Chapter 4 of this booklet).

- The care you receive is considered medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

- You generally must receive your care from a network provider for our plan to cover the services.
If we do not cover services you receive from an out-of-network provider, the services will be covered by Original Medicare if they are Medicare-covered services. Except for emergency or urgently needed care, if you get services covered by Original Medicare from an out-of-network provider then you must pay Original Medicare's cost-sharing amounts. For information on Original Medicare's cost-sharing amounts, call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

You should get supplemental benefits from a network provider. If you get covered supplemental benefits, such as dental care, from an out-of-network provider, then you must pay the entire cost of the service.

If an out-of-network provider sends you a bill that you think we should pay, please contact Member Services (phone numbers are printed on the back cover of this booklet). Generally, it is best to ask an out-of-network provider to bill Original Medicare first, and then to bill us for the remaining amount. We may require the out-of-network provider to bill Original Medicare. We will then pay any applicable Medicare coinsurance and deductibles minus your copayments on your behalf.

- **You have a network primary care provider** (a PCP) who is providing and overseeing your care. As a member of our plan, you must choose a network PCP (for more information about this, see Section 2.1 in this chapter).
  - In most situations, your network PCP must give you approval in advance before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. This is called giving you a "referral" (for more information about this, see Section 2.3 in this chapter).
  - Referrals from your PCP are not required for emergency care or urgently needed care. There are also some other kinds of care you can get without having approval in advance from your PCP (for more information about this, see Section 2.2 in this chapter).

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

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

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

Your primary care provider will provide and arrange the medical services that you receive. Physicians who specialize in internal medicine, pediatrics and family practice will serve as PCPs. Your PCP will provide most of your health care and will coordinate care from other Medical Group physicians and other providers by arranging specialty care when you need it. Your PCP must be a Medical Group physician, unless we designate otherwise. If you do not select a PCP, then one will be selected for you from the available Medical Group physicians. You are free to see other Medical Group PCPs if your PCP is not available, and to receive care...
at Kaiser Permanente medical offices other than the one where your PCP practices. You may change your PCP at any time by going online or calling Member Services.

When your PCP believes that you may need specialty care, he or she will request authorization from us. If specialty care is medically necessary, we will issue a referral to a particular Medical Group specialist for an initial consultation and/or for a certain number of visits. If we authorize a referral, you may seek the authorized services from the specialist to whom you were referred. Unless we have authorized additional visits without the need to obtain another referral, you must return to your PCP after the consultation unless we have given you a referral for authorized services beyond the initial consultation. See Section 2.2 in this chapter for more information about services that don't require this authorization.

If at all possible, call our automated appointment line 24 hours in advance if you cannot keep a scheduled appointment at 703-359-7878 inside the Washington, DC Metropolitan Area or 1-800-777-7904 outside the Washington, DC Metropolitan Area. Our TTY inside the Washington, DC Metropolitan Area is 703-359-7616 and outside the Washington, DC Metropolitan Area is 1-800-700-4901.

**How do you choose your PCP?**

You may select a primary care plan physician from any of our available plan physicians who practice in these specialties: internal medicine, family medicine, and pediatrics. Also, women can select any available primary care plan physician from obstetrics/gynecology. When you make a selection, it is effective immediately. To learn how to select a primary care plan physician, please call Member Services. You can also make your selection at kp.org. If there is a particular plan specialist or hospital that you want to use, check first to be sure your PCP makes referrals to that specialist, or uses that hospital.

**Changing your PCP**

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

To change your PCP, call Member Services. When you call, be sure to tell Member Services if you are seeing specialists or getting other covered services that need your PCP's approval (such as home health services and durable medical equipment). Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Member Services will tell you when the change to your new PCP will take effect. Generally, changes are effective the first of the month following the date when we receive your request.

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

You can get services such as those listed below without getting approval in advance from your PCP:
• Routine women's health care, which includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider.
• Flu shots, and Hepatitis B vaccinations, pneumonia vaccinations, as long as you get them from a network provider.
• Emergency services from network providers or from out-of-network providers.
• Urgently needed care from in-network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible, for example, when you are temporarily outside of our service area.
• If you visit the service area of another Kaiser Permanente region or Group Health Cooperative (GHC) for not more than 90 days, you can receive certain care from designated providers in that service area. Please call Member Services for more information about getting care when visiting another Kaiser Permanente region's service area or the GHC service area, including coverage information and facility locations in parts of California, Colorado, Georgia, Hawaii, Idaho, Ohio, Oregon, and Washington.

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

A specialist is a doctor who provides health care services for a specific disease or part of the body. There are many kinds of specialists. Here are a few examples:
• Oncologists care for patients with cancer.
• Cardiologists care for patients with heart conditions.
• Orthopedists care for patients with certain bone, joint, or muscle conditions.

Referrals from your PCP

You will usually see your PCP first for most of your routine health care needs. There are only a few types of covered services you may get on your own, without getting approval from your PCP first, which are described in Section 2.2. Also, your PCP will need to request authorization from our plan for referrals to specialists.

• If you are seeing a non-plan specialist when you enroll in our plan, you will be required in most instances to switch to a plan specialist. If your current specialist is not a plan specialist and you wish to continue to receive services from that non-plan specialist, then you may continue to do so under Original Medicare, if he/she participates in the Medicare program. In that instance, you will be required to pay cost-sharing under Original Medicare.

Prior authorization

For some covered services and items, your PCP will need to get approval in advance from our plan or Medical Group (this is called getting "prior authorization"). Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals. See Chapter 4, Section 2.1, for details about prior authorization including the services and items that require prior authorization. If you get care without prior authorization
by our plan or Medical Group, the care will not be covered by our plan and you will have to pay Original Medicare's out-of-pocket amounts for the care.

- **In-network specialty care.** When your PCP believes that you need specialty care, he or she will request authorization from us. If specialty care is medically necessary, we will issue a referral to a Medical Group specialist and authorize an initial consultation and/or a certain number of visits. If we approve a referral, you may seek the initial consultation from the specialist to whom we refer you. You must then return to your PCP after the consultation unless we have authorized a certain number of additional visits without the need to obtain another referral. Do not go to the specialist for return visits unless we have authorized such visits in your referral or the services will not be covered and you will be responsible for paying Original Medicare cost-sharing and out-of-pocket expenses, instead of our plan's cost-sharing amounts. Here are some other things you should know about obtaining specialty care:

  - If you need to see a specialist frequently because you have been diagnosed with a condition or disease that requires specialized care, your PCP and your attending specialist may develop a treatment plan that allows you to see the specialist without additional referrals. Your PCP must contact us and your specialist must use our criteria when creating your treatment plan, and the specialist will need to get authorization before starting any treatment.

- **Inpatient care.** For nonemergency admissions, your care will be coordinated through the Medical Group and our plan will determine which hospital you will be admitted. Your PCP or specialist must receive authorization in advance for these services, including admission to behavioral health and skilled nursing facilities or other inpatient setting. We will determine the most appropriate facility for care. Depending upon your medical needs, we may transfer you from one network provider hospital or other inpatient setting, to another where Medical Group physicians are on duty. In addition, we may transfer you from one network provider skilled nursing facility to another where Medical Group physicians make rounds and are available for urgent care. If you require emergency care, please go to the nearest hospital. After your condition has stabilized, we may choose to move you to a hospital where Medical Group physicians are on duty.

- Medically necessary transgender surgery and associated procedures.

- **Out-of-network specialty care.** If your PCP decides that you require covered services not available from network providers, he or she will recommend to the Medical Group that you be referred to an out-of-network provider inside or outside our service area. The appropriate Medical Group designee will authorize the services if he or she determines that the covered services are medically necessary and are not available from a network provider. Referrals to out-of-network physicians will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your network physician what services have been authorized. If the out-of-network specialist wants you to come back for more care, be sure to check if the referral covers more visits to the specialist. If it doesn't, please contact your PCP.

See Chapter 4, Section 2.1, for more information about prior authorization.
What if a specialist or another network provider leaves our plan?

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- When possible we will provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure, that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.

If you find out your doctor or specialist is leaving your plan, please contact us at 1-888-777-5536 (TTY 711) so we can assist you in finding a new provider and managing your care.

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

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

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

What is covered if you have a medical emergency?

You may get covered emergency medical care whenever you need it, anywhere in the United States or its territories. Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. For more information, see the Medical Benefits Chart in Chapter 4 of this booklet.

Also, you may get covered emergency medical care whenever you need it, anywhere in the world (see Chapter 4 for more information).

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

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. Your follow-up care will be either covered by our plan or Original Medicare. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow and we may choose to move you to a hospital where Medical Group physicians are on duty 24 hours a day, 7 days a week. Our plan will cover your post-stabilization care if the services are provided by network providers, authorized by our plan, or the care is covered out-of-area urgent care. Otherwise, your post-stabilization care will be covered by Original Medicare and you will have to pay Original Medicare cost-sharing for post-stabilization care.

What if it wasn't a medical emergency?

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

However, after the doctor has said that it was not an emergency, we will cover additional care only if you go to a network provider to get the additional care. If you get additional care from an out-of-network provider after the doctor says it was not an emergency, you will normally have to pay Original Medicare's cost-sharing.

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

What is "urgently needed care"?

"Urgently needed care" is a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or

113
Agreement 564-14
inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

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

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

We know that sometimes it's difficult to know what type of care you need. That's why we have telephone advice nurses available to assist you. Our advice nurses are registered nurses specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. Whether you are calling for advice or to make an appointment, you can speak to an advice nurse. They can often answer questions about a minor concern, tell you what to do if a network facility 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 speak with an advice nurse or make an appointment, please refer to your *Provider Directory* for appointment and advice telephone numbers.

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

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

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

**Section 4.1 You can ask us to pay our share of the cost for covered services**

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

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

Our plan covers all medical services that are medically necessary, listed in the Medical Benefits Chart (this chart is in Chapter 4 of this booklet), and obtained consistent with plan rules. You are responsible for paying the full cost of services that aren't covered by Original Medicare or our plan, either because they are not plan covered services or they were obtained out-of-network and were not authorized. You have the right to seek care from any provider that is qualified to treat
Medicare members. However, Original Medicare pays your claims and you must pay your cost-sharing.

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services to get more information about how to do this (phone numbers are printed on the back cover of this booklet).

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

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

#### Section 5.1 What is a "clinical research study"?

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

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

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

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for the covered services you receive as part of the study. When you are in a clinical research study, you may stay enrolled in our plan and continue to get the rest of your care (the care that is not related to the study) through our plan.
If you want to participate in a Medicare-approved clinical research study, you do not need to get approval from us or your PCP. The providers that deliver your care as part of the clinical research study do not need to be part of our plan's network of providers.

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

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

If you plan on participating in a clinical research study, contact Member Services (phone numbers are printed on the back cover of this booklet).

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

Once you join a Medicare-approved clinical research study, you are covered for routine items and services you receive as part of the study, including:
- Room and board for a hospital stay that Medicare would pay for even if you weren't in a study.
- An operation or other medical procedure if it is part of the research study.
- Treatment of side effects and complications of the new care.

Original Medicare pays most of the cost of the covered services you receive as part of the study.

When you are part of a clinical research study, **neither Medicare nor our plan will pay for any of the following:**
- Generally, Medicare will not pay for the new item or service that the study is testing, unless Medicare would cover the item or service even if you were not in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

**Do you want to know more?**

You can get more information about joining a clinical research study by reading the publication "Medicare and Clinical Research Studies" on the Medicare website ([http://www.medicare.gov](http://www.medicare.gov)). You can also call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.
SECTION 6. Rules for getting care covered in a "religious nonmedical health care institution"

Section 6.1 What is a religious nonmedical health care institution?

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

Section 6.2 What care from a religious nonmedical health care institution is covered by our plan?

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan's coverage of services you receive is limited to nonreligious aspects of care.
- If you get services from this institution that are provided to you in your home, we will cover these services only if your condition would ordinarily meet the conditions for coverage of services given by home health agencies that are not religious nonmedical health care institutions.
- If you get services from this institution that are provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to receive covered services for inpatient hospital care or skilled nursing facility care.
  - You must get approval in advance from our plan before you are admitted to the facility or your stay will not be covered.
Note: Covered services are subject to the same limitations and cost-sharing required for services provided by network providers as described in Chapters 4 and 12.

SECTION 7. Rules for ownership of durable medical equipment

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

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

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

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

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

If you made payments for the durable medical equipment item under Original Medicare before you joined our plan, these previous Original Medicare payments also do not count toward the 13 consecutive payments. You will have to make 13 consecutive payments for the item under Original Medicare in order to acquire ownership. There are no exceptions to this case when you return to Original Medicare.
**CHAPTER 4. Medical Benefits Chart (what is covered and what you pay)**

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

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Types of out-of-pocket costs you may pay for your covered services</td>
<td>42</td>
</tr>
<tr>
<td>1.2 What is the most you will pay for Medicare Part A and Part B covered</td>
<td></td>
</tr>
<tr>
<td>medical services?</td>
<td>43</td>
</tr>
<tr>
<td>1.3 Our plan does not allow providers to &quot;balance bill&quot; you</td>
<td>43</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>2.1 Your medical benefits and costs as a member of our plan</td>
<td>44</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Section</th>
<th>Page</th>
</tr>
</thead>
<tbody>
<tr>
<td>3.1 Benefits we do not cover (exclusions)</td>
<td>92</td>
</tr>
</tbody>
</table>
SECTION 1. Understanding your out-of-pocket costs for covered services

This chapter focuses on your covered services and what you pay for your medical benefits. It includes a Medical Benefits Chart that lists your covered services and some limitations, and shows how much you will pay for each covered service as a member of our plan. Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services. In addition, please see Chapters 3, 11, and 12 for additional coverage information, including limitations (for example, coordination of benefits, durable medical equipment, home health care, skilled nursing facility care, and third party liability).

Also, be sure to read the Amendment titled "What You Need to Know – Your Important State-mandated Health Care Benefits and Rights and Other Legal Notices" for more information about your additional coverage.

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

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

- A "copayment" is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service, unless we do not collect all cost-sharing at that time and send you a bill later. (The Medical Benefits Chart in Section 2 tells you more about your copayments.)

- "Coinsurance" is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service, unless we do not collect all cost-sharing at that time and send you a bill later. (The Medical Benefits Chart in Section 2 tells you more about your coinsurance.)

Some people qualify for state Medicaid programs to help them pay their out-of-pocket costs for Medicare. These "Medicare Savings Programs" include the Qualified Medicare Beneficiary (QMB), Specified Low-Income Medicare Beneficiary (SLMB), Qualified Individual (QI), and Qualified Disabled & Working Individuals (QDWI) programs. If you are enrolled in one of these programs, you may still have to pay a copayment for the service, depending upon the rules in your state.
Section 1.2 What is the most you will pay for Medicare Part A and Part B covered medical services?

There is a limit to how much you have to pay out-of-pocket each year for in-network medical services that are covered under Medicare Part A and Part B (see the Medical Benefits Chart in Section 2 below). This limit is called the maximum out-of-pocket amount for medical services.

As a member of our plan, the most you will have to pay out-of-pocket for in-network Part A and Part B services in 2015 is $3,400. The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for your plan premiums and Part D prescription drugs do not count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk * in the Medical Benefits Chart.

If you reach the maximum out-of-pocket amount of $3,400, you will not have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay your plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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

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

Here is how this protection works:

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

SECTION 2. Use this Medical Benefits Chart to find out what is covered for you and how much you will pay

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

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

- Your Medicare covered services must be provided according to the coverage guidelines established by Medicare.
- Your services (including medical care, services, supplies, and equipment) must be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered by our plan. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
  - If you get Medicare-covered services from an out-of-network provider and we do not cover the services, Original Medicare will cover the services. For any services covered by Original Medicare instead of our plan, you must pay Original Medicare's cost-sharing amounts.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in our plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart with a footnote (†). Please see Chapter 3, Section 2.3, for details about prior authorization and other services that require prior authorization that are not listed in the Medical Benefits Chart.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay more in our plan than you would in Original Medicare. For others,
you pay less. (If you want to know more about the coverage and costs of Original Medicare, look in your Medicare & You 2015 handbook. View it online at http://www.medicare.gov or ask for a copy by calling 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.)

- We do not charge office visit cost-sharing if the sole purpose of the visit is to obtain preventive services. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, a copayment will apply for the care received for the existing medical condition.

Sometimes Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2015, either Medicare or our plan will cover those services.

粦 You will see this apple next to the preventive services in the Medical Benefits Chart.
## Medical Benefits Chart

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Abdominal aortic aneurysm screening</strong>&lt;br&gt;A one-time screening ultrasound for people at risk. Our plan only covers this screening if you get a referral for it as a result of your &quot;Welcome to Medicare&quot; preventive visit.</td>
<td>There is no coinsurance, copayment, or deductible for beneficiaries eligible for this preventive screening.</td>
</tr>
<tr>
<td><strong>Ambulance services</strong>&lt;br&gt;• Covered ambulance services include fixed wing, rotary wing, and ground ambulance services to the nearest appropriate facility that can provide care only if they are furnished to a member whose medical condition is such that other means of transportation are contraindicated (could endanger the person's health) or if authorized by our plan.&lt;br&gt;• † Nonemergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation are contraindicated (could endanger the person's health) and that transportation by ambulance is medically required.</td>
<td>No charge.</td>
</tr>
<tr>
<td><strong>Annual routine physical exams</strong>&lt;br&gt;Routine physical exams are covered if the exam is medically appropriate preventive care in accord with generally accepted professional standards of practice. This exam is covered once every 12 months.</td>
<td>There is no coinsurance, copayment, or deductible for this preventive care</td>
</tr>
<tr>
<td><strong>Annual wellness visit</strong>&lt;br&gt;If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. &lt;br&gt;Note: Your first annual wellness visit can't take place within 12 months of your &quot;Welcome to Medicare&quot;</td>
<td>There is no coinsurance, copayment, or deductible for the annual wellness visit.</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
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<td>---------------------------------</td>
<td>-------------------------------------------</td>
</tr>
<tr>
<td>Preventive visit. However, you don't need to have had a &quot;Welcome to Medicare&quot; visit to be covered for annual wellness visits after you've had Part B for 12 months.</td>
<td></td>
</tr>
<tr>
<td><strong>Bone mass measurement†</strong></td>
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</tr>
<tr>
<td>For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.</td>
<td>There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.</td>
</tr>
<tr>
<td><strong>Breast cancer screening (mammograms)</strong></td>
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</tr>
</tbody>
</table>
| Covered services include:  
• One baseline mammogram between the ages of 35 and 39.  
• One screening mammogram every 12 months for women age 40 and older.  
• Clinical breast exams once every 24 months. | There is no coinsurance, copayment, or deductible for covered screening mammograms. |
<p>| <strong>Cardiac rehabilitation services†</strong> | You pay $15 per visit. |
| Comprehensive programs for cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's referral. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs. | |
| <strong>Cardiovascular disease risk reduction visit (therapy for cardiovascular disease)</strong> | There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit. |
| We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating well. | |</p>
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
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</thead>
<tbody>
<tr>
<td><strong>Cardiovascular disease testing†</strong>&lt;br&gt;Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every five years (60 months).</td>
<td>There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every five years.</td>
</tr>
<tr>
<td><strong>Cervical and vaginal cancer screening</strong>&lt;br&gt;Covered services include:&lt;br&gt;• For all women: Pap tests and pelvic exams are covered once every 24 months.&lt;br&gt;• If you are at high risk of cervical cancer or have had an abnormal Pap test and are of childbearing age: one Pap test every 12 months.</td>
<td>There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.</td>
</tr>
<tr>
<td><strong>Chiropractic services†</strong>&lt;br&gt;Covered services include:&lt;br&gt;• We cover only manual manipulation of the spine to correct subluxation.</td>
<td>You pay $15 per visit.</td>
</tr>
<tr>
<td><strong>Colorectal cancer screening</strong>&lt;br&gt;• For people 50 and older, the following are covered:&lt;br&gt;  ♦ Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months.&lt;br&gt;  ♦ Fecal occult blood test, every 12 months.&lt;br&gt;• For people at high risk of colorectal cancer, we cover a screening colonoscopy (or screening barium enema as an alternative) every 24 months.&lt;br&gt;• For people not at high risk of colorectal cancer, we cover a screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy.</td>
<td>There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.</td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
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<tr>
<td><strong>Dental services</strong>&lt;sup&gt;*&lt;/sup&gt;&lt;sup&gt;†&lt;/sup&gt;</td>
<td>Refer to &quot;Dental benefits and fee schedule&quot; at the end of the Medical Benefits Chart for cost-sharing information.</td>
</tr>
<tr>
<td>In general, preventive dental services (such as cleaning, routine dental exams, and dental X-rays) are not covered by Original Medicare. However, we cover the following preventive and comprehensive dental care when provided by a participating dental provider as described at the end of this chart under &quot;Dental benefits and fee schedule&quot; (please refer to that section for details about preventive and comprehensive dental coverage).</td>
<td></td>
</tr>
<tr>
<td>• Accidental dental services: Prompt repair, but not replacement, of sound natural teeth within one year of the accident, when services begin within 60 days of the injury. <strong>Note:</strong> Injuries incurred while eating or chewing are not covered.</td>
<td><strong>You pay $15 per visit.</strong></td>
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<tr>
<td><strong>Limitations:</strong></td>
<td></td>
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<tr>
<td>• For Maryland or D.C. residents, Health Plan pays up to a <strong>$2,000 maximum</strong> benefit per accident (this limit does not apply to residents of Virginia).</td>
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<tr>
<td>• Services must be provided by a plan provider.</td>
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</tr>
<tr>
<td><strong>Depression screening</strong></td>
<td>There is no coinsurance, copayment, or deductible for an annual depression screening visit.</td>
</tr>
<tr>
<td>We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and referrals.</td>
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</tr>
<tr>
<td><strong>Diabetes screening</strong></td>
<td>There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.</td>
</tr>
<tr>
<td>We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.</td>
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<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
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<tr>
<td><strong>Diabetes self-management training and diabetic services and supplies†</strong></td>
<td>No charge.</td>
</tr>
<tr>
<td>For all people who have diabetes (insulin and noninsulin users), covered services include:</td>
<td></td>
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<tr>
<td>• Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices, lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.</td>
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<tr>
<td>Diabetes self-management training is covered under certain conditions.</td>
<td>There is no coinsurance, copayment, or deductible for beneficiaries eligible for the diabetes self-management training preventive benefit.</td>
</tr>
<tr>
<td>• For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the noncustomized removable inserts provided with such shoes). Coverage includes fitting.</td>
<td>No charge.</td>
</tr>
<tr>
<td><strong>Durable medical equipment and related supplies†</strong></td>
<td>No charge.</td>
</tr>
<tr>
<td>(For a definition of &quot;durable medical equipment,&quot; see Chapter 12 of this booklet.)</td>
<td></td>
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<tr>
<td>Covered items include, but are not limited to: wheelchairs, crutches, hospital bed, IV infusion pump, oxygen equipment, nebulizer, and walker.</td>
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<tr>
<td>We cover all medically necessary durable medical equipment covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you.</td>
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<tr>
<td>You may also obtain any medically necessary durable medical equipment from any supplier that contracts with</td>
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</table>
Services that are covered for you

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<tr>
<th>What you must pay when you get these services</th>
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<tr>
<td>fee-for-service Medicare (Original Medicare). However, if our plan does not contract with this supplier, you will have to pay the cost-sharing under fee-for-service Medicare.</td>
</tr>
</tbody>
</table>

Emergency care

Emergency care refers to services that are:
- Furnished by a provider qualified to furnish emergency services, and
- Needed to evaluate or stabilize an emergency medical condition.

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

You have worldwide emergency coverage.
- Outpatient prescription drugs prescribed and provided outside the United States as part of covered Emergency Care are covered. These drugs are not covered under the Medicare Part D benefit and do not accumulate to the Part D thresholds (the maximum drug costs paid by the member as established by CMS in order for the member to qualify for the next level of health plan coverage or cost share).

You pay $50 per Emergency Department visit.

This copayment does not apply if you are admitted directly to the hospital as an inpatient (it does apply if you are admitted as anything other than an inpatient; for example, it does apply if you are admitted for observation).

† If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost-sharing you would pay at a network hospital.

Health and wellness education programs

These are programs focused on clinical health conditions such as hypertension, cholesterol, asthma, and special diets. Programs are designed to enrich the health and lifestyles of members include weight management, smoking cessation, fitness, and stress management classes at Kaiser Permanente medical centers. They include online recipes, information on a variety of health topics, a health

No charge.
<table>
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<th>Services that are covered for you</th>
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<tr>
<td><strong>encyclopedia, a drug encyclopedia, online health calculators which help members check their progress to better health, walking, and weight control programs. We offer healthy living seminars conducted by health care professionals, physical activity programs, and health fair activities including preventive care screenings and services that involve working with Kaiser Permanente representatives to complete and review total health assessments. Communication materials are provided to aid human resources managers and/or benefit managers in the implementation of onsite activities, as well as tailored programs for groups. Access to this information as well as online sign-up for classes available in your area can be found at <a href="http://kp.org/myhealth">kp.org/myhealth</a> after selecting your region.</strong></td>
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<tr>
<td><strong>Hearing services†</strong></td>
<td><strong>You pay $15 per visit.</strong></td>
</tr>
<tr>
<td>• Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider.</td>
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<tr>
<td><strong>HIV screening</strong></td>
<td><strong>There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered preventive HIV screening.</strong></td>
</tr>
<tr>
<td>• For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover one screening exam every 12 months.</td>
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<tr>
<td>• For women who are pregnant, we cover up to three screening exams during a pregnancy.</td>
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<tr>
<td><strong>Home health agency care†</strong></td>
<td><strong>No charge</strong> per Medicare-covered home health care visit.</td>
</tr>
<tr>
<td>Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to:</td>
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<tr>
<td><strong>Services that are covered for you</strong></td>
<td><strong>What you must pay when you get these services</strong></td>
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</tbody>
</table>
| • Part-time or intermittent skilled nursing and home health aide services. To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week.  
• Physical therapy, occupational therapy, and speech therapy.  
• Medical and social services.  
• Medical equipment and supplies. |  |

**Home infusion therapy**  
We cover home infusion supplies and drugs if all of the following are true:  
• Your prescription drug is on our Medicare Part D formulary.  
• We approved your prescription drug for home infusion therapy.  
• Your prescription is written by a network provider and filled at a network home-infusion pharmacy.  

<table>
<thead>
<tr>
<th><strong>Hospice care†</strong></th>
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</table>
| You may receive care from any Medicare-certified hospice program. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include:  
• Drugs for symptom control and pain relief.  
• Short-term respite care.  
• Home care. | When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal condition are paid for by Original Medicare, **not** our plan.  

**For hospice services and services that are covered by Medicare Part A or B and are related to your terminal condition:** Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.  

Members with Medicare Part B only must use a Plan hospice.
## Services that are covered for you

<table>
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<tr>
<th>What you must pay when you get these services</th>
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</table>

**For services that are covered by Medicare Part A or B and are not related to your terminal condition:** If you need nonemergency, non–urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal condition, your cost for these services depends on whether you use a provider in our plan’s network:

- If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services.
- If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare).

**For drugs that may be covered by the plan’s Part D benefit:** Drugs are never covered by both hospice and our plan at the same time. For more information, please see Chapter 5, Section 9.4 (“What if you-are in Medicare-certified hospice”).

**Note:** If you need nonhospice care (care that is not related to your terminal condition), you should contact us to arrange the services. Getting your nonhospice care through our network providers will lower your share of the costs for the services.

- Our plan covers hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit. **You pay $15 per visit.**

## Immunizations

Covered Medicare Part B services include:

- Pneumonia vaccine.
- Flu shots, once a year in the fall or winter.
- Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B.
- Other vaccines if you are at risk and they meet Medicare

There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Part B coverage rules.</td>
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<tr>
<td>We also cover some vaccines under our Part D prescription drug benefit.</td>
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<tr>
<td>In addition, we cover the following routine immunizations endorsed by the Centers for Disease Control and Prevention (CDC) that is not covered by Medicare Part B:</td>
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<tr>
<td>• Tetanus-diphtheria (Td) booster – once every 10 years, ages 19 and over (except as provided for under childhood immunizations).</td>
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</table>

**Infertility services†**
Medically necessary services only.

**Inpatient:**
Per benefit period, for a Medicare-covered stay in a network hospital, you pay **$100**.

**Outpatient surgery:**
You pay **nothing**.

**Office visits:**
$15 per visit.

**Related prescription drugs:**
50% coinsurance.

**Inpatient hospital care†**
Includes inpatient acute, inpatient rehabilitation, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day.

There is no limit to the number of medically necessary hospital days or services that are generally and customarily provided by acute care general hospitals.

Covered services include, but are not limited to:
• Semiprivate room (or a private room if medically necessary).

Per benefit period, for a Medicare-covered stay in a network hospital, you pay **$100**.

**There is no charge for subsequent covered hospital stays within the same benefit period.**

A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or skilled nursing facility (SNF). The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 calendar days in a row.
<table>
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<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
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<tbody>
<tr>
<td>Meals including special diets.</td>
<td>†If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital.</td>
</tr>
<tr>
<td>Regular nursing services.</td>
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<tr>
<td>Costs of special care units (such as intensive care or coronary care units).</td>
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<tr>
<td>Drugs and medications.</td>
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<td>Lab tests.</td>
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<td>X-rays and other radiology services.</td>
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<tr>
<td>Necessary surgical and medical supplies.</td>
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<tr>
<td>Use of appliances, such as wheelchairs.</td>
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<tr>
<td>Operating and recovery room costs.</td>
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<tr>
<td>Physical, occupational, and speech language therapy.</td>
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<tr>
<td>Inpatient substance abuse services for medical management of withdrawal symptoms associated with substance abuse (detoxification).</td>
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</tr>
<tr>
<td>Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If local transplant providers are willing to accept the Original Medicare rate, then you can choose to obtain your transplant services locally or at a distant location offered by the plan. If we provide transplant services at a distant location (outside of the service area) and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion.</td>
<td></td>
</tr>
<tr>
<td>Blood—including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need. You must either pay the costs for the first three pints of blood you get in a</td>
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</table>
## Services that are covered for you

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<th>What you must pay when you get these services</th>
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</table>

- calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used.

- Physician services.

**Note:** To be an "inpatient," your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

### Inpatient mental health care

Covered services include mental health care services that require a hospital stay. You are covered for unlimited days each Benefit Period. There is no lifetime limit for stays in a Medicare-certified psychiatric facility, including Mental Health services provided in a psychiatric unit of a general hospital.

<table>
<thead>
<tr>
<th>Per benefit period, for a Medicare-covered stay in a network hospital, you pay $100. <strong>There is no charge for subsequent covered hospital stays within the same benefit period.</strong></th>
</tr>
</thead>
</table>

A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or skilled nursing facility (SNF). The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 calendar days in a row.

**Note:** If a benefit period begins in 2014 for you and does not end until sometime in 2015, the 2014 cost-sharing will continue until the benefit period ends.
<table>
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<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
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<tbody>
<tr>
<td><strong>Inpatient services covered during a noncovered inpatient stay†</strong></td>
<td>You pay the following for covered outpatient services and other items covered under Medicare Part B:</td>
</tr>
<tr>
<td>If you have exhausted your skilled nursing facility (SNF) benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient or SNF stay. However, in some cases, we will cover certain services you receive while you are in the hospital or SNF. Covered services include, but are not limited to:</td>
<td>You pay $15 per visit</td>
</tr>
<tr>
<td>• Physician services.</td>
<td></td>
</tr>
<tr>
<td>• Physical therapy, speech therapy, and occupational therapy.</td>
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</tr>
<tr>
<td>• Radium, and isotope therapy, including technician materials and services</td>
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</tr>
<tr>
<td>• Diagnostic tests (like lab tests).</td>
<td>No charge.</td>
</tr>
<tr>
<td>• X-ray.</td>
<td></td>
</tr>
<tr>
<td>• Surgical dressings.</td>
<td>No charge.</td>
</tr>
<tr>
<td>• Splints, casts and other devices used to reduce fractures and dislocations.</td>
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</tr>
<tr>
<td>• Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices.</td>
<td>No charge.</td>
</tr>
<tr>
<td>• Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes (including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition).</td>
<td></td>
</tr>
<tr>
<td><strong>Medical foods</strong></td>
<td>25% coinsurance.</td>
</tr>
<tr>
<td>Coverage is provided for medical foods and modified food products.</td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>-----------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td>🍋 Medical nutrition therapy†</td>
<td>There is no coinsurance, copayment, or deductible for beneficiaries eligible for Medicare-covered medical nutrition therapy services</td>
</tr>
</tbody>
</table>

This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when referred by your doctor.

We cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare health plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's referral. A physician must prescribe these services and renew his or her referral yearly if your treatment is needed into the next calendar year.

### Medicare Part B prescription drugs

These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:

- Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services.
- Drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan.
- Clotting factors you give yourself by injection if you have hemophilia.
- Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant.
- 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.

There is no charge for clinically administered drugs, peritoneal dialysis drugs, and oral chemotherapy drugs.

For all other Medicare Part B prescription drugs, you pay the following depending upon the plan in which you are enrolled and the type of pharmacy and drug:

**Preferred network pharmacy located at a Kaiser Permanente facility or our mail order pharmacy up to a 60-day supply:**
- Generic: $15
- Brand-name: $15

**Network pharmacy (an affiliated pharmacy) up to a 60-day supply:**
- Generic: $25
- Brand-name: $25
### Services that are covered for you

<table>
<thead>
<tr>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Out-of-network pharmacy up to a 30-day supply:</strong></td>
</tr>
<tr>
<td>Generic: $12.50</td>
</tr>
<tr>
<td>Brand-name: $12.50</td>
</tr>
<tr>
<td><strong>Network Long-term Care (an affiliated pharmacy) up to a 31-day supply:</strong></td>
</tr>
<tr>
<td>Generic: $12.50</td>
</tr>
<tr>
<td>Brand-name: $12.50</td>
</tr>
<tr>
<td><strong>Mail-order pharmacy up to a 90-day supply:</strong></td>
</tr>
<tr>
<td>Generic: $10</td>
</tr>
<tr>
<td>Brand-name: $10</td>
</tr>
<tr>
<td><strong>Preferred network pharmacy up to a 90-day supply:</strong></td>
</tr>
<tr>
<td>Generic: $22.50</td>
</tr>
<tr>
<td>Brand-name: $22.50</td>
</tr>
<tr>
<td><strong>Network pharmacy per 90-day supply:</strong></td>
</tr>
<tr>
<td>Generic: $37.50</td>
</tr>
<tr>
<td>Brand-name: $37.50</td>
</tr>
</tbody>
</table>

Certain prescription drugs will have maximum quantity limits.

**Note:** If the retail price of a covered prescription drug or device is less than the plan copayment or coinsurance, you will pay the retail price of the drug.

### Morbid obesity†

We cover diagnosis and treatment of morbid obesity that is recognized by the National Institutes of Health and is consistent with guidelines approved by the National Institutes of Health. BMI means a practical marker that is

### Inpatient:

Per benefit period, for a Medicare-covered stay in a network hospital, you pay **$100**.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>used to assess the degree of obesity and is calculated by dividing the weight in kilograms divided by height in meters squared. You must be at least 18 years of age or older and have either: - A body mass index (BMI) of 50 or greater or - A BMI of 35 up to 49.9 when a combination of the following severe or life threatening conditions are also present: ♦ Sleep apnea. ♦ Diabetes. ♦ Degenerative joint disease of weight-bearing joints. ♦ Hypertension. ♦ Congestive heart failure and/or cardiomyopathy. ♦ Other severe or life threatening conditions directly related to obesity, when recommended by your plan provider. <strong>Note:</strong> You will need to meet the above qualifications before your plan provider will refer you to our bariatric surgery program. This program may refer you to other plan providers to determine if you meet the additional criteria necessary for bariatric surgery, including nutritional, psychological, medical and social readiness for surgery. Final approval for surgical treatment will be required from the plan-designated physician.</td>
<td>You are covered for unlimited days each Benefit Period. <strong>Outpatient surgery:</strong> You pay <strong>nothing.</strong> <strong>Office visits:</strong> You pay $15 per visit.</td>
</tr>
</tbody>
</table>

### Obesity screening and therapy to promote sustained weight loss

If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.

There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient diagnostic tests and therapeutic services and supplies</strong>†</td>
<td></td>
</tr>
<tr>
<td>Covered services include, but are not limited to:</td>
<td></td>
</tr>
<tr>
<td>• X-rays.</td>
<td><strong>No charge.</strong></td>
</tr>
<tr>
<td>• Laboratory tests.</td>
<td></td>
</tr>
<tr>
<td>• Sleep studies (home).</td>
<td></td>
</tr>
<tr>
<td>• Ultrasound (office visit).</td>
<td></td>
</tr>
<tr>
<td>• Radiation (radium and isotope) therapy, including technician materials and supplies.</td>
<td><strong>You pay $15 per visit.</strong></td>
</tr>
<tr>
<td>• Sleep studies (specialty office visit).</td>
<td></td>
</tr>
<tr>
<td>• Designated ultrasound (specialty office visit).</td>
<td></td>
</tr>
<tr>
<td>• Designated ultrasound (radiology).</td>
<td><strong>No charge.</strong></td>
</tr>
<tr>
<td>• Interventional radiology.</td>
<td></td>
</tr>
<tr>
<td>• Other outpatient diagnostic tests.</td>
<td></td>
</tr>
<tr>
<td>• Magnetic resonance imaging (MRI), computed tomography (CT), positron emission tomography (PET), and nuclear medicine scans.</td>
<td></td>
</tr>
<tr>
<td>• Blood. Coverage begins with the fourth pint of blood that you need. You either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. Coverage of storage and administration begins with the first pint of blood that you need.</td>
<td><strong>No charge after first three pints.</strong></td>
</tr>
<tr>
<td>• Surgical supplies, such as dressings.</td>
<td><strong>No charge.</strong></td>
</tr>
<tr>
<td>• Splints, casts, and other devices used to reduce fractures and dislocations.</td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------------------</td>
</tr>
<tr>
<td><strong>Outpatient hospital services†</strong></td>
<td></td>
</tr>
<tr>
<td>We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury.</td>
<td>No charge.</td>
</tr>
<tr>
<td>Covered services include, but are not limited to:</td>
<td></td>
</tr>
<tr>
<td>• Services in an emergency department or outpatient clinic, such as observation services or outpatient surgery.</td>
<td></td>
</tr>
<tr>
<td>• X-rays and other radiology services billed by the hospital.</td>
<td>No charge when received as part of the outpatient visit.</td>
</tr>
<tr>
<td>• Laboratory tests billed by the hospital.</td>
<td></td>
</tr>
<tr>
<td>• Blood transfusion (administration)†.</td>
<td></td>
</tr>
<tr>
<td>• Certain drugs and biologicals that you can't give yourself.</td>
<td></td>
</tr>
<tr>
<td>• Medical supplies such as splints and casts.</td>
<td></td>
</tr>
<tr>
<td>• Certain screenings and preventive services.</td>
<td>No charge for preventive services that are covered at no cost under Original Medicare.</td>
</tr>
<tr>
<td>• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it.</td>
<td>You pay $15 per visit.</td>
</tr>
<tr>
<td>• Dental anesthesia and related hospital or ambulatory facility charges are covered when provided in conjunction with dental care to a member who is:</td>
<td>Outpatient Hospital/Ambulatory Surgery Services</td>
</tr>
<tr>
<td>• seven years of age or younger or is developmentally disabled; and</td>
<td>You pay nothing per Medicare-covered visit.</td>
</tr>
<tr>
<td>• an individual for whom a successful result cannot be expected from care provided under local anesthesia because of a physical, intellectual, or other medically compromising condition; and</td>
<td>Note: If the procedure results in a situation that requires hospitalization and you are admitted as an inpatient, the cost-sharing for inpatient care would also apply (see</td>
</tr>
</tbody>
</table>
Services that are covered for you | What you must pay when you get these services
---|---
* an individual for whom a superior result can be expected from dental care provided under general anesthesia; or
* an extremely uncooperative, fearful, or uncommunicative child who is 17 years of age or younger with dental needs of such magnitude that treatment should not be delayed or deferred; and
* an individual for whom lack of treatment can be expected to result in oral pain, infection, loss of teeth, or other increased oral or dental morbidity; or
* an adult age 17 and older when the Member's medical condition (e.g., heart disease, hemophilia) requires that dental service be performed in a hospital or ambulatory surgical center for the safety of the member.

"Inpatient hospital care" in this chart for details).

Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at http://www.medicare.gov/Publications/Pubs/pdf/11435.pdf or by calling 1-800-MEDICARE (1-800-633-4227). TTY users call 1-877-486-2048. You can call these numbers for free, 24 hours a day, 7 days a week.

Outpatient mental health care†
Covered services include:
* Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.

You pay $15 per individual or group therapy visit.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Outpatient rehabilitation services†</strong></td>
<td>You pay $15 per visit.</td>
</tr>
<tr>
<td>• Covered services include: physical therapy, occupational therapy, and speech language therapy.</td>
<td></td>
</tr>
<tr>
<td>• Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient substance abuse services†</strong></td>
<td>You pay $15 per individual or group therapy visit.</td>
</tr>
<tr>
<td>Treatment for substance abuse is covered if medically necessary and reasonable for the patient's condition.</td>
<td></td>
</tr>
<tr>
<td><strong>Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers†</strong></td>
<td>No charge.</td>
</tr>
<tr>
<td><strong>Note:</strong> If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.</td>
<td></td>
</tr>
<tr>
<td><strong>Partial hospitalization services†</strong></td>
<td>You pay $15 per visit.</td>
</tr>
<tr>
<td>&quot;Partial hospitalization&quot; is a structured program of active psychiatric treatment, provided in a hospital outpatient setting or by a community mental health center that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization.</td>
<td></td>
</tr>
<tr>
<td><strong>Note:</strong> Because there are no community mental health centers in our network, we cover partial hospitalization only in a network hospital outpatient setting.</td>
<td></td>
</tr>
</tbody>
</table>
# Services that are covered for you

<table>
<thead>
<tr>
<th>Covered services include:</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medically necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location.</td>
<td>You pay $15 per visit.</td>
</tr>
<tr>
<td>• Consultation, diagnosis, and treatment by a specialist.</td>
<td></td>
</tr>
<tr>
<td>• Basic hearing and balance exams performed by a network provider, if your doctor orders it to see if you need medical treatment.</td>
<td></td>
</tr>
<tr>
<td>• Second opinion by another network provider prior to surgery.</td>
<td></td>
</tr>
<tr>
<td>• Nonroutine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician).</td>
<td></td>
</tr>
<tr>
<td>• Family planning and consultation services.</td>
<td></td>
</tr>
<tr>
<td>• Allergy consultations and evaluations.</td>
<td></td>
</tr>
<tr>
<td>• Allergy testing and treatment.</td>
<td></td>
</tr>
<tr>
<td>• Allergy injections.</td>
<td></td>
</tr>
<tr>
<td>• House calls.</td>
<td></td>
</tr>
<tr>
<td>• Postpartum care.</td>
<td></td>
</tr>
<tr>
<td>• Prenatal care.</td>
<td></td>
</tr>
<tr>
<td>• Allergy serum.</td>
<td>No charge</td>
</tr>
<tr>
<td>• Interactive video visits for professional services when care can be provided in this format as determined by a plan provider.</td>
<td></td>
</tr>
<tr>
<td>• Scheduled telephone appointment visits for professional services when care can be provided in this format as determined by a plan provider.</td>
<td></td>
</tr>
</tbody>
</table>
### Services that are covered for you

<table>
<thead>
<tr>
<th>Podiatry services†</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>Covered services include:</td>
<td>You pay $15 per visit.</td>
</tr>
<tr>
<td>• Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs).</td>
<td></td>
</tr>
<tr>
<td>• Routine foot care for members with certain medical conditions affecting the lower limbs.</td>
<td></td>
</tr>
</tbody>
</table>

### Prescription drug coverage outside of the United States* |

Prescription drugs prescribed and provided outside the United States as part of a covered emergency care visit and/or out-of-area urgently needed care visit are covered.

- These drugs are not covered under Medicare Part D and do not accumulate to Part D thresholds. Cost sharing and limitations may apply.

You pay the following for outpatient prescription drugs per 30-day supply:

- **Generic**: $25.
- **Brand**: $25.

### Prostate cancer screening exams

For men age 50 and older, covered services include the following once every 12 months:

- Digital rectal exam.
- Prostate Specific Antigen (PSA) test.

There is no coinsurance, copayment, or deductible for an annual PSA test.

### Prosthetic devices and related supplies†

Devices (other than dental) that replace all or part of a body part or function. These include, but are not limited to: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices. Also includes some coverage following cataract removal or cataract surgery (see "Vision care" later in this section for more detail).

No charge for external devices.

No charge for internally implanted devices.
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pulmonary rehabilitation services</strong></td>
<td>You pay $15 per visit.</td>
</tr>
<tr>
<td>Comprehensive programs for pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and a referral for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.</td>
<td></td>
</tr>
<tr>
<td><strong>Screening and counseling to reduce alcohol misuse</strong></td>
<td>There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.</td>
</tr>
<tr>
<td>We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.</td>
<td></td>
</tr>
<tr>
<td><strong>Screening for sexually transmitted infections (STIs) and counseling to prevent STIs</strong></td>
<td>There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling to prevent STIs preventive benefit.</td>
</tr>
<tr>
<td>We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20- to 30-minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.</td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
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<tr>
<td>----------------------------------</td>
<td>-----------------------------------------------</td>
</tr>
<tr>
<td><strong>Services to treat kidney disease and conditions†</strong></td>
<td>No charge</td>
</tr>
<tr>
<td>Covered services include:</td>
<td></td>
</tr>
<tr>
<td>• Kidney disease education services to teach kidney care and help members make informed decisions about their care. For members with stage IV chronic kidney disease when referred by their doctor, we cover up to six sessions of kidney disease education services per lifetime.</td>
<td></td>
</tr>
<tr>
<td>• Outpatient dialysis treatments.</td>
<td></td>
</tr>
<tr>
<td>• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments).</td>
<td></td>
</tr>
<tr>
<td>• Home dialysis equipment and supplies.</td>
<td></td>
</tr>
<tr>
<td>• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply).</td>
<td></td>
</tr>
<tr>
<td>• Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care).</td>
<td><strong>Inpatient</strong></td>
</tr>
<tr>
<td>Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B drugs, please go to the section called &quot;Medicare Part B prescription drugs.&quot;</td>
<td>You pay <strong>$100 per Benefit Period</strong> for a Medicare-covered stay in a network hospital. You are covered for unlimited days each Benefit Period. <strong>Note:</strong> If a benefit period begins in 2014 for you and does not end until sometime in 2015, the 2014 cost-sharing will continue until the benefit period ends.</td>
</tr>
</tbody>
</table>

### Sexual dysfunction drugs

Sexual dysfunction drugs are covered. These drugs are not covered under Medicare Part D and do not accumulate to Part D thresholds. Cost-sharing and limitations may apply. **You pay 50% coinsurance** of the cost for up to a 60-day supply (16 tablets)
## Services that are covered for you

<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Skilled nursing facility (SNF) care†</strong></td>
<td>You pay <strong>nothing</strong> per Benefit Period if Original Medicare would cover the stay.</td>
</tr>
<tr>
<td>(For a definition of &quot;skilled nursing facility care,&quot; see Chapter 12 of this booklet. Skilled nursing facilties are sometimes called &quot;SNFs.&quot;)</td>
<td>You pay <strong>$100</strong> per medically necessary admission if Original Medicare would not cover the stay.</td>
</tr>
<tr>
<td>We cover up to 100 days per benefit period of skilled inpatient services in a skilled nursing facility in accord with Medicare guidelines (a prior hospital stay is not required). Covered services include, but are not limited to:</td>
<td>A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or skilled nursing facility (SNF). The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 calendar days in a row. There is no limit to the number of benefit periods you can have. <strong>Note:</strong> If a benefit period begins in 2014 for you and does not end until sometime in 2015, the 2014 cost-sharing will continue until the benefit period ends.</td>
</tr>
<tr>
<td>• Semiprivate room (or a private room if medically necessary).</td>
<td></td>
</tr>
<tr>
<td>• Meals, including special diets.</td>
<td></td>
</tr>
<tr>
<td>• Skilled nursing services.</td>
<td></td>
</tr>
<tr>
<td>• Physical therapy, occupational therapy, and speech therapy.</td>
<td></td>
</tr>
<tr>
<td>• Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors).</td>
<td></td>
</tr>
<tr>
<td>• Blood—including storage and administration. Coverage of whole blood and packed red cells begins only with the fourth pint of blood that you need. You must either pay the costs for the first three pints of blood you get in a calendar year or have the blood donated by you or someone else. All other components of blood are covered beginning with the first pint used.</td>
<td></td>
</tr>
<tr>
<td>• Medical and surgical supplies ordinarily provided by SNFs.</td>
<td></td>
</tr>
<tr>
<td>• Laboratory tests ordinarily provided by SNFs.</td>
<td></td>
</tr>
<tr>
<td>• X-rays and other radiology services ordinarily provided by SNFs.</td>
<td></td>
</tr>
<tr>
<td>• Use of appliances such as wheelchairs ordinarily provided by SNFs.</td>
<td></td>
</tr>
<tr>
<td>• Physician/practitioner services.</td>
<td></td>
</tr>
<tr>
<td>Services that are covered for you</td>
<td>What you must pay when you get these services</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------------------------------------</td>
</tr>
</tbody>
</table>
| **Smoking and tobacco use cessation**  
(counseling to stop smoking or tobacco use) | There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits. |
| **If you use tobacco, but do not have signs or symptoms of tobacco-related disease:** We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. | |
| **If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:** We cover cessation counseling services. We cover two counseling quit attempts within a 12-month period, however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits. | |

**Urgently needed care**

Urgently needed care is care provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed care may be furnished by in-network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

- **Inside our service area:** You must obtain urgent care from network providers, unless our provider network is temporarily unavailable or inaccessible due to an unusual and extraordinary circumstance (for example, major disaster).
- **Outside our service area:** You have worldwide urgent care coverage when you travel if you need medical attention right away for an unforeseen illness or injury and you reasonably believed that your health would seriously deteriorate if you delayed treatment until you returned to our service area.

See Chapter 3, Section 3, for more information.

**Office visits:**

- You pay $15 per visit.

**Emergency Department:**

- You pay $50 per Emergency Room visit.
## Services that are covered for you

<table>
<thead>
<tr>
<th>Covered services include:</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Outpatient physician services for the diagnosis and treatment of diseases and injuries</td>
<td>You pay $15 per visit</td>
</tr>
<tr>
<td>of the eye, including treatment for age-related macular degeneration.</td>
<td></td>
</tr>
<tr>
<td>• Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. However, our plan does cover the following exams:</td>
<td></td>
</tr>
<tr>
<td>♦ Routine eye exams (eye refraction exams) to determine the need for vision correction</td>
<td></td>
</tr>
<tr>
<td>and to provide a prescription for eyeglass lenses.</td>
<td></td>
</tr>
<tr>
<td>• For people who are at high risk of glaucoma, such as people with a family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older: glaucoma screening once per year.</td>
<td>No charge.</td>
</tr>
<tr>
<td>• One pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you cannot reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.</td>
<td>20% coinsurance.</td>
</tr>
</tbody>
</table>

### Additional eyewear benefits:

- **Eyeglass lenses:** Regular eyeglass lenses, including add-ons. Regular eyeglass lenses are any lenses with a refractive value. If only one eye needs correction, we also provide a balance lens for the other eye.

- **Eyeglass frames:** Eyeglass frames, including the mounting of eyeglass lenses in the frame, original fitting of the frames, and subsequent adjustment.

- **Contact lenses:** Coverage for the initial purchase of contact lenses only for the first time you are examined for contact lenses at a Kaiser Permanente facility. This

| 85% of Plan Charges per calendar year. | 75% of Plan Charges per calendar year. |
Services that are covered for you | What you must pay when you get these services
---|---
discount includes: Fitting of contact lenses, initial pair of lenses, training for the insertion and removal of contact lens, and three months of follow-up visits. | There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.

"Welcome to Medicare" preventive visit
Our plan covers the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed.

**Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.

Note: Refer to Chapter 1 (Section 7) and Chapter 11 for information about coordination of benefits that applies to all covered services described in this Medical Benefits Chart.

Dental benefits and fee schedule‡

**General terms and conditions**
- Subject to the terms, conditions, limitations, and exclusions specified in this Kaiser Permanente Medicare Plus Evidence of Coverage including Chapter 12, "Definitions of Important Words," you may receive Covered Dental Services from Participating Dental Providers.
- Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc. has entered into an Agreement with Dental Administrator to provide Covered Dental Services through Participating Dental Providers.
- All dental procedures listed in the dental fee schedule below are covered dental services. When you receive any of the listed procedures from a Participating Dental Provider, you will pay the fee listed for that service. The Participating Dental Provider has agreed to accept that fee as payment in full for that procedure. Neither Kaiser Permanente nor Dental Administrator is liable for payment of these fees or for any fees incurred as the result of receipt of a non-Covered Dental Service.
- You will receive a list of Participating Dental Providers from the Health Plan or Dental Administrator. You should select a Participating Dental Provider "general dentist" from whom...
<table>
<thead>
<tr>
<th>Services that are covered for you</th>
<th>What you must pay when you get these services</th>
</tr>
</thead>
<tbody>
<tr>
<td>you and your family members will receive Covered Preventive Dental Services and other Covered Dental Services. Family members may use different Participating Dental Providers. Specialty care is also available should that be required; however, you must be referred to a Participating Dental Provider specialist by your general dentist. Your fees are usually higher for care received by a specialist. Please refer to the attached dental fee schedule for those discounted fees.</td>
<td></td>
</tr>
<tr>
<td>• You may obtain a list of Participating Dental Providers by contacting Dental Administrator or our Member Services Department at the following numbers:</td>
<td></td>
</tr>
<tr>
<td>• Within the Washington, D.C. Metropolitan Service Area: 301-468-6000. Insert hours of operation</td>
<td></td>
</tr>
<tr>
<td>• Outside the Washington, D.C. Metropolitan Service Area: (toll free) 1-800-777-7902. TTY users call 301-879-6380</td>
<td></td>
</tr>
<tr>
<td>• Dental Administrator (DOMINION Dental Services USA, Inc.): Health Plan has entered into an agreement with DOMINION Dental Services USA, Inc. to provide Covered Dental Services as described in this section. For assistance concerning dental coverage questions, or for help finding a Participating Dental Provider, DOMINION Member Services specialists are available Monday through Friday from 7:30 a.m. to 6:00 p.m., or you may call the following numbers:</td>
<td></td>
</tr>
<tr>
<td>• Within the Washington, D.C. Metropolitan Service Area: 703-518-5338.</td>
<td></td>
</tr>
<tr>
<td>• Outside the Washington, D.C. Metropolitan Service Area (toll free): 1-888-518-5338</td>
<td></td>
</tr>
<tr>
<td>• TTY users call 1-800-688-4889. Hearing impaired members may also use the Internet at <a href="http://www.IP-RELAY.com">www.IP-RELAY.com</a></td>
<td></td>
</tr>
<tr>
<td>• DOMINION's Integrated Voice Response System is available 24 hours a day for information about Participating Dental Providers in your area, or to help you select a Participating Dental Provider. The most up-to-date list of Participating Dental Providers can be found at the following website: <a href="http://www.dominiondental.com/Kaiserdentists">www.dominiondental.com/Kaiserdentists</a></td>
<td></td>
</tr>
<tr>
<td>• DOMINION also provides many other secure features online at <a href="http://www.dominiondental.com">www.dominiondental.com</a>.</td>
<td></td>
</tr>
<tr>
<td>• Participating Dental Providers may charge you an administrative fee if you miss a scheduled dental appointment without giving 24 hours advance notice.</td>
<td></td>
</tr>
</tbody>
</table>

**Dental emergencies outside the service area**

When a dental emergency occurs outside the service area, Dental Administrator will reimburse you for the reasonable charges for Covered Dental Services that may be provided, less any discounted fee, upon proof of payment, not to exceed $50 per incident. Coverage is provided for emergency dental treatment as may be required to alleviate pain, bleeding, or swelling. You must receive all post-emergency care from a Participating Dental Provider.
Services that are covered for you

<table>
<thead>
<tr>
<th>Description of Services</th>
<th>*What you must pay to:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Diagnostic Services</strong></td>
<td><strong>Dentist</strong></td>
</tr>
<tr>
<td>D0120 Periodic oral evaluation</td>
<td>FC $30</td>
</tr>
<tr>
<td>D0140 Limited oral evaluation - problem focused</td>
<td>FC $30</td>
</tr>
<tr>
<td>D0145 Oral evaluation for a patient under 3 years of age</td>
<td>FC $30</td>
</tr>
<tr>
<td>D0150 Comprehensive oral evaluation - new or established patient</td>
<td>FC $30</td>
</tr>
</tbody>
</table>

**Discounted schedule of fees $30 preventive plan**

Procedures not shown in this list are not covered. Refer to the description of your dental benefit for a complete description of the terms and conditions of your covered benefit.

Fees quoted in the "You pay to Dentist" column apply only when performed by a participating general dentist. If specialty care is required, your general dentist must refer you to a participating specialist. Services received from non-participating dentists are not covered under this plan.

FC $30: You pay a combined fixed copayment of $30 for any visit during which one or more of the following procedures are performed: (a) an oral exam (D0120, D0140, D0145, D0150, D0170 or D0180); (b) X-rays (D0220, D0230, D0240, D0250, D0260, D0270, D0272, D0273, D0274, D0277, D0340 or D0350); (c) a pulp vitality test (D0460); (d) a diagnostic cast (D0470); (e) a routine cleaning (D1110 or D1120); (f) fluoride application (D1203, D1204 or D1206); or (g) you are given oral hygiene instructions (D1310, D1320 or D1330). You pay a separate fee for any other procedure performed. Coverage for periodic oral exams, prophylaxes (cleanings) and fluoride applications is limited to two times per plan year.

**NOTE:** The Schedule of Dental Fees is reviewed annually and is subject to change effective January 1 of each year. Contact Dominion for details at 703-518-5338 or toll-free at 1-888-518-5338, Monday through Friday, 7:30 a.m. to 6 p.m., (TTY 711).
<table>
<thead>
<tr>
<th>ADA Code</th>
<th>Description of Services</th>
<th>*What you must pay to:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Dentist</td>
</tr>
<tr>
<td>D0170</td>
<td>Re-evaluation - limited, problem focused</td>
<td>FC $30</td>
</tr>
<tr>
<td>D0180</td>
<td>Comprehensive periodontal evaluation - new or established patient - not in conjunction with D0150 and limited to once per 18 months</td>
<td>FC $30</td>
</tr>
<tr>
<td>D0210</td>
<td>Intraoral - complete series (including bitewings)</td>
<td>$54</td>
</tr>
<tr>
<td>D0220</td>
<td>Intraoral - periapical first film</td>
<td>FC $30</td>
</tr>
<tr>
<td>D0230</td>
<td>Intraoral - periapical each additional film</td>
<td>FC $30</td>
</tr>
<tr>
<td>D0240</td>
<td>Intraoral - occlusal film</td>
<td>FC $30</td>
</tr>
<tr>
<td>D0250</td>
<td>Extraoral - first film</td>
<td>FC $30</td>
</tr>
<tr>
<td>D0260</td>
<td>Extraoral - each additional film</td>
<td>FC $30</td>
</tr>
<tr>
<td>D0270</td>
<td>Bitewing - single film</td>
<td>FC $30</td>
</tr>
<tr>
<td>D0272</td>
<td>Bitewings - two films</td>
<td>FC $30</td>
</tr>
<tr>
<td>D0273</td>
<td>Bitewings - three films</td>
<td>FC $30</td>
</tr>
<tr>
<td>D0274</td>
<td>Bitewings - four films</td>
<td>FC $30</td>
</tr>
<tr>
<td>D0277</td>
<td>Vertical bitewings - 7 to 8 films</td>
<td>FC $30</td>
</tr>
<tr>
<td>D0330</td>
<td>Panoramic film</td>
<td>$43</td>
</tr>
<tr>
<td>D0340</td>
<td>Cephalometric film</td>
<td>FC $30</td>
</tr>
<tr>
<td>D0350</td>
<td>Oral/facial photographic images</td>
<td>FC $30</td>
</tr>
<tr>
<td>D0460</td>
<td>Pulp vitality tests</td>
<td>FC $30</td>
</tr>
<tr>
<td>D0470</td>
<td>Diagnostic casts (not in conjunction with Orthodontics)</td>
<td>FC $30</td>
</tr>
<tr>
<td>ADA Code</td>
<td>Description of Services</td>
<td>*What you must pay to:</td>
</tr>
<tr>
<td>----------</td>
<td>------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dentist</td>
</tr>
<tr>
<td>Preventive Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>D1110</td>
<td>Prophylaxis (cleaning) - adult</td>
<td>FC $30</td>
</tr>
<tr>
<td>D1110*</td>
<td>Additional cleaning – beyond benefit limitation</td>
<td>$40</td>
</tr>
<tr>
<td>D1120</td>
<td>Prophylaxis - child</td>
<td>FC $30</td>
</tr>
<tr>
<td>D1203</td>
<td>Topical application of fluoride (prophylaxis not included) – child</td>
<td>FC $30</td>
</tr>
<tr>
<td>D1204</td>
<td>Topical appl of fluoride excl. prophy- adult (twice a year)</td>
<td>FC $30</td>
</tr>
<tr>
<td>D1206</td>
<td>Topical fluoride varnish for moderate/high risk caries patients</td>
<td>FC $30</td>
</tr>
<tr>
<td>D1310</td>
<td>Nutritional counseling for control of dental disease</td>
<td>FC $30</td>
</tr>
<tr>
<td>D1320</td>
<td>Tobacco counseling for control and prev. of oral disease</td>
<td>FC $30</td>
</tr>
<tr>
<td>D1330</td>
<td>Oral hygiene instructions</td>
<td>FC $30</td>
</tr>
<tr>
<td>D1351</td>
<td>Sealant - per tooth (under 16 years of age)</td>
<td>$30</td>
</tr>
<tr>
<td>D1352</td>
<td>Prev resin rest. mod/high caries risk – perm. tooth</td>
<td>$30</td>
</tr>
<tr>
<td>D1510</td>
<td>Space maintainer - fixed - unilateral</td>
<td>$200</td>
</tr>
<tr>
<td>D1515</td>
<td>Space maintainer - fixed - bilateral</td>
<td>$278</td>
</tr>
<tr>
<td>D1520</td>
<td>Space maintainer - removable - unilateral</td>
<td>$246</td>
</tr>
<tr>
<td>D1525</td>
<td>Space maintainer - removable - bilateral</td>
<td>$278</td>
</tr>
<tr>
<td>D1550</td>
<td>Re-cementation of space maintainer</td>
<td>$23</td>
</tr>
<tr>
<td>Restorative Services</td>
<td></td>
<td></td>
</tr>
<tr>
<td>ADA Code</td>
<td>Description of Services</td>
<td><em>What you must pay to:</em></td>
</tr>
<tr>
<td>----------</td>
<td>-------------------------</td>
<td>-------------------------</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Dentist</td>
</tr>
<tr>
<td>D2140</td>
<td>Amalgam - one surface, primary or permanent</td>
<td>$68</td>
</tr>
<tr>
<td>D2150</td>
<td>Amalgam - two surfaces, primary or permanent</td>
<td>$88</td>
</tr>
<tr>
<td>D2160</td>
<td>Amalgam - three surfaces, primary or permanent</td>
<td>$105</td>
</tr>
<tr>
<td>D2161</td>
<td>Amalgam - four or more surfaces, primary or permanent</td>
<td>$126</td>
</tr>
<tr>
<td>D2330</td>
<td>Resin-based composite - one surface, anterior</td>
<td>$83</td>
</tr>
<tr>
<td>D2331</td>
<td>Resin-based composite - two surfaces, anterior</td>
<td>$105</td>
</tr>
<tr>
<td>D2332</td>
<td>Resin-based composite - three surfaces, anterior</td>
<td>$129</td>
</tr>
<tr>
<td>D2335</td>
<td>Resin-based composite - four or more surfaces or involving incisal angle (anterior)</td>
<td>$163</td>
</tr>
<tr>
<td>D2390</td>
<td>Resin-based composite crown, anterior</td>
<td>$216</td>
</tr>
<tr>
<td>D2391</td>
<td>Resin-based composite - one surface, posterior</td>
<td>$108</td>
</tr>
<tr>
<td>D2392</td>
<td>Resin-based composite - two surfaces, posterior</td>
<td>$143</td>
</tr>
<tr>
<td>D2393</td>
<td>Resin-based composite - three surfaces, posterior</td>
<td>$179</td>
</tr>
<tr>
<td>D2394</td>
<td>Resin-based composite - four or more surfaces, posterior</td>
<td>$204</td>
</tr>
<tr>
<td>D2510</td>
<td>Inlay - metallic - one surface</td>
<td>$493</td>
</tr>
<tr>
<td>D2520</td>
<td>Inlay - metallic - two surfaces</td>
<td>$556</td>
</tr>
<tr>
<td>D2530</td>
<td>Inlay - metallic - three or more surfaces</td>
<td>$604</td>
</tr>
<tr>
<td>D2542</td>
<td>Onlay – metallic - two surfaces</td>
<td>$641</td>
</tr>
<tr>
<td>D2543</td>
<td>Onlay – metallic - three surfaces</td>
<td>$653</td>
</tr>
<tr>
<td>D2544</td>
<td>Dental onlay metl 4/more surfaces</td>
<td>$657</td>
</tr>
<tr>
<td>ADA Code</td>
<td>Description of Services</td>
<td>*What you must pay to:</td>
</tr>
<tr>
<td>---------</td>
<td>-------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>D2610</td>
<td>Inlay - porcelain/ceramic - one surface</td>
<td>$541</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>D2620</td>
<td>Inlay - porcelain/ceramic - two surfaces</td>
<td>$576</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>D2630</td>
<td>Inlay - porcelain/ceramic - three or more surfaces</td>
<td>$665</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>D2642</td>
<td>Onlay - porcelain/ceramic - two surfaces</td>
<td>$616</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>D2643</td>
<td>Onlay - porcelain/ceramic - three surfaces</td>
<td>$666</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>D2644</td>
<td>Dental onlay porc 4/more surfaces</td>
<td>$710</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>D2650</td>
<td>Inlay - resin-based composite - one surface</td>
<td>$498</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>D2651</td>
<td>Inlay - resin-based composite - two surfaces</td>
<td>$538</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>D2652</td>
<td>Inlay - resin-based composite - three or more surfaces</td>
<td>$699</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>D2662</td>
<td>Onlay - resin-based composite - two surfaces</td>
<td>$568</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>D2663</td>
<td>Onlay - resin-based composite - three surfaces</td>
<td>$699</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>D2664</td>
<td>Onlay - resin-based composite - &gt;=4 surfaces</td>
<td>$662</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>D2710</td>
<td>Crown - resin (indirect)</td>
<td>$277</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>D2712</td>
<td>Crown 3/4 resin-based composite (exclusive of veneers)</td>
<td>$255</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>D2720</td>
<td>Crown - resin with high noble metal</td>
<td>$675</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>D2721</td>
<td>Crown - resin with predominantly base metal</td>
<td>$601</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>D2722</td>
<td>Crown - resin with noble metal</td>
<td>$628</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>D2740</td>
<td>Crown - porcelain/ceramic substrate</td>
<td>$741</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>D2750</td>
<td>Crown - porcelain fused to high noble metal</td>
<td>$755</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Not covered</td>
</tr>
<tr>
<td>ADA Code</td>
<td>Description of Services</td>
<td>*What you must pay to:</td>
</tr>
<tr>
<td>----------</td>
<td>--------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td>D2751</td>
<td>Crown - porcelain fused to predominantly base metal</td>
<td>$653 Not covered</td>
</tr>
<tr>
<td>D2752</td>
<td>Crown - porcelain fused to noble metal</td>
<td>$679 Not covered</td>
</tr>
<tr>
<td>D2780</td>
<td>Crown - 3/4 cast high noble metal</td>
<td>$724 Not covered</td>
</tr>
<tr>
<td>D2781</td>
<td>Crown - 3/4 cast predominantly base metal</td>
<td>$566 Not covered</td>
</tr>
<tr>
<td>D2782</td>
<td>Crown - 3/4 cast noble metal</td>
<td>$611 Not covered</td>
</tr>
<tr>
<td>D2783</td>
<td>Crown - 3/4 porcelain/ceramic</td>
<td>$628 Not covered</td>
</tr>
<tr>
<td>D2790</td>
<td>Crown - full cast high noble metal</td>
<td>$675 Not covered</td>
</tr>
<tr>
<td>D2791</td>
<td>Crown - full cast predominantly base metal</td>
<td>$601 Not covered</td>
</tr>
<tr>
<td>D2792</td>
<td>Crown - full cast noble metal</td>
<td>$628 Not covered</td>
</tr>
<tr>
<td>D2794</td>
<td>Crown – titanium</td>
<td>$679 Not covered</td>
</tr>
<tr>
<td>D2910</td>
<td>Recement inlay</td>
<td>$68 Not covered</td>
</tr>
<tr>
<td>D2920</td>
<td>Recement crown</td>
<td>$68 Not covered</td>
</tr>
<tr>
<td>D2930</td>
<td>Prefabricated stainless steel crown - primary tooth</td>
<td>$141 Not covered</td>
</tr>
<tr>
<td>D2931</td>
<td>Prefabricated stainless steel crown - permanent tooth</td>
<td>$186 Not covered</td>
</tr>
<tr>
<td>D2932</td>
<td>Prefabricated resin crown</td>
<td>$254 Not covered</td>
</tr>
<tr>
<td>D2940</td>
<td>Sedative filling</td>
<td>$77 Not covered</td>
</tr>
<tr>
<td>D2950</td>
<td>Core buildup, including any pins</td>
<td>$172 Not covered</td>
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<tr>
<td>D2951</td>
<td>Pin retention - per tooth, in addition to restoration</td>
<td>$40 Not covered</td>
</tr>
<tr>
<td>D2952</td>
<td>Cast post and core in addition to crown</td>
<td>$252 Not covered</td>
</tr>
<tr>
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<td>Description of Services</td>
<td>*What you must pay to:</td>
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<tr>
<td></td>
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<td>Dentist</td>
</tr>
<tr>
<td>D2954</td>
<td>Prefabricated post and core in addition to crown</td>
<td>$224</td>
</tr>
<tr>
<td>D2955</td>
<td>Post removal (not in conj. with endo. therapy)</td>
<td>$194</td>
</tr>
<tr>
<td>D2970</td>
<td>Temporary crown (fractured tooth)</td>
<td>$188</td>
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<tr>
<td>D2980</td>
<td>Crown repair, by report</td>
<td>$138</td>
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**Endodontic Services**

<table>
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<th>Description of Services</th>
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<tbody>
<tr>
<td>D3110</td>
<td>Pulp cap - direct (excluding final restoration)</td>
<td>$47</td>
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<tr>
<td>D3120</td>
<td>Pulp cap - indirect (excluding final restoration)</td>
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<tr>
<td>D3220</td>
<td>Therapeutic pulpotomy (excluding final restoration) - removal of pulp coronal to the dentinocemental junction and application of medicament</td>
<td>$104 $122</td>
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<tr>
<td>D3221</td>
<td>Pulpal debridement, prim. and perm. teeth</td>
<td>$126</td>
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<tr>
<td>D3310</td>
<td>Anterior (excluding final restoration)</td>
<td>$439 $505</td>
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<tr>
<td>D3320</td>
<td>Bicuspid (excluding final restoration)</td>
<td>$525 $604</td>
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<tr>
<td>D3330</td>
<td>Molar (excluding final restoration)</td>
<td>$687 $789</td>
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<tr>
<td>D3333</td>
<td>Internal root repair of perforation defects</td>
<td>Not covered $225</td>
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<td>D3346</td>
<td>Retreatment of previous root canal therapy - anterior</td>
<td>Not covered $609</td>
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<tr>
<td>D3347</td>
<td>Retreatment of previous root canal therapy - bicuspid</td>
<td>Not covered $812</td>
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<tr>
<td>D3348</td>
<td>Retreatment of previous root canal therapy - molar</td>
<td>Not covered $1,047</td>
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<tr>
<td>D3410</td>
<td>Apicoectomy/periradicular surgery - anterior</td>
<td>$422 $524</td>
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<tr>
<td>D3421</td>
<td>Apicoectomy/periradicular surgery - bicuspid (first root)</td>
<td>$471 $655</td>
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<td>D3425</td>
<td>Apicoectomy/periradicular surgery - molar (first root)</td>
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<td>D3426</td>
<td>Apicoectomy/periradicular surgery (each additional root)</td>
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<tr>
<td>D3430</td>
<td>Retrograde filling - per root</td>
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<td>D3450</td>
<td>Root amputation - per root</td>
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<tr>
<td>D3920</td>
<td>Hemisection (including any root removal), not including root canal therapy</td>
<td>$258</td>
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<tr>
<td>D3950</td>
<td>Canal prep/fitting of preformed dowel or post</td>
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**Periodontic Services**

<table>
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<td>Dentist</td>
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<tr>
<td>D4210</td>
<td>Gingivectomy or gingivoplasty - four or more contiguous teeth per quadrant</td>
<td>$372</td>
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<tr>
<td>D4211</td>
<td>Gingivectomy or gingivoplasty - one to three teeth, per quadrant</td>
<td>$161</td>
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<tr>
<td>D4240</td>
<td>Gingival flap procedure, including root planing - four or more contiguous teeth</td>
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<tr>
<td>D4241</td>
<td>Gingival flap procedure, including root planing - one to three teeth, per quadrant</td>
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<tr>
<td>D4260</td>
<td>Osseous surgery (including flap entry and closure) - four or more per quadrant</td>
<td>$709</td>
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<tr>
<td>D4261</td>
<td>Osseous surgery (including flap entry and closure) - one to three teeth, per quadrant</td>
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<td>D4268</td>
<td>Surgical revision procedure, per tooth</td>
<td>$389</td>
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<tr>
<td>D4274</td>
<td>Distal or proximal wedge procedure</td>
<td>$329</td>
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<tr>
<td>D4341</td>
<td>Periodontal scaling and root planing - four or more contiguous</td>
<td>$137</td>
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<td></td>
<td>teeth or bounded teeth spaces per quadrant</td>
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<tr>
<td>D4342</td>
<td>Periodontal scaling and root planing - one to three teeth,</td>
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<td></td>
<td>per quadrant</td>
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<tr>
<td>D4355</td>
<td>Full mouth debridement to enable comprehensive evaluation and</td>
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<td></td>
<td>diagnosis</td>
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<tr>
<td>D4381</td>
<td>Localized delivery of chemotherapeutic agents</td>
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<tr>
<td>D4910</td>
<td>Periodontal maintenance</td>
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**Prosthetics – Removable**

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<tr>
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<td>Dentist</td>
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<tr>
<td>D5110</td>
<td>Complete denture - maxillary</td>
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<tr>
<td>D5120</td>
<td>Complete denture - mandibular</td>
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<tr>
<td>D5130</td>
<td>Immediate denture - maxillary</td>
<td>$910</td>
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<tr>
<td>D5140</td>
<td>Immediate denture - mandibular</td>
<td>$910</td>
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<tr>
<td>D5211</td>
<td>Maxillary partial denture - resin base (including any conventional clasps, rests and teeth)</td>
<td>$653</td>
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<tr>
<td>D5212</td>
<td>Mandibular partial denture - resin base (including any conventional clasps, rests and teeth)</td>
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</tr>
<tr>
<td>D5213</td>
<td>Maxillary partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
<td>$906</td>
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<tr>
<td>D5214</td>
<td>Mandibular partial denture - cast metal framework with resin denture bases (including any conventional clasps, rests and teeth)</td>
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<tr>
<td>D5225</td>
<td>Maxillary partial denture</td>
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<td>D5226</td>
<td>Mandibular partial denture</td>
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<td>D5281</td>
<td>Removable unilateral partial denture - one piece cast metal (including clasps and teeth)</td>
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<tr>
<td>D5410</td>
<td>Adjust complete denture - maxillary</td>
<td>$79</td>
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<tr>
<td>D5411</td>
<td>Adjust complete denture - mandibular</td>
<td>$79</td>
</tr>
<tr>
<td>D5421</td>
<td>Adjust partial denture - maxillary</td>
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<tr>
<td>D5422</td>
<td>Adjust partial denture - mandibular</td>
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<tr>
<td>D5510</td>
<td>Repair broken complete denture base</td>
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<tr>
<td>D5520</td>
<td>Replace missing or broken teeth - complete denture (each tooth)</td>
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<td>D5610</td>
<td>Repair resin denture base</td>
<td>$102</td>
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<tr>
<td>D5620</td>
<td>Repair cast framework</td>
<td>$147</td>
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<tr>
<td>D5630</td>
<td>Repair or replace broken clasp</td>
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<tr>
<td>D5640</td>
<td>Replace broken teeth - per tooth</td>
<td>$88</td>
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<tr>
<td>D5650</td>
<td>Add tooth to existing partial denture</td>
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<tr>
<td>D5660</td>
<td>Add clasp to existing partial denture</td>
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<tr>
<td>D5670</td>
<td>Replace all teeth and acrylic on cast metal framework (maxillary)</td>
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<tr>
<td>D5671</td>
<td>Replace all teeth and acrylic on cast metal framework (mandibular)</td>
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*What you must pay to:*

<table>
<thead>
<tr>
<th>Dentist</th>
<th>Specialist</th>
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<td>------------------------------------------------------------------</td>
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<tr>
<td></td>
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<tr>
<td>D5710</td>
<td>Rebase complete maxillary denture</td>
</tr>
<tr>
<td>D5711</td>
<td>Rebase complete mandibular denture</td>
</tr>
<tr>
<td>D5720</td>
<td>Rebase maxillary partial denture</td>
</tr>
<tr>
<td>D5721</td>
<td>Rebase mandibular partial denture</td>
</tr>
<tr>
<td>D5730</td>
<td>Reline complete maxillary denture (chairside)</td>
</tr>
<tr>
<td>D5731</td>
<td>Reline complete mandibular denture (chairside)</td>
</tr>
<tr>
<td>D5740</td>
<td>Reline maxillary partial denture (chairside)</td>
</tr>
<tr>
<td>D5741</td>
<td>Reline mandibular partial denture (chairside)</td>
</tr>
<tr>
<td>D5750</td>
<td>Reline complete maxillary denture (laboratory)</td>
</tr>
<tr>
<td>D5751</td>
<td>Reline complete mandibular denture (laboratory)</td>
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<tr>
<td>D5760</td>
<td>Reline maxillary partial denture (laboratory)</td>
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<tr>
<td>D5761</td>
<td>Reline mandibular partial denture (laboratory)</td>
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<tr>
<td>D5810</td>
<td>Interim complete denture (maxillary)</td>
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<tr>
<td>D5811</td>
<td>Interim complete denture (mandibular)</td>
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<tr>
<td>D5820</td>
<td>Interim partial denture (maxillary)</td>
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<td>D5821</td>
<td>Interim partial denture (mandibular)</td>
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<tr>
<td>D5850</td>
<td>Tissue conditioning, maxillary</td>
</tr>
<tr>
<td>D5851</td>
<td>Tissue conditioning, mandibular</td>
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**Prosthetics – Fixed**
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<tr>
<td>D6000-</td>
<td>ALL IMPLANT SERVICES - 15% DISCOUNT (incl. D0360-D0363 cone beam imaging w/ implants)</td>
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<td>D6199</td>
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<tr>
<td>D6210</td>
<td>Pontic - cast high noble metal</td>
<td>$610</td>
</tr>
<tr>
<td>D6211</td>
<td>Pontic - cast predominantly base metal</td>
<td>$624</td>
</tr>
<tr>
<td>D6212</td>
<td>Pontic - cast noble metal</td>
<td>$586</td>
</tr>
<tr>
<td>D6214</td>
<td>Pontic – titanium</td>
<td>$571</td>
</tr>
<tr>
<td>D6240</td>
<td>Pontic - porcelain fused to high noble metal</td>
<td>$755</td>
</tr>
<tr>
<td>D6241</td>
<td>Pontic - porcelain fused to predominantly base metal</td>
<td>$653</td>
</tr>
<tr>
<td>D6242</td>
<td>Pontic - porcelain fused to noble metal</td>
<td>$679</td>
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<tr>
<td>D6245</td>
<td>Pontic – porcelain/ceramic</td>
<td>$741</td>
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<tr>
<td>D6250</td>
<td>Pontic - resin with high noble metal</td>
<td>$745</td>
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<tr>
<td>D6251</td>
<td>Pontic - resin with predominantly base metal</td>
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<td>D6252</td>
<td>Pontic - resin with noble metal</td>
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<tr>
<td>D6545</td>
<td>Retainer - cast metal for resin bonded fixed prosthesis</td>
<td>$270</td>
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<tr>
<td>D6548</td>
<td>Retainer - porcelain/ceramic for resin bonded fixed prosthesis</td>
<td>$481</td>
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<tr>
<td>D6600</td>
<td>Inlay - porcelain/ceramic, two surfaces</td>
<td>$400</td>
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<td>D6601</td>
<td>Inlay - porcelain/ceramic, &gt;=3 surfaces</td>
<td>$426</td>
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<tr>
<td>D6602</td>
<td>Inlay - cast high noble metal, two surfaces</td>
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<tr>
<td>D6603</td>
<td>Inlay - cast high noble metal, three or more surfaces</td>
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<td>*What you must pay to:</td>
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<tr>
<td>D6604</td>
<td>Inlay - cast predominantly base metal, two surfaces</td>
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<tr>
<td>D6605</td>
<td>Inlay - cast predominantly base metal, three or more surfaces</td>
<td>$404</td>
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<td>Inlay - cast noble metal, two surfaces</td>
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<td>D6607</td>
<td>Inlay - cast noble metal, three or more surfaces</td>
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<td>D6608</td>
<td>Onlay - porcelain./ceramic, two surfaces</td>
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<td>Onlay - porcelain./ceramic, three or more surfaces</td>
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<td>Onlay - cast high noble metal, two surfaces</td>
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<td>Onlay cast high noble metal &gt;=3 surfaces</td>
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<td>Onlay - cast predominantly base metal, two surfaces</td>
<td>$431</td>
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<td>Onlay - cast predominantly base metal, three or more surfaces</td>
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<td>Onlay - cast noble metal, two surfaces</td>
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<td>Onlay cast noble metal &gt;=3 surfaces</td>
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<td>D6624</td>
<td>Inlay – titanium</td>
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<tr>
<td>D6634</td>
<td>Onlay – titanium</td>
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<td>D6720</td>
<td>Crown - resin with high noble metal</td>
<td>$747</td>
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<td>Crown - resin with predominantly base metal</td>
<td>$666</td>
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<td>Crown - resin with noble metal</td>
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<td>Crown – Porcelain/ceramic</td>
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<tr>
<td>D6750</td>
<td>Crown - porcelain fused to high noble metal</td>
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<td>Crown - porcelain fused to predominantly base metal</td>
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</tr>
<tr>
<td>D6752</td>
<td>Crown - porcelain fused to noble metal</td>
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<td>D6780</td>
<td>Crown - 3/4 cast high noble metal</td>
<td>$724</td>
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<td>D6781</td>
<td>Crown - 3/4 cast predominantly base metal</td>
<td>$566</td>
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<td>Crown - 3/4 cast noble metal</td>
<td>$578</td>
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<td>D6783</td>
<td>Crown - 3/4 porc./ceramic</td>
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<td>D6790</td>
<td>Crown - full cast high noble metal</td>
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<td>Crown - full cast predominantly base metal</td>
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<td>Crown - full cast noble metal</td>
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<td>D6794</td>
<td>Crown – titanium</td>
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<td>D6930</td>
<td>Recement fixed partial denture</td>
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<td>Stress breaker</td>
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<td>Post and core in addition to fixed part. dent. ret.</td>
<td>$212</td>
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<td>Prefab post and core in addition to fixed part. dent. ret.</td>
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<td>D6973</td>
<td>Core build up for retainer, including any pins</td>
<td>$152</td>
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<td>D6975</td>
<td>Coping – metal</td>
<td>$431</td>
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<tr>
<td>D6976</td>
<td>Each add. indirectly fabricated post - same tooth</td>
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<tr>
<td>D6977</td>
<td>Each add. prefab post - same tooth</td>
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<td>D6980</td>
<td>Fixed partial denture repair, by report</td>
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<td><strong>Oral Surgery</strong></td>
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<td>D7111</td>
<td>Coronal remnants - deciduous tooth</td>
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<td>D7140</td>
<td>Extraction, erupted tooth or exposed root (elevation and/or forceps removal)</td>
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<td>D7210</td>
<td>Surgical removal of erupted tooth requiring elevation of mucoperiosteal flap and removal of bone and/or section of tooth</td>
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<td>D7220</td>
<td>Removal of impacted tooth - soft tissue</td>
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<tr>
<td>D7230</td>
<td>Removal of impacted tooth - partially bony</td>
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<td>D7240</td>
<td>Removal of impacted tooth - completely bony</td>
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<tr>
<td>D7241</td>
<td>Removal of impacted tooth - completely bony, with unusual surg. complications</td>
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<tr>
<td>D7250</td>
<td>Surgical removal of residual tooth roots (cutting procedure)</td>
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<td>D7270</td>
<td>Tooth reimplantation and/or stabilization of accidentally evulsed or displaced tooth</td>
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<td>D7280</td>
<td>Surgical access of an unerupted tooth</td>
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<tr>
<td>D7282</td>
<td>Mobiliz. of erupted or malpos. tooth-aid erup</td>
<td>$96</td>
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<td>D7285</td>
<td>Biopsy of oral tissue - hard (bone, tooth)</td>
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<tr>
<td>D7286</td>
<td>Biopsy of oral tissue - soft (all others)</td>
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<td>D7291</td>
<td>Transseptal fiberotomy-supra crestal fiberotomy, by report</td>
<td>$142</td>
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<tr>
<td>ADA Code</td>
<td>Description of Services</td>
<td>*What you must pay to:</td>
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<tr>
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</tr>
<tr>
<td></td>
<td></td>
<td>Dentist</td>
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<tr>
<td>D7310</td>
<td>Alveoloplasty in conjunction with extractions - per quadrant</td>
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<td>D7311</td>
<td>Alveoloplasty in conjunction with extractions</td>
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<td>D7320</td>
<td>Alveoloplasty not in conjunction with extractions – per quadrant</td>
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<tr>
<td>D7321</td>
<td>Alveoloplasty not in conjunction with extractions</td>
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<td>D7471</td>
<td>Removal of lateral exostosis</td>
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<td>D7472</td>
<td>Removal of torus palatinus</td>
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<td>D7473</td>
<td>Removal of torus mandibularis</td>
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<td>D7485</td>
<td>Surgical reduction of osseous tuberosity</td>
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<td>D7510</td>
<td>Incision and drainage of abscess - intraoral soft tissue</td>
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<td>D7511</td>
<td>Incision and drainage of abscess - intraoral</td>
<td>$226</td>
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<tr>
<td>D7910</td>
<td>Suture of recent small wounds up to 5 cm</td>
<td>$246</td>
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<tr>
<td>D7960</td>
<td>Frenulectomy (frenectomy or frenotomy) - separate procedure</td>
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<tr>
<td>D7963</td>
<td>Frenuloplasty</td>
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<td>D7970</td>
<td>Excision of hyperplastic tissue - per arch</td>
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<td>D7971</td>
<td>Excision of pericoronal gingiva</td>
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<td>D7972</td>
<td>Surgical reduction of fibrous tuberosity</td>
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**Orthodontics**

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<thead>
<tr>
<th>ADA Code</th>
<th>Description of Services</th>
<th>*What you must pay to:</th>
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<tbody>
<tr>
<td>D8070</td>
<td>Comprehensive orthodontic treatment of the transitional</td>
<td>Not covered</td>
</tr>
<tr>
<td>ADA Code</td>
<td>Description of Services</td>
<td>*What you must pay to:</td>
</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>------------------------</td>
</tr>
<tr>
<td></td>
<td>dentition</td>
<td></td>
</tr>
<tr>
<td>D8080</td>
<td>Comprehensive orthodontic treatment of the adolescent dentition</td>
<td>Not covered</td>
</tr>
<tr>
<td>D8090</td>
<td>Comprehensive orthodontic treatment of the adult dentition</td>
<td>Not covered</td>
</tr>
<tr>
<td>D8660</td>
<td>Pre-orthodontic treatment visit</td>
<td>Not covered</td>
</tr>
<tr>
<td>D8670</td>
<td>Periodic orthodontic treatment visit (as part of contract)</td>
<td>Not covered</td>
</tr>
<tr>
<td>D8680</td>
<td>Orthodontic retention (removal of appliances, construction and placement of retainer(s))</td>
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**Additional Procedures**

<table>
<thead>
<tr>
<th>ADA Code</th>
<th>Description of Services</th>
<th>*What you must pay to:</th>
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<tbody>
<tr>
<td>D9110</td>
<td>Palliative (emergency) treatment of dental pain - minor procedure</td>
<td>$30</td>
<td>$75</td>
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<tr>
<td>D9210</td>
<td>Local anesthesia not in conjunction with operative or surgical procedures</td>
<td>$0</td>
<td>Not covered</td>
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<tr>
<td>D9211</td>
<td>Regional block anesthesia</td>
<td>$0</td>
<td>Not covered</td>
<td></td>
</tr>
<tr>
<td>D9212</td>
<td>Trigeminal division block anesthesia</td>
<td>$0</td>
<td>Not covered</td>
<td></td>
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<tr>
<td>D9215</td>
<td>Local anesthesia</td>
<td>$0</td>
<td>Not covered</td>
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<td>D9220</td>
<td>Deep sedation/general anesth - first 30 minutes</td>
<td>$80</td>
<td>$277</td>
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<tr>
<td>D9221</td>
<td>Deep sedation/general anesth - each addtl. 15 minutes</td>
<td>$40</td>
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<tr>
<td>D9230</td>
<td>Analgesia, anxiolysis, inhalation of nitrous oxide</td>
<td>$36</td>
<td>$41</td>
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<td>D9241</td>
<td>Intrav conscious sed./analgesia - first 30 minutes</td>
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<td>$272</td>
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<td>D9242</td>
<td>Intrav conscious sed./analgesia - each addtl. 15 minutes</td>
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<tr>
<td>ADA Code</td>
<td>Description of Services</td>
<td>*What you must pay to:</td>
<td></td>
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</tr>
<tr>
<td>---------</td>
<td>----------------------------------------------------------------------------------------</td>
<td>------------------------</td>
<td></td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Dentist</td>
<td>Specialist</td>
<td></td>
</tr>
<tr>
<td>D9310</td>
<td>Consultation (diagnostic service provided by dentist or physician other than practitioner providing treatment)</td>
<td>$59</td>
<td>$96</td>
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<tr>
<td>D9439</td>
<td>Office visit - Not including an FC30 visit</td>
<td>$10</td>
<td>$10</td>
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<tr>
<td>D9440</td>
<td>Office visit - after regularly scheduled hours</td>
<td>$27</td>
<td>$111</td>
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<tr>
<td>D9910</td>
<td>Application of desensitizing medicament</td>
<td>$30</td>
<td>$60</td>
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<tr>
<td>D9930</td>
<td>Treatment of complications (post-surgical)</td>
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<td>D9940</td>
<td>Occlusal guard, by report</td>
<td>$338</td>
<td>$519</td>
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<tr>
<td>D9950</td>
<td>Occlusion analysis - mounted case</td>
<td>$169</td>
<td>$169</td>
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<tr>
<td>D9951</td>
<td>Occlusal adjustment - limited</td>
<td>$88</td>
<td>$115</td>
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<tr>
<td>D9952</td>
<td>Occlusal adjustment - complete</td>
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<td>$597</td>
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<tr>
<td>D9990</td>
<td>Broken office appointment</td>
<td>$50</td>
<td>$50</td>
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</table>

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

Section 3.1 Benefits we do not cover (exclusions)

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

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

If you get benefits that are excluded, you must pay for them yourself. We won't pay for the excluded medical benefits listed in this section (or elsewhere in this booklet), and neither will Original Medicare. The only exception: If a benefit on the exclusion list is found upon appeal to be a medical benefit that we should have paid for or covered because of your specific situation.
In addition to any exclusions or limitations described in the Medical Benefits Chart, or anywhere else in this Evidence of Coverage (see Chapters 3, 11, 12, and the Amendment "What You Need to Know — Your Important State-mandated Health Care Benefits and Rights and Other Legal Notices" for important coverage limitations), the following items and services aren't covered under Original Medicare or by our plan:

- Services considered not reasonable and necessary, according to the standards of Original Medicare, unless these services are listed by our plan as covered services.
- Experimental medical and surgical procedures, equipment, and medications, unless covered by Original Medicare or under a Medicare-approved clinical research study or by our plan. (See Chapter 3, Section 5, for more information about clinical research studies.) Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.
- Travel and lodging expenses.
- Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance).
- Licensed ambulance services if the ambulance is not used to transport or is otherwise not covered by Medicare.
- Outpatient oral nutrition, such as dietary supplements, herbal supplements, weight loss aids, formulas, and food (except medical food and modified food products).
- Private room in a hospital, except when it is considered medically necessary.
- Private duty nurses.
- Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television.
- Comfort, convenience, or luxury equipment or features.
- Full-time nursing care in your home.
- Care in a licensed intermediate care facility.
- Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care. Custodial care is personal care that does not require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.
- Homemaker services include basic household assistance, including light housekeeping or light meal preparation.
- Fees charged by your immediate relatives or members of your household.
- Meals delivered to your home.
- Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance), except when medically necessary.

- Cosmetic surgery or procedures, unless needed because of an accidental injury or to improve the function of a malformed part of the body. However, all stages of reconstruction are covered for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.

- Reconstructive surgery that offers only a minimal improvement in appearance or is performed to alter or reshape normal structures of the body in order to improve appearance. However, we cover reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defect, developmental abnormalities, accidental injury, trauma, infection, tumors, or disease, if a network physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible. In addition, we cover reconstructive surgery 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.

- Surgery that, in the judgment of a network 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.

- Chiropractic care, other than manual manipulation of the spine consistent with Medicare coverage guidelines.

- Routine foot care, except for the limited coverage provided according to Medicare guidelines.

- Orthopedic shoes, unless the shoes are part of a leg brace and are included in the cost of the brace or the shoes are for a person with diabetic foot disease.

- Supportive devices for the feet, except for orthopedic or therapeutic shoes for people with diabetic foot disease.

- Services not approved by the federal Food and Drug Administration. Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S., but are not approved by the FDA. This exclusion applies to services provided anywhere, even outside the U.S. It does not apply to Medicare-covered clinical trials or covered emergency care you receive outside the U.S.

- Services requested by the Member that are not deemed medically necessary by the Plan Provider in consultation with the Kaiser Permanente Complementary and Alternative Medicine Department; and the Member's medical condition does not satisfy Health Plan's clinical guidelines established for alternative care.

- Routine hearing exams, hearing aids, or exams to fit hearing aids. This exclusion does not apply to cochlear implants and osseointegrated external hearing devices covered by Medicare.
• Services (such as eye surgery or contact lenses to reshape the eye, including radial keratotomy and LASIK surgery) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism.

• Vision therapy/rehabilitation except when covered in accord with Medicare guidelines.

• Low-vision aids and services.

• Reversal of sterilization procedures, and nonprescription contraceptive supplies.

• Cost of donor semen and donor eggs, storage and freezing of eggs. Services other than artificial insemination, related to conception by artificial means, including but not limited to, in vitro fertilization, ovum transplants, gamete intrafallopian transfer, zygote intrafallopian transfer and prescription drugs related to such services. Services to reverse involuntary, surgically induced infertility.

• Acupuncture.

• Naturopath services (uses natural or alternative treatments).

• Massage therapy, except when ordered as part of a physical therapy program in accord with Medicare guidelines.

• Physical examinations related to employment, insurance, licensing, court orders, parole, or probation, unless a plan provider determines that the services are medically necessary.

• Services provided to veterans in Veterans Affairs (VA) facilities. However, when emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our plan's cost-sharing amounts.

• When a service or item is not covered, all services directly related to the noncovered service or item are excluded, except for services or items we would otherwise cover to treat complications of the noncovered service or item if covered in accord with Medicare guidelines.

Our plan will not cover the excluded services listed above. Even if you receive the services at an emergency facility, the excluded services are still not covered.
CHAPTER 5. Using our plan's coverage for your Part D prescription drugs

SECTION 1. Introduction ........................................................................................................... 98
   Section 1.1 This chapter describes your coverage for Part D drugs................................. 98
   Section 1.2 Basic rules for our plan's Part D drug coverage............................................. 99

SECTION 2. Fill your prescription at a network pharmacy or through our mail-order service .................................................................................. 99
   Section 2.1 To have your prescription covered, use a network pharmacy .......................... 99
   Section 2.2 Finding network pharmacies .......................................................................... 100
   Section 2.3 Using our mail-order services ....................................................................... 101
   Section 2.4 How can you get a long-term supply of drugs? ............................................. 101
   Section 2.5 When can you use a pharmacy that is not in our network? ............................. 102

SECTION 3. Your drugs need to be on our Drug List ...................................................... 103
   Section 3.1 The Drug List tells which Part D drugs are covered ...................................... 103
   Section 3.2 There are three "cost-sharing tiers" for drugs on our Drug List .................... 103
   Section 3.3 How can you find out if a specific drug is on our Drug List? ........................ 104

SECTION 4. There are restrictions on coverage for some drugs ...................................... 104
   Section 4.1 Why do some drugs have restrictions? .......................................................... 104
   Section 4.2 What kinds of restrictions? ............................................................................ 105
   Section 4.3 Do any of these restrictions apply to your drugs? .......................................... 105

SECTION 5. What if one of your drugs is not covered in the way you'd like it to be covered? ....................................................................................... 106
   Section 5.1 There are things you can do if your drug is not covered in the way you'd like it to be covered ........................................................................ 106
   Section 5.2 What can you do if your drug is not on our Drug List or if the drug is restricted in some way? ................................................................. 107
   Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high? ........................................................................................................... 109

SECTION 6. What if your coverage changes for one of your drugs? ............................. 109
   Section 6.1 The Drug List can change during the year ..................................................... 109
Section 6.2  What happens if coverage changes for a drug you are taking? ...................... 109

SECTION 7.  What types of drugs are not covered by our plan? .................................. 110
Section 7.1  Types of drugs we do not cover ................................................................. 110

SECTION 8.  Show your plan membership card when you fill a prescription.................. 112
Section 8.1  Show your membership card ................................................................. 112
Section 8.2  What if you don't have your membership card with you? .................. 112

SECTION 9.  Part D drug coverage in special situations ........................................... 112
Section 9.1  What if you're in a hospital or a skilled nursing facility for a stay that is
covered by our plan? .................................................................................................. 112
Section 9.2  What if you're a resident in a long-term care facility? ......................... 113
Section 9.3  What if you're also getting drug coverage from an employer or retiree
group plan? ............................................................................................................. 113
Section 9.4  What if you're in Medicare-certified hospice? ....................................... 114

SECTION 10. Programs on drug safety and managing medications ......................... 114
Section 10.1  Programs to help members use drugs safely ........................................ 114
Section 10.2  Medication Therapy Management (MTM) Programs to help members
manage their medications .......................................................................................... 115
Did you know there are programs to help people pay for their drugs?

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

Are you currently getting help to pay for your drugs?

If you are in a program that helps pay for your drugs, some information in this Evidence of Coverage about the costs for Part D prescription drugs does not apply to you. We will send you a document, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this rider by December 31, 2014, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are printed on the back cover of this booklet.

SECTION 1. Introduction

Section 1.1 This chapter describes your coverage for Part D drugs

This chapter explains rules for using your coverage for Part D drugs. The next chapter tells you what you pay for Part D drugs (Chapter 6, "What you pay for your Part D prescription drugs").

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

- We cover drugs you are given during covered stays in the hospital or in a skilled nursing facility. Chapter 4, "Medical Benefits Chart (what is covered and what you pay)," tells you about the benefits and costs for drugs during a covered hospital or skilled nursing facility stay.

- Medicare Part B also provides benefits for some drugs. Part B drugs include certain chemotherapy drugs, certain drug injections you are given during an office visit, and drugs you are given at a dialysis facility. Chapter 4, "Medical Benefits Chart (what is covered and what you pay)," tells you about your benefits and costs for Part B drugs.

In addition to our plan's Part D and medical benefits coverage, your drugs may be covered by Original Medicare if you are in Medicare hospice. For more information, please see Section 9.4 in this chapter, "What if you're in Medicare-certified hospice."
Section 1.2 Basic rules for our plan’s Part D drug coverage

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

• You must have a provider (a doctor or other prescriber) write your prescription.
  ♦ Effective June 1, 2015, your prescriber must either accept Medicare or file documentation with CMS showing that he or she is qualified to write prescriptions. You should ask your prescribers the next time you call or visit if they meet this condition.

• You generally must use a network pharmacy to fill your prescription. (See Section 2, "Fill your prescriptions at a network pharmacy or through our mail-order service.")

• Your drug must be on our Kaiser Permanente 2015 Abridged Formulary or Kaiser Permanente 2015 Comprehensive Formulary (we call it the "Drug List" for short). (See Section 3, "Your drugs need to be on our Drug List.")

• Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. (See Section 3 for more information about a medically accepted indication.)

SECTION 2. Fill your prescription at a network pharmacy or through our mail-order service

Section 2.1 To have your prescription covered, use a network pharmacy

In most cases, your prescriptions are covered only if they are filled at our network pharmacies. (See Section 2.5 for information about when we would cover prescriptions filled at out-of-network pharmacies.) Our network includes pharmacies with preferred cost-sharing, which may offer you lower cost-sharing than the standard cost-sharing offered by other pharmacies within the network.

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

Our network includes pharmacies that offer standard cost-sharing and pharmacies that offer preferred cost-sharing. You may go to either type of network pharmacy to receive your covered prescription drugs. Your cost-sharing may be less at pharmacies with preferred cost-sharing.
Section 2.2 Finding network pharmacies

How do you find a network pharmacy in your area?
To find a network pharmacy, you can look in your Pharmacy Directory, visit our website (kp.org/seniormedrx), or call Member Services (phone numbers are printed on the back cover of this booklet). Choose whatever is easiest for you.

You may go to any of our network pharmacies. However, your costs may be even less for your covered drugs if you use a network pharmacy that offers preferred cost-sharing rather than a network pharmacy that offers standard cost-sharing. The Pharmacy Directory will tell you which of the network pharmacies offer preferred cost-sharing.

If you switch from one network pharmacy to another, and you need a refill of a drug you have been taking, you can ask either to have a new prescription written by a provider or to have your prescription transferred to your new network pharmacy.

What if the pharmacy you have been using leaves the network?
If the pharmacy you have been using leaves our plan's network, you will have to find a new pharmacy that is in our network. Or if the pharmacy you have been using stays within the network but is no longer a preferred cost-sharing, you may want to switch to a different pharmacy. To find another network pharmacy in your area, you can get help from Member Services (phone numbers are printed on the back cover of this booklet) or use the Pharmacy Directory. You can also find information on our website at kp.org/seniormedrx.

What if you need a specialized pharmacy?
Sometimes prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a long-term care facility (such as a nursing home) has its own pharmacy. Residents may get prescription drugs through the facility's pharmacy as long as it is part of our network. If your long-term care pharmacy is not in our network, please contact Member Services.
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network. However, currently this is not applicable to our plan because there are no such pharmacies inside our service area.
- Pharmacies that dispense drugs that are restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use.
  Note: This scenario should happen rarely.

To locate a specialized pharmacy, look in your Pharmacy Directory or call Member Services (phone numbers are printed on the back cover of this booklet).
Section 2.3 Using our mail-order services

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

Our mail-order service allows you to order up to a 90-day supply.

To get information about filling your prescriptions by mail, call the Kaiser Permanente pharmacy at 703-709-1825 or toll free 1-800-733-6345, Monday through Thursday, 8:30 a.m. to 7 p.m., and Friday, 8:30 a.m. to 6 p.m. (TTY 711).

You can conveniently order your prescription refills in the following ways:

- Calling our EZ Refill Line at 1-866-299-9415, seven days a week, 24 hours a day, (TTY 711), Monday through Thursday, 8 a.m. to 7 p.m., and Friday, 8 a.m. to 5 p.m. Be sure to select the mail delivery option when prompted.
- Order online at kp.org/refill. To register to use our secure online mail-order service, please go to kp.org/register and follow the on-screen instructions.

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

Usually a mail-order pharmacy order will get to you in no more than 7-10 days. If your mail-order prescription is delayed, please call the Kaiser Permanente pharmacy for assistance at 1-800-733-6345 or 703-709-1825, Monday through Thursday, 8:30 a.m. to 7 p.m., and Friday, 8:30 a.m. to 6 p.m. The TTY number is 711, Monday through Friday, 8 a.m. to 6 p.m.

Section 2.4 How can you get a long-term supply of drugs?

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

1. Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your Pharmacy Directory tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services for more information (phone numbers are printed on the back cover of this booklet).
2. For certain kinds of drugs, you can use our plan's network mail-order services. The drugs available through our mail-order service are marked as "mail-order" drugs on
our Drug List. Our mail-order service allows you to order up to a 90-day supply. See Section 2.3 for more information about using our mail-order services.

Section 2.5 When can you use a pharmacy that is not in our network?

Your prescription may be covered in certain situations

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

- If you are traveling within the United States and its territories but outside the service area and you become ill or run out of your covered Part D prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy in limited, nonroutine circumstances according to our Medicare Part D formulary guidelines.

- If you need a Medicare Part D prescription drug in conjunction with covered out-of-network emergency care or out-of-area urgent care, we will cover up to a 30-day supply from an out-of-network pharmacy. Note: Prescription drugs prescribed and provided outside of the United States and its territories as part of covered emergency or urgent care are covered up to a 30-day supply in a 30-day period. These drugs are not covered under Medicare Part D; therefore, payments for these drugs do not count toward reaching the catastrophic coverage stage.

- If you are unable to obtain a covered drug in a timely manner within our service area because there is no network pharmacy within a reasonable driving distance that provides 24-hour service. We may not cover your prescription if a reasonable person could have purchased the drug at a network pharmacy during normal business hours.

- If you are trying to fill a prescription for a drug that is not regularly stocked at an accessible network pharmacy or available through our mail-order pharmacy (including high-cost drugs).

In these situations, please check first with Member Services to see if there is a network pharmacy nearby. Phone numbers for Member Services are printed on the back cover of this booklet.

How do you ask for reimbursement from our plan?

If you must use an out-of-network pharmacy, you will generally have to pay the full cost (rather than your normal share of the cost) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Chapter 7, Section 2.1, explains how to ask us to pay you back.)
SECTION 3. Your drugs need to be on our Drug List

Section 3.1 The Drug List tells which Part D drugs are covered

Our plan has a Kaiser Permanente 2015 Abridged Formulary and Kaiser Permanente 2015 Comprehensive Formulary. In this Evidence of Coverage, we call it the Drug List for short.

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

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

We will generally cover a drug on our plan's Drug List as long as you follow the other coverage rules explained in this chapter and the use of the drug is a medically accepted indication. A "medically accepted indication" is a use of the drug that is either:

- Approved by the Food and Drug Administration. (That is, the Food and Drug Administration has approved the drug for the diagnosis or condition for which it is being prescribed.)
- Or supported by certain reference books. (These reference books are the American Hospital Formulary Service Drug Information, the DRUGDEX Information System, and the USPDI or its successor.)

Our Drug List includes both brand-name and generic drugs

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

What is not on our Drug List?

Our plan does not cover all prescription drugs.

- In some cases, the law does not allow any Medicare plan to cover certain types of drugs (for more information about this, see Section 7.1 in this chapter).
- In other cases, we have decided not to include a particular drug on our Drug List.

Section 3.2 There are three "cost-sharing tiers" for drugs on our Drug List

Every drug on our plan's Drug List is in one of three cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug. Preferred and non-preferred generic drugs listed in the formulary will be subject to the generic drug cost-sharing and preferred and non-preferred brand-name and specialty drugs listed in the formulary will be subject to the brand-name cost-sharing. You will pay the applicable cost-sharing depending upon the tier the drug is in:
- Cost-sharing Tier 1 for generic drugs.
- Cost-sharing Tier 2 for brand-name drugs.
- Cost-sharing Tier 3 for injectable Part D vaccines.

To find out which cost-sharing tier your drug is in, look it up on our Drug List. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6 ("What you pay for your Part D prescription drugs").

### Section 3.3 How can you find out if a specific drug is on our Drug List?

You have three ways to find out:

1. Check the most recent Drug List we sent you in the mail. Please note: The Drug List (Kaiser Permanente 2015 Abridged Formulary) we sent you includes information for the covered drugs that are most commonly used by our members. However, we cover additional drugs that are not included in the printed Drug List. If one of your drugs is not listed in the Drug List, you should visit our website or contact Member Services to find out if we cover it.

2. Visit our website (kp.org/seniormedrx). Our Drug List (Kaiser Permanente 2015 Comprehensive Formulary) on the website is always the most current.

3. Call Member Services to find out if a particular drug is on our plan's Drug List (Kaiser Permanente 2015 Comprehensive Formulary) or to ask for a copy of the list. Phone numbers for Member Services are printed on the back cover of this booklet.

### SECTION 4. There are restrictions on coverage for some drugs

#### Section 4.1 Why do some drugs have restrictions?

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

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

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

Please note that sometimes a drug may appear more than once on our Drug List (Kaiser Permanente 2015 Comprehensive Formulary). This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

Section 4.2 What kinds of restrictions?

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

Restricting brand-name drugs when a generic version is available

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

Getting plan approval in advance

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

Quantity limits

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

Section 4.3 Do any of these restrictions apply to your drugs?

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

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

SECTION 5. What if one of your drugs is not covered in the way you’d like it to be covered?

Section 5.1 There are things you can do if your drug is not covered in the way you’d like it to be covered

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

- What if the drug you want to take is not covered by our plan? For example, the drug might not be covered at all. Or maybe a generic version of the drug is covered but the brand-name version you want to take is not covered.

- What if the drug is covered, but there are extra rules or restrictions on coverage for that drug? As explained in Section 4, some of the drugs covered by our plan have extra rules to restrict their use. For example, there might be limits on what amount of the drug (number of pills, etc.) is covered during a particular time period. In some cases, you may want us to waive the restriction for you. For example, you may want us to cover more of a drug (number of pills, etc.) than we normally will cover.

- What if the drug is covered, but it is in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be? Our plan puts each covered drug into one of three different cost-sharing tiers. How much you pay for your prescription depends in part on which cost-sharing tier your drug is in.

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

- If your drug is not on our Drug List or if your drug is restricted, go to Section 5.2 to learn what you can do.
- If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.3 to learn what you can do.
Section 5.2  What can you do if your drug is not on our Drug List or if the drug is restricted in some way?

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

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

You may be able to get a temporary supply

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

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

1. The change to your drug coverage must be one of the following types of changes:
   ♦ The drug you have been taking is no longer on our plan's Drug List.
   ♦ Or the drug you have been taking is now restricted in some way (Section 4 in this chapter tells you about restrictions).

2. You must be in one of the situations described below:
   ♦ For those members who were in our plan last year and aren't in a long-term care (LTC) facility: We will cover a temporary supply of your drug during the first 90 days of the calendar year. This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy.
   ♦ For those members who are new to our plan and aren't in a long-term care (LTC) facility: We will cover a temporary supply of your drug during the first 90 days of your membership in our plan. This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy.
   ♦ For those members who were in our plan last year and reside in a long-term care (LTC) facility: We will cover a temporary supply of your drug during the first 90 days of the calendar year. The total supply will be for a maximum of a 98-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 98-day supply of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
For those members who are new to our plan and reside in a long-term care (LTC) facility: We will cover a temporary supply of your drug during the first 90 days of your membership in our plan. The total supply will be for a maximum of up to a 98-day supply. If your prescription is written for fewer days, we will allow multiple fills to provide up to a maximum of a 98-day supply of medication. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

For those members who have been in our plan for more than 90 days and reside in a long-term care (LTC) facility and need a supply right away: We will cover one 31-day supply, or less if your prescription is written for fewer days. This is in addition to the above long-term care transition supply.

As a current member of our plan, if you have a covered inpatient stay in the hospital or in a skilled nursing facility, the drugs you obtain during your stay will be covered under your medical benefit rather than your Medicare Part D prescription drug coverage. When you are discharged home or to a custodial level of care at a long-term care facility, many outpatient prescription drugs you obtain at a pharmacy will be covered under your Medicare Part D coverage. Since your drug coverage is different depending upon the setting where you obtain the drug, it is possible that a drug you were taking that was covered under your medical benefit might not be covered by Medicare Part D (for example, over-the-counter drugs or cough medicine). If this happens, you will have to pay full price for that drug unless you have other coverage (for example, employer group or union coverage).

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

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

You can change to another drug
Start by talking with your provider. Perhaps there is a different drug covered by our plan that might work just as well for you. You can call Member Services to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you. Phone numbers for Member Services are printed on the back cover of this booklet.

You can ask for an exception
You and your provider can ask us to make an exception for you and cover the drug in the way you would like it to be covered. If your provider says that you have medical reasons that justify asking us for an exception, your provider can help you request an exception to the rule. For example, you can ask us to cover a drug even though it is not on our plan's Drug List. Or you can ask us to make an exception and cover the drug without restrictions.
If you and your provider want to ask for an exception, Chapter 9, Section 6.4, tells you what to do. It explains the procedures and deadlines that have been set by Medicare to make sure your request is handled promptly and fairly.

**Section 5.3 What can you do if your drug is in a cost-sharing tier you think is too high?**

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

**You can change to another drug**

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

**SECTION 6. What if your coverage changes for one of your drugs?**

**Section 6.1 The Drug List can change during the year**

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

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

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

**Section 6.2 What happens if coverage changes for a drug you are taking?**

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

If there is a change to coverage for a drug you are taking, we will send you a notice to tell you. Normally, we will let you know at least 60 days ahead of time.
Once in a while, a drug is suddenly recalled because it's been found to be unsafe or for other reasons. If this happens, we will immediately remove the drug from the Drug List. We will let you know of this change right away. Your provider will also know about this change, and can work with you to find another drug for your condition.

**Do changes to your drug coverage affect you right away?**

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

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

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

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

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

### SECTION 7. What types of drugs are not covered by our plan?

#### Section 7.1 Types of drugs we do not cover

This section tells you what kinds of prescription drugs are "excluded." This means Medicare does not pay for these drugs.
If you get drugs that are excluded, you must pay for them yourself. We won't pay for the drugs that are listed in this section except when the requested drug is found upon appeal to be a drug that is not excluded under Part D and we should have paid for or covered it because of your specific situation. (For information about appealing a decision we have made to not cover a drug, go to Chapter 9, Section 6.5, in this booklet.)

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

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

Also, by law, these categories of drugs are not covered by Medicare drug plans. Our plan covers certain drugs listed below through our enhanced drug coverage. More information is provided below:

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

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

In addition, if you are receiving "Extra Help" from Medicare to pay for your prescriptions, the "Extra Help" program will not pay for the drugs not normally covered. (Please refer to the plan’s Drug List or call Member Services for more information. Phone numbers for Member Services are printed on the back cover of this booklet.) However, if you have drug coverage through
Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Please contact your state Medicaid program to determine what drug coverage may be available to you. (You can find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

SECTION 8. Show your plan membership card when you fill a prescription

Section 8.1 Show your membership card

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

Section 8.2 What if you don't have your membership card with you?

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

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

SECTION 9. Part D drug coverage in special situations

Section 9.1 What if you're in a hospital or a skilled nursing facility for a stay that is covered by our plan?

If you are admitted to a hospital or to a skilled nursing facility for a stay covered by our plan, we will generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, we will cover your drugs as long as the drugs meet all of our rules for coverage. See the previous parts of this section that tell you about the rules for getting drug coverage. Chapter 6 ("What you pay for your Part D prescription drugs") gives you more information about drug coverage and what you pay.

Please note: When you enter, live in, or leave a skilled nursing facility, you are entitled to a special enrollment period. During this time period, you can switch plans or change your coverage. (Chapter 10, "Ending your membership in our plan," tells you when you can leave our plan and join a different Medicare plan.)
Section 9.2  What if you're a resident in a long-term care facility?

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

Check your Pharmacy Directory to find out if your long-term care facility's pharmacy is part of our network. If it isn't, or if you need more information, please contact Member Services (phone numbers are printed on the back cover of this booklet).

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

If you need a drug that is not on our Drug List or is restricted in some way, we will cover a temporary supply of your drug during the first 90 days of your membership. The first supply will be for a maximum of up to a 98-day supply, or less if your prescription is written for fewer days. (Please note that the long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)

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

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

Section 9.3  What if you're also getting drug coverage from an employer or retiree group plan?

Do you currently have other prescription drug coverage through your (or your spouse's) employer or retiree group? If so, please contact that group's benefits administrator. He or she can help you determine how your current prescription drug coverage will work with our plan.

In general, if you are currently employed, the prescription drug coverage you get from us will be secondary to your employer or retiree group coverage. That means your group coverage would pay first.

Special note about 'creditable coverage'

Each year your employer or retiree group should send you a notice that tells you if your prescription drug coverage for the next calendar year is "creditable" and the choices you have for drug coverage.
If the coverage from the group plan is "creditable," it means that the plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.

Keep these notices about creditable coverage because you may need them later. If you enroll in a Medicare plan that includes Part D drug coverage, you may need these notices to show that you have maintained creditable coverage. If you didn't get a notice about creditable coverage from your employer or retiree group plan, you can get a copy from the employer or retiree group's benefits administrator or the employer or union.

Section 9.4 What if you're in Medicare-certified hospice?

Drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication, or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. See the previous parts of this chapter that tell about the rules for getting drug coverage under Part D. Chapter 6, "What you pay for your Part D prescription drugs," gives more information about drug coverage and what you pay.

SECTION 10. Programs on drug safety and managing medications

Section 10.1 Programs to help members use drugs safely

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

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

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

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

Section 10.2 Medication Therapy Management (MTM) and other Programs to help members manage their medications

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

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

Our program is called a Medication Therapy Management (MTM) program. Some members who take several medications for different medical conditions may qualify. A pharmacist or other health professional will give you a comprehensive review of all your medications. You can talk about how best to take your medications, your costs, or any problems you're having. You'll get a written summary of this discussion. The summary has a medication action plan that recommends what you can do to make the best use of your medications, with space for you to take notes or write down any follow-up questions. You'll also get a personal medication list that will include all the medications you're taking and why you take them.

It's a good idea to schedule your medication review before your yearly "Wellness" visit, so you can talk to your doctor about your action plan and medication list. Bring your action plan and medication list with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Also, take your medication list with you if you go to the hospital or emergency room.

If we have a program that fits your needs, we will automatically enroll you in the program and send you information. If you decide not to participate, please notify us and we will withdraw you from the program. If you have any questions about these programs, please contact Member Services (phone numbers are printed on the back cover of this booklet).
CHAPTER 6. What you pay for your Part D prescription drugs

SECTION 1. Introduction ........................................................................................................ 118
Section 1.1 Use this chapter together with other materials that explain your drug coverage .......................................................... 118
Section 1.2 Types of out-of-pocket costs you may pay for covered drugs ......................... 119

SECTION 2. What you pay for a drug depends upon which "drug payment stage" you are in when you get the drug ........................................ 119
Section 2.1 What are the drug payment stages for Medicare Plus members? ...................... 119

SECTION 3. We send you reports that explain payments for your drugs and which payment stage you are in ........................................... 120
Section 3.1 We send you a monthly report called the "Explanation of Benefits" (the "EOB") ................................................................. 120
Section 3.2 Help us keep our information about your drug payments up-to-date .................. 121

SECTION 4. There is no deductible for Medicare Plus ................................................. 122
Section 4.1 You do not pay a deductible for your Part D drugs ........................................ 122

SECTION 5. During the Initial Coverage Stage, our plan pays its share of your drug costs and you pay your share ........................................ 122
Section 5.1 What you pay for a drug depends upon the drug and where you fill your prescription ............................................................... 122
Section 5.2 A table that shows your costs for a one-month supply of a drug .................... 123
Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply ...................... 124
Section 5.4 A table that shows your costs for a long-term (up to a 90-day) supply of a drug ........................................................................ 125
Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,700 ................................................................. 126
Section 5.6 How Medicare calculates your out-of-pocket costs for prescription drugs ........ 127

SECTION 6. There is no coverage gap for our plan ......................................................... 128
Section 6.1 You do not have a coverage gap for your Part D drugs ................................. 128
SECTION 7. During the Catastrophic Coverage Stage, we pay most of the cost for your drugs.................................................................129

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year.................................................................129

SECTION 8. What you pay for vaccinations covered by Part D depends upon how and where you get them.................................................................129

Section 8.1 Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot........................................129

Section 8.2 You may want to call Member Services before you get a vaccination..............131

SECTION 9. Do you have to pay the Part D "late enrollment penalty"? ....................131

Section 9.1 What is the Part D "late enrollment penalty"?.........................................................131

Section 9.2 How much is the Part D late enrollment penalty?.........................................................132

Section 9.3 In some situations, you can enroll late and not have to pay the penalty ..........132

Section 9.4 What can you do if you disagree about your late enrollment penalty?..............133
Did you know there are programs to help people pay for their drugs?
There are programs to help people with limited resources pay for their drugs. These include "Extra Help" and State Pharmaceutical Assistance Programs. For more information, see Chapter 2, Section 7.

Are you currently getting help to pay for your drugs?
If you are in a program that helps pay for your drugs, some information in this Evidence of Coverage about the costs for Part D prescription drugs does not apply to you. We will send you a document, called the "Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs" (also known as the "Low Income Subsidy Rider" or the "LIS Rider"), which tells you about your drug coverage. If you don't have this rider by December 31, 2014, please call Member Services and ask for the "LIS Rider." Phone numbers for Member Services are printed on the back cover of this booklet.

SECTION 1. Introduction

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

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

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

- Our Kaiser Permanente 2015 Abridged Formulary and Kaiser Permanente 2015 Comprehensive Formulary. To keep things simple, we call this the "Drug List."
  - This Drug List tells you which drugs are covered for you.
  - It also tells you which of the six "cost-sharing tiers" the drug is in and whether there are any restrictions on your coverage for the drug.
  - If you need a copy of the Drug List, call Member Services (phone numbers are printed on the back cover of this booklet). You can also find the Drug List on our website at kp.org/seniormedrx. The Drug List on the website is always the most current.

- Chapter 5 of this booklet. Chapter 5 gives you the details about your prescription drug coverage, including rules you need to follow when you get your covered drugs. Chapter 5 also tells you which types of prescription drugs are not covered by our plan.
- **Our plan's Pharmacy Directory.** In most situations, you must use a network pharmacy to get your covered drugs (see Chapter 5 for the details). The *Pharmacy Directory* has a list of pharmacies in our plan's network. It also tells you which pharmacies in our network can give you a long-term supply of a drug (such as filling a prescription for a three-month supply).

### Section 1.2 Types of out-of-pocket costs you may pay for covered drugs

To understand the payment information we give you in this chapter, you need to know about the types of out-of-pocket costs you may pay for your covered services. The amount that you pay for a drug is called "cost-sharing," and there are three ways you may be asked to pay.

- The "**deductible**" is the amount you must pay for drugs before our plan begins to pay its share.
- "**Copayment**" means that you pay a fixed amount each time you fill a prescription.
- "**Coinsurance**" means that you pay a percent of the total cost of the drug each time you fill a prescription.

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

#### Section 2.1 What are the drug payment stages for Medicare Plus members?

As shown in the table below, there are "drug payment stages" for your prescription drug coverage under our plan. How much you pay for a drug depends upon which of these stages you are in at the time you get a prescription filled or refilled.
### Stage 1
**Yearly Deductible Stage**
Because there is no deductible for our plan, this payment stage does not apply to you.

### Stage 2
**Initial Coverage Stage**
You begin in this stage when you fill your first prescription of the year. During this stage, we pay our share of the cost of your drugs and you pay your share of the cost.

You stay in this stage until your year-to-date "**total drug costs**" (your payments plus any Part D plan's payments) total $4,700.

(Details are in Section 5 of this chapter.)

### Stage 3
**Coverage Gap Stage**
Because there is no coverage gap for our plan, this payment stage does not apply to you.

### Stage 4
**Catastrophic Coverage Stage**
During this stage, we will pay most of the cost of your drugs for the rest of the calendar year (through December 31, 2015).

(Details are in Section 7 of this chapter.)

---

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

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

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

- We keep track of how much you have paid. This is called your "**out-of-pocket**" cost.
- We keep track of your "**total drug costs**." This is the amount you pay out-of-pocket or others pay on your behalf plus the amount paid by the plan.
Our plan will prepare a written report called the *Explanation of Benefits* (it is sometimes called the "EOB") when you have had one or more prescriptions filled through our plan during the previous month. It includes:

- **Information for that month.** This report gives you the payment details about the prescriptions you have filled during the previous month. It shows the total drug costs, what the plan paid, and what you and others on your behalf paid.

- **Totals for the year since January 1.** This is called "year-to-date" information. It shows you the total drug costs and total payments for your drugs since the year began.

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

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

- **Show your membership card when you get a prescription filled.** To make sure we know about the prescriptions you are filling and what you are paying, show your plan membership card every time you get a prescription filled.

- **Make sure we have the information we need.** There are times you may pay for prescription drugs when we will not automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, you may give us copies of receipts for drugs that you have purchased. (If you are billed for a covered drug, you can ask us to pay our share of the cost. For instructions about how to do this, go to Chapter 7, Section 2, of this booklet.) Here are some types of situations when you may want to give us copies of your drug receipts to be sure we have a complete record of what you have spent for your drugs:
  - When you purchase a covered drug at a network pharmacy at a special price or using a discount card that is not part of our plan's benefit.
  - When you made a copayment for drugs that are provided under a drug manufacturer patient assistance program.
  - Anytime you have purchased covered drugs at out-of-network pharmacies or other times you have paid the full price for a covered drug under special circumstances.

- **Send us information about the payments others have made for you.** Payments made by certain other individuals and organizations also count toward your out-of-pocket costs and help qualify you for catastrophic coverage. For example, payments made by a State Pharmaceutical Assistance Program, an AIDS drug assistance program, the Indian Health Service, and most charities count toward your out-of-pocket costs. You should keep a record of these payments and send them to us so we can track your costs.

- **Check the written report we send you.** When you receive an *Explanation of Benefits* (an EOB) in the mail, please look it over to be sure the information is complete and correct. If you think something is missing from the report, or you have any questions, please call Member Services (phone numbers are printed on the back cover of this booklet). You can
also choose to view your EOB online instead of by mail. Please visit kp.org/goinggreen and sign on to learn more about choosing to view your EOB securely online. Be sure to keep these reports. They are an important record of your drug expenses.

SECTION 4. There is no deductible for Medicare Plus

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

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

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

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

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

Our plan has three cost-sharing tiers

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

- Cost-sharing Tier 1 for generic.
- Cost-sharing Tier 2 for brand-name.
- Cost-sharing Tier 3 for injectable Part D vaccines.

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List. Preferred and nonpreferred generic drugs listed in the formulary will be subject to the generic drug cost-sharing and preferred and nonpreferred brand-name and specialty drugs listed in the formulary will be subject to the brand-name cost-sharing.

Your pharmacy choices

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

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

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

Generally, we will cover your prescriptions only if they are filled at one of our network pharmacies. Some of our network pharmacies are also preferred. You may go to either preferred network pharmacies or other network pharmacies to receive your covered prescription drugs. Your costs may be less at preferred pharmacies.

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

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

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

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

• If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay either the full price of the drug or the copayment amount, whichever is lower.
• We cover prescriptions filled at out-of-network pharmacies in only limited situations. Please see Chapter 5, Section 2.5, for information about when we will cover a prescription filled at an out-of-network pharmacy.
Your share of the cost when you get a one-month supply of a covered Part D prescription drug from:

<table>
<thead>
<tr>
<th>Cost-sharing tier</th>
<th>Standard retail or standard mail order cost-sharing (in-network)</th>
<th>Preferred retail cost-sharing (in-network)</th>
<th>Preferred mail-order cost-sharing</th>
<th>Long-term care (LTC) cost-sharing</th>
<th>Out-of-network cost-sharing (coverage is limited to certain situations; see Chapter 5 for details)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 – Preferred &amp; Nonpreferred generic drugs</td>
<td>Up to a 60-day supply.</td>
<td>Up to a 60-day supply.</td>
<td>Up to a 60-day supply.</td>
<td>Up to a 31-day supply.</td>
<td>Up to a 30-day supply.</td>
</tr>
<tr>
<td>$25</td>
<td>$15</td>
<td>$10</td>
<td>$12.50</td>
<td>$12.50</td>
<td></td>
</tr>
<tr>
<td>Tier 2 – Preferred &amp; Nonpreferred brand drugs</td>
<td>Up to a 60-day supply.</td>
<td>Up to a 60-day supply.</td>
<td>Up to a 60-day supply.</td>
<td>Up to a 31-day supply.</td>
<td>Up to a 30-day supply.</td>
</tr>
<tr>
<td>$25</td>
<td>$15</td>
<td>$10</td>
<td>$12.50</td>
<td>$12.50</td>
<td></td>
</tr>
<tr>
<td>Tier 3 – Injectable Part D vaccines</td>
<td>Up to a 60-day supply.</td>
<td>Up to a 60-day supply.</td>
<td>Up to a 60-day supply.</td>
<td>Up to a 31-day supply.</td>
<td>Up to a 30-day supply.</td>
</tr>
<tr>
<td>$0</td>
<td>$0</td>
<td>Mail order is not available for drugs in Tier 3.</td>
<td>$0</td>
<td>$0</td>
<td></td>
</tr>
</tbody>
</table>

**Section 5.3 If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply**

Typically, you pay a copayment to cover a full month's supply of a covered drug. However your doctor can prescribe less than a month's supply of drugs. There may be times when you want to ask your doctor about prescribing less than a month's supply of a drug (for example, when you are trying a medication for the first time that is known to have serious side effects). If your doctor agrees, you will not have to pay for the full month's supply for certain drugs.

The amount you pay when you get less than a full month's supply will depend on whether you are responsible for paying coinsurance (a percentage of the total cost) or a copayment (a flat dollar amount).
If you are responsible for coinsurance, you pay a percentage of the total cost of the drug. You pay the same percentage regardless of whether the prescription is for a full month's supply or for fewer days. However, because the entire drug cost will be lower if you get less than a full month's supply, the amount you pay will be less.

If you are responsible for a copayment for the drug, your copayment will be based on the number of days of the drug that you receive. We will calculate the amount you pay per day for your drug (the "daily cost-sharing rate") and multiply it by the number of days of the drug you receive.

- Here's an example: Let's say the copayment for your drug for a full month's supply (a 30-day supply) is $30. This means that the amount you pay per day for your drug is $1. If you receive a 7 days' supply of the drug, your payment will be $1 per day multiplied by 7 days, for a total payment of $7.
- You should not have to pay more per day just because you begin with less than a month's supply. Let's go back to the example above. Let's say you and your doctor agree that the drug is working well and that you should continue taking the drug after your 7 days' supply runs out. If you receive a second prescription for the rest of the month, or 23 days more of the drug, you will still pay $1 per day, or $23. Your total cost for the month will be $7 for your first prescription and $23 for your second prescription, for a total of $30—the same as your copayment would be for a full month's supply.

Daily cost-sharing allows you to make sure a drug works for you before you have to pay for an entire month's supply.

### Section 5.4 A table that shows your costs for a long-term (up to a 90-day) supply of a drug

For some drugs, you can get a long-term supply (also called an "extended supply") when you fill your prescription. A long-term supply is up to a 90-day supply. (For details on where and how to get a long-term supply of a drug, see Chapter 5, Section 2.4.)

The table below shows what you pay when you get a long-term (up to a 90-day) supply of a drug.

**Please note:** If your covered drug costs less than the copayment amount listed in the chart, you will pay that lower price for the drug. You pay either the full price of the drug or the copayment amount, whichever is lower.
Your share of the cost when you get a *long-term* supply of a covered Part D prescription drug from:

<table>
<thead>
<tr>
<th>Cost-sharing tier</th>
<th>Standard retail or standard mail order cost-sharing (in-network)</th>
<th>Preferred retail cost-sharing (in-network)</th>
<th>Preferred mail-order cost-sharing</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tier 1 – Preferred &amp; nonpreferred generic drugs</td>
<td>Up to a 90-day supply.</td>
<td>Up to a 90-day supply.</td>
<td>$10</td>
</tr>
<tr>
<td>Tier 2 – Preferred &amp; nonpreferred brand drugs</td>
<td>$37.50</td>
<td>$22.50</td>
<td>$10</td>
</tr>
<tr>
<td>Tier 3 – Injectable Part D vaccines</td>
<td>$0</td>
<td>$0</td>
<td>Mail order is not available for drugs in Tier 3.</td>
</tr>
</tbody>
</table>

### Section 5.5 You stay in the Initial Coverage Stage until your total drug costs for the year reach $4,700

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach $4,700. Medicare has rules about what counts and what does not count as your out-of-pocket costs. (See Section 5.6 for information about how Medicare counts your out-of-pocket costs.) When you reach an out-of-pocket limit of $4,700, you leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.

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

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

We will let you know if you reach this $4,700 amount. If you do reach this amount, you will leave the Initial Coverage Stage and move on to the Catastrophic Coverage Stage.
Section 5.6 How Medicare calculates your out-of-pocket costs for prescription drugs

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

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

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

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

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

**It matters who pays:**

- If you make these payments yourself, they are included in your out-of-pocket costs.
- These payments are also included if they are made on your behalf by certain other individuals or organizations. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, by a State Pharmaceutical Assistance Program that is qualified by Medicare, or by the Indian Health Service. Payments made by Medicare's "Extra Help" Program are also included.
- Some of the payments made by the Medicare Coverage Gap Discount Program are included. The amount the manufacturer pays for your brand-name drugs is included. But the amount our plan pays for your generic drugs is not included.

**Moving on to the Catastrophic Coverage Stage:**

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

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

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

- The amount you contribute, if any, toward your group's premium.
- Drugs you buy outside the United States and its territories.
- Drugs that are not covered by our plan.
- Drugs you get at an out-of-network pharmacy that do not meet our plan's requirements for out-of-network coverage.
- Prescription drugs covered by Part A or Part B.
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare prescription drug plan.
- Payments you make toward prescription drugs not normally covered in a Medicare prescription drug plan.
- Payments made by our plan for your generic drugs while in the Coverage Gap.
- Payments for your drugs that are made or funded by group health plans, including employer health plans.
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Administration.
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).

Reminder: If any other organization such as the ones listed above pays part or all of your out-of-pocket costs for drugs, you are required to tell our plan. Call Member Services to let us know (phone numbers are printed on the back cover of this booklet).

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

SECTION 6. There is no coverage gap for our plan

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

There is no coverage gap for our plan. Once you leave the Initial Coverage Stage, you move to the Catastrophic Coverage Stage. See Section 7 for information about your coverage in the Catastrophic Coverage Stage.
SECTION 7. During the Catastrophic Coverage Stage, we pay most of the cost for your drugs

Section 7.1 Once you are in the Catastrophic Coverage Stage, you will stay in this stage for the rest of the year

You qualify for the Catastrophic Coverage Stage when your out-of-pocket costs have reached the $4,700 limit for the calendar year. Once you are in the Catastrophic Coverage Stage, you will stay in this payment stage until the end of the calendar year. During this stage, we will pay most of the cost for your drugs.

<table>
<thead>
<tr>
<th>Cost-sharing tier</th>
<th>You pay</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tiers 1 – Generic drugs.</td>
<td>$2</td>
</tr>
<tr>
<td>Tiers 2 – Brand-name drugs.</td>
<td>$7.50</td>
</tr>
<tr>
<td>Tier 3 – Injectable Part D vaccines</td>
<td>$0</td>
</tr>
</tbody>
</table>

We will pay the rest.

SECTION 8. What you pay for vaccinations covered by Part D depends upon how and where you get them

Section 8.1 Our plan has separate coverage for the Part D vaccine medication itself and for the cost of giving you the vaccination shot

Our plan provides coverage for a number of Part D vaccines. We also cover vaccines that are considered medical benefits. You can find out about coverage of these vaccines by going to the Medical Benefits Chart in Chapter 4, Section 2.1.

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

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

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

1. **The type of vaccine** (what you are being vaccinated for).
   - Some vaccines are considered medical benefits. You can find out about your coverage of these vaccines by going to Chapter 4, "Medical Benefits Chart (what is covered and what you pay)."
   - Other vaccines are considered Part D drugs. You can find these vaccines listed in our Kaiser Permanente 2015 Comprehensive Formulary.

2. **Where you get the vaccine medication.**

3. **Who gives you the vaccination shot.**

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

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

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

**Situation 1:**
- You buy the Part D vaccine at the pharmacy and you get your vaccination shot at the network pharmacy. (Whether you have this choice depends upon where you live. Some states do not allow pharmacies to administer a vaccination.)
  - You will have to pay the pharmacy the amount of your copayment for the vaccine and the cost of giving you the vaccination shot.
  - Our plan will pay the remainder of the costs.

**Situation 2:**
- You get the Part D vaccination at your doctor's office.
  - When you get the vaccination, you will pay for the entire cost of the vaccine and its administration.
  - You can then ask us to pay our share of the cost by using the procedures that are described in Chapter 7 of this booklet ("Asking us to pay our share of a bill you have received for covered medical services or drugs").
  - You will be reimbursed the amount you paid less your normal copayment for the vaccine (including administration) less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)
Situation 3:

- You buy the Part D vaccine at your pharmacy, and then take it to your doctor's office where they give you the vaccination shot.
  - You will have to pay the pharmacy the amount of your copayment for the vaccine itself.
  - When your doctor gives you the vaccination shot, you will pay the entire cost for this service. You can then ask us to pay our share of the cost by using the procedures described in Chapter 7 of this booklet.
  - You will be reimbursed the amount charged by the doctor for administering the vaccine less any difference between the amount the doctor charges and what we normally pay. (If you get "Extra Help," we will reimburse you for this difference.)

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

### Section 8.2 You may want to call Member Services before you get a vaccination

The rules for coverage of vaccinations are complicated. We are here to help. We recommend that you first call Member Services whenever you are planning to get a vaccination. Phone numbers for Member Services are printed on the back cover of this booklet.

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

### SECTION 9. Do you have to pay the Part D "late enrollment penalty"?

#### Section 9.1 What is the Part D "late enrollment penalty"?

**Note:** If you receive "Extra Help" from Medicare to pay for your prescription drugs, You will not pay a late enrollment penalty.

The late enrollment penalty is an amount that is added to your Part D premium. You may owe a late enrollment penalty if at any time after your initial enrollment period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. "Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard
prescription drug coverage. The amount of the penalty depends upon how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your initial enrollment period or how many full calendar months you went without creditable prescription drug coverage. You will have to pay this penalty for as long as you have Part D coverage.

The penalty is added to your monthly premium. When you first enroll in our plan, we let you know the amount of the penalty. Your late enrollment penalty is considered part of your plan premium. If you do not pay your late enrollment penalty, you could lose your prescription drug benefits for failure to pay your plan premium.

### Section 9.2 How much is the Part D late enrollment penalty?

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

- First count the number of full months that you delayed enrolling in a Medicare drug plan, after you were eligible to enroll. Or count the number of full months in which you did not have creditable prescription drug coverage, if the break in coverage was 63 days or more. The penalty is 1% for every month that you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty will be 14%.

- Then Medicare determines the amount of the average monthly premium for Medicare drug plans in the nation from the previous year. For 2015, this average premium amount is $33.13.

- To calculate your monthly penalty, you multiply the penalty percentage and the average monthly premium, and then round it to the nearest 10 cents. In the example here, it would be 14% times $33.13, which equals $4.64. This rounds to $4.60. This amount would be added to the monthly premium for someone with a late enrollment penalty.

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

- First, the penalty may change each year because the average monthly premium can change each year. If the national average premium (as determined by Medicare) increases, your penalty will increase.

- Second, you will continue to pay a penalty every month for as long as you are enrolled in a plan that has Medicare Part D drug benefits.

- Third, if you are under 65 and currently receiving Medicare benefits, the late enrollment penalty will reset when you turn 65. After age 65, your late enrollment penalty will be based only on the months that you don't have coverage after your initial enrollment period for aging into Medicare.

### Section 9.3 In some situations, you can enroll late and not have to pay the penalty

Even if you have delayed enrolling in a plan offering Medicare Part D coverage when you were first eligible, sometimes you do not have to pay the late enrollment penalty.
You will not have to pay a penalty for late enrollment if you are in any of these situations:

- If you already have prescription drug coverage that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. Medicare calls this "creditable drug coverage." **Please note:**
  - Creditable coverage could include drug coverage from a former employer or union, TRICARE, or the Department of Veterans Affairs. Your insurer or your human resources department will tell you each year if your drug coverage is creditable coverage. This information may be sent to you in a letter or included in a newsletter from the plan. Keep this information because you may need it if you join a Medicare drug plan later. Please note: If you receive a "certificate of creditable coverage" when your health coverage ends, it may not mean your prescription drug coverage was creditable. The notice must state that you had "creditable" prescription drug coverage that expected to pay as much as Medicare's standard prescription drug plan pays.
  - The following are not creditable prescription drug coverage: prescription drug discount cards, free clinics, and drug discount websites.
  - For additional information about creditable coverage, please look in your *Medicare & You 2015* handbook or call Medicare at **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.

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

**Section 9.4 What can you do if you disagree about your late enrollment penalty?**

If you disagree about your late enrollment penalty, you or your representative can ask for a review of the decision about your late enrollment penalty. Generally, you must request this review **within 60 days** after you are notified you have to pay a late enrollment penalty. Call Member Services to find out more about how to do this (phone numbers are printed on the back cover of this booklet).

**Important:** Do not stop paying your late enrollment penalty while you're waiting for a review of the decision about your late enrollment penalty. If you do, you could be disenrolled for failure to pay your plan premiums.
Section 10. Do you have to pay an extra Part D amount because of your income?

Section 10.1 Who pays an extra Part D amount because of income?

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

If you have to pay an extra amount, Social Security, not our plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. You must pay the extra amount to the government. It cannot be paid with your monthly plan premium.

Section 10.2 How much is the extra Part D amount?

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

The chart below shows the extra amount you will pay to Medicare based on your income.

<table>
<thead>
<tr>
<th>If you filed an individual tax return and your income in 2013 was:</th>
<th>If you were married but filed a separate tax return and your income in 2013 was:</th>
<th>If you filed a joint tax return and your income in 2013 was:</th>
<th>This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Equal to or less than $85,000</td>
<td>Equal to or less than $85,000</td>
<td>Equal to or less than $170,000</td>
<td>$0</td>
</tr>
<tr>
<td>Greater than $85,000 and less than or equal to $107,000</td>
<td>Greater than $170,000 and less than or equal to $214,000</td>
<td>$12.30</td>
<td></td>
</tr>
</tbody>
</table>
If you filed an individual tax return and your income in 2013 was:  

If you were married but filed a separate tax return and your income in 2013 was:  

If you filed a joint tax return and your income in 2013 was:  

This is the monthly cost of your extra Part D amount (to be paid in addition to your plan premium)

<table>
<thead>
<tr>
<th>Income Range</th>
<th>Extra Cost</th>
</tr>
</thead>
<tbody>
<tr>
<td>Greater than $107,000 and less than or equal to $160,000</td>
<td>$31.80</td>
</tr>
<tr>
<td>Greater than $160,000 and less than or equal to $214,000</td>
<td>$51.30</td>
</tr>
<tr>
<td>Greater than $214,000</td>
<td>$70.80</td>
</tr>
</tbody>
</table>

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

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

**Section 10.4 What happens if you do not pay the extra Part D amount?**

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you will lose your prescription drug coverage.
CHAPTER 7. Asking us to pay our share of a bill you have received for covered medical services or drugs

SECTION 1. Situations in which you should ask us to pay our share of the cost of your covered services or drugs .................................................. 137

Section 1.1 If you pay our share of the cost of your covered services or drugs, or if you receive a bill, you can ask us for payment ................................................. 137

SECTION 2. How to ask us to pay you back or to pay a bill you have received ................................................................................................ 139

Section 2.1 How and where to send us your request for payment .................................................. 139

SECTION 3. We will consider your request for payment and say yes or no ............................................................. 140

Section 3.1 We check to see whether we should cover the service or drug and how much we owe ............................................................. 140

Section 3.2 If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal ........................................................................ 140

SECTION 4. Other situations in which you should save your receipts and send copies to us .................................................................................. 141

Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs ................................................................ 141
SECTION 1. Situations in which you should ask us to pay our share of the cost of your covered services or drugs

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

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

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

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

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

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed care from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill our plan for our share of the cost.

• If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.

• At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  ♦ If the provider is owed anything, we will pay the provider directly.
  ♦ If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

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

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

• You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service, and even if there is a dispute and we
don't pay certain provider charges. For more information about "balance billing," go to Chapter 4, Section 1.3.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

**If you are retroactively enrolled in our plan**

Sometimes a person's enrollment in our plan is retroactive. ("Retroactive" means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

- Please call Member Services for additional information about how to ask us to pay you back and deadlines for making your request. Phone numbers for Member Services are printed on the back cover of this booklet.

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

If you go to an out-of-network pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. We cover prescriptions filled at out-of-network pharmacies only in a few special situations. Please go to Chapter 5, Section 2.5, to learn more.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.

**When you pay the full cost for a prescription because you don't have your plan membership card with you**

If you do not have your plan membership card with you, you can ask the pharmacy to call us or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

- Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost.
When you pay the full cost for a prescription in other situations
You may pay the full cost of the prescription because you find that the drug is not covered for some reason.

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

When you pay copayments under a drug manufacturer patient assistance program
If you get help from, and pay copayments under, a drug manufacturer patient assistance program outside our plan's benefit, you may submit a paper claim to have your out-of-pocket expense count toward qualifying you for catastrophic coverage.

• Save your receipt and send a copy to us.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 9 of this booklet, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," has information about how to make an appeal.

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

Section 2.1 How and where to send us your request for payment
Send us your request for payment, along with your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records.

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

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

Mail your request for payment together with any bills or receipts to us at this address:
Kaiser Permanente
Attn: Member Services
2101 East Jefferson Street

217
Agreement 564-14
You must submit your claim to us within 365 days after service date.

Contact Member Services if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

Section 3.1 We check to see whether we should cover the service or drug and how much we owe

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

- If we decide that the medical care or drug is covered and you followed all the rules for getting the care or drug, we will pay for our share of the cost. If you have already paid for the service or drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or drug yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered. Chapter 5 explains the rules you need to follow for getting your Part D prescription drugs covered.)
- If we decide that the medical care or drug is not covered, or you did not follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care or drug, you can make an appeal

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

For the details about how to make this appeal, go to Chapter 9 of this booklet, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)." The appeals process is a detailed legal process with complicated procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 9. Section 4 is an introductory section that explains the process for coverage decisions and
appeals and gives you definitions of terms such as "appeal." Then, after you have read Section 4, you can go to the section in Chapter 9 that tells you what to do for your situation:

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

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

#### Section 4.1 In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

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

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

**When you get a drug through a patient assistance program offered by a drug manufacturer**

Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside our plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program.

- Save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage.
- **Please note:** Because you are getting your drug through the patient assistance program and not through our plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly.

Since you are not asking for payment in the case described above, this situation is not considered a coverage decision. Therefore, you cannot make an appeal if you disagree with our decision.
CHAPTER 8. Your rights and responsibilities

SECTION 1. We must honor your rights as a member of our plan ................. 143

Section 1.1  We must provide information in a way that works for you (in languages other than English, Braille, or large print) .............................................................. 143

Section 1.2  We must treat you with fairness and respect at all times................................. 143

Section 1.3  We must ensure that you get timely access to your covered services and drugs .......................................................................................................................... 143

Section 1.4  We must protect the privacy of your personal health information .................. 144

Section 1.5  We must give you information about our plan, our network of providers, and your covered services .................................................................................................. 145

Section 1.6  We must support your right to make decisions about your care ......................... 146

Section 1.7  You have the right to make complaints and to ask us to reconsider decisions we have made ........................................................................................................... 148

Section 1.8  What can you do if you believe you are being treated unfairly or your rights are not being respected? ...................................................................................... 148

Section 1.9  How to get more information about your rights ................................................. 149

Section 1.10 Information about new technology assessments .............................................. 149

SECTION 2. You have some responsibilities as a member of our plan .............. 149

Section 2.1  What are your responsibilities? ........................................................................ 149
SECTION 1. We must honor your rights as a member of our plan

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

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

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

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

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

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

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

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

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

As a member of our plan, you have the right to choose a primary care provider (PCP) in our network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral, as well as other primary care providers described in Chapter 3, Section 2.2.
As a plan member, you have the right to get appointments and covered services from our network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

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

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

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

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

How do we protect the privacy of your health information?

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

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

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

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

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

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

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

- **Information about our plan.** This includes, for example, information about our plan's financial condition. It also includes information about the number of appeals made by members and our plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.

- **Information about our network providers, including our network pharmacies.**
  - For example, you have the right to get information from us about the qualifications of the providers in our network and how we pay the providers in our network.
  - For a list of the providers in our network, see the Provider Directory.
  - For a list of the pharmacies in our network, see the Pharmacy Directory.
  - For more detailed information about our providers or pharmacies, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our website at kp.org.

- **Information about your coverage and the rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - To get the details on your Part D prescription drug coverage, see Chapters 5 and 6 of this booklet plus our plan's List of Covered Drugs (Formulary). These chapters, together with the List of Covered Drugs (Formulary), tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs.
If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).

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

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

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

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.

- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking a medication, you accept full responsibility for what happens to your body as a result.
To receive an explanation if you are denied coverage for care. You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 9 of this booklet tells you how to ask us for a coverage decision.

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

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

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

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

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

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

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

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

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

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with:

**District of Columbia Residents:**
Delmarva Foundation of the District of Columbia
924 Centreville Road
Easton, MD 21601

**State of Maryland Residents:**
Maryland Insurance Administration
Consumer Complaint Investigation
200 St. Paul Place, Suite 2700
Baltimore, MD 21202

**Commonwealth of Virginia Residents:**
State Corporation Commission
Virginia Bureau of Insurance
P.O. Box 1157
Richmond, VA 23218
1-800-552-7945

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

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

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

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

---

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

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

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

Is it about something else?

If you believe you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:
• You can call Member Services (phone numbers are printed on the back cover of this booklet).
• You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.
• Or you can call Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.9 How to get more information about your rights

There are several places where you can get more information about your rights:
• You can call Member Services (phone numbers are printed on the back cover of this booklet).
• You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to Chapter 2, Section 3.
• You can contact Medicare:
  ♦ You can visit the Medicare website to read or download the publication "Your Medicare Rights & Protections." (The publication is available at [http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf](http://www.medicare.gov/Publications/Pubs/pdf/10112.pdf).)
  ♦ Or you can call 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

Section 1.10 Information about new technology assessments

Rapidly changing technology affects health care and medicine as much as any other industry. To determine whether a medical development has long-term benefits, our plan carefully monitors and evaluates new technologies for inclusion as covered benefits. These technologies include medical procedures, medical devices, and new medications.

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

Section 2.1 What are your responsibilities?

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

• Get familiar with your covered services and the rules you must follow to get these covered services. Use this Evidence of Coverage booklet to learn what is covered for you and the rules you need to follow to get your covered services.
Chapters 3 and 4 give the details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay.

Chapters 5 and 6 give the details about your coverage for Part D prescription drugs.

- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Please call Member Services to let us know (phone numbers are printed on the back cover of this booklet).

- We are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "coordination of benefits" because it involves coordinating the health and drug benefits you get from us with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to Chapter 1, Section 7.)

- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D prescription drugs.

- Notifying out-of-network providers when seeking care (unless it is an emergency) that although you are enrolled in our plan, the provider should bill Original Medicare. You should present your membership card and your Medicare card.

- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care.**
  - To help your doctors and other health care providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon.
  - Make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.

- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - Paying your Medicare premiums.
  - In order to be eligible for our plan, you must have Medicare Part B (or both Part A and Part B). For that reason, some plan members must pay a premium for Medicare Part A and most plan members must pay a premium for Medicare Part B to remain a member of our plan.
  - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). Chapter 4 tells you what you must pay for
your medical services. Chapter 6 tells you what you must pay for your Part D prescription drugs.

♦ If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.

♦ If you disagree with our decision to deny coverage for a service or drug, you can make an appeal. Please see Chapter 9 of this booklet for information about how to make an appeal.

♦ If you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage.

♦ If you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to keep your prescription drug coverage.

• **Tell us if you move.** If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).

♦ If you move outside of our plan service area, you cannot remain a member of our plan. (Chapter 1 tells you about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a Special Enrollment Period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.

♦ If you move within our service area, we still need to know so we can keep your membership record up-to-date and know how to contact you.

♦ If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.

• **Call Member Services for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan.

♦ Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.

♦ For more information about how to reach us, including our mailing address, please see Chapter 2.
CHAPTER 9. What to do if you have a problem or complaint  
(coverage decisions, appeals, and complaints)

Background 155

SECTION 1. Introduction .............................................................................................................. 155
  Section 1.1 What to do if you have a problem or concern.....................................................155
  Section 1.2 What about the legal terms?................................................................................155

SECTION 2. You can get help from government organizations that are not connected with us ............................................................................................................. 156
  Section 2.1 Where to get more information and personalized assistance............................156

SECTION 3. To deal with your problem, which process should you use?.............. 156
  Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints? .................................................................156

Coverage decisions and appeals 157

SECTION 4. A guide to the basics of coverage decisions and appeals ............... 157
  Section 4.1 Asking for coverage decisions and making appeals—The big picture ............157
  Section 4.2 How to get help when you are asking for a coverage decision or making an appeal .........................................................................................................................158
  Section 4.3 Which section of this chapter gives the details for your situation?.....................159

SECTION 5. Your medical care: How to ask for a coverage decision or make an appeal ...................................................................................................................... 160
  Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care..........................................................................................................................160
  Section 5.2 Step-by-step: How to ask for a coverage decision (how to ask us to authorize or provide the medical care coverage you want) .........................................................161
  Section 5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan).......................................................164
  Section 5.4 Step-by-step: How a Level 2 Appeal is done..........................................................167
Section 5.5 What if you are asking us to pay you for our share of a bill you have received for medical care?  .................................................................169

SECTION 6. Your Part D prescription drugs: How to ask for a coverage decision or make an appeal .................................................................170

Section 6.1 This section tells what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug .................................................................170

Section 6.2 What is an exception? ........................................................................................................172

Section 6.3 Important things to know about asking for exceptions ........................................................................................................173

Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception ......174

Section 6.5 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan) .................................................................177

Section 6.6 Step-by-step: How to make a Level 2 Appeal .................................................................179

SECTION 7. How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon .........................................181

Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights .................................................................182

Section 7.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date ........................................................................................................183

Section 7.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date ........................................................................................................185

Section 7.4 What if you miss the deadline for making your Level 1 Appeal? ..............................186

SECTION 8. How to ask us to keep covering certain medical services if you think your coverage is ending too soon .........................................189

Section 8.1 This section is about three services only: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services .................................................................189

Section 8.2 We will tell you in advance when your coverage will be ending ................................190

Section 8.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time ........................................................................................................190

Section 8.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time ........................................................................................................192

Section 8.5 What if you miss the deadline for making your Level 1 Appeal? ..............................193
SECTION 9. Taking your appeal to Level 3 and beyond ........................................... 196

Section 9.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals ....................... 196
Section 9.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals ............................... 198

Making complaints 199

SECTION 10. How to make a complaint about quality of care, waiting times, customer service, or other concerns ................................................................. 199

Section 10.1 What kinds of problems are handled by the complaint process? .......... 199
Section 10.2 The formal name for "making a complaint" is "filing a grievance" ............. 201
Section 10.3 Step-by-step: Making a complaint ......................................................... 201
Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization ................................................................. 202
Section 10.5 You can also tell Medicare about your complaint ................................... 202
Background

SECTION 1. Introduction

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

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

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

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

**Which one do you use?**

That depends upon the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Section 1.2 What about the legal terms?

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

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

However, it can be helpful, and sometimes quite important, for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.
SECTION 2. You can get help from government organizations that are not connected with us

Section 2.1 Where to get more information and personalized assistance

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

Get help from an independent government organization

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

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

You can also get help and information from Medicare

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

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

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

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.
To figure out which part of this chapter will help you with your specific problem or concern, START HERE:

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care or prescription drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or prescription drugs.)

• Yes, my problem is about benefits or coverage:
  
  Go to the next section in this chapter, Section 4: "A guide to the basics of coverage decisions and appeals."

• No, my problem is not about benefits or coverage:

  Skip ahead to Section 10 at the end of this chapter: "How to make a complaint about quality of care, waiting times, customer service, or other concerns."

Coverage decisions and appeals

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

Section 4.1 Asking for coverage decisions and making appeals—The big picture

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

Asking for coverage decisions

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

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

**Making an appeal**

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

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

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

### Section 4.2   How to get help when you are asking for a coverage decision or making an appeal

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

- **You can call Member Services** (phone numbers are printed on the back cover of this booklet).
- To get free help from an independent organization that is not connected with our plan, contact your **State Health Insurance Assistance Program** (see Section 2 in this chapter).
- **Your doctor can make a request for you.**
  - For medical care, your doctor can request a coverage decision or a Level 1 appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
  - For Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under state law.
If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at [http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf](http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf).) The form gives that person permission to act on your behalf. It must be signed by you and by the person whom you would like to act on your behalf. You must give us a copy of the signed form.

- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision.

### Section 4.3 Which section of this chapter gives the details for your situation?

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

- **Section 5** in this chapter: "Your medical care: How to ask for a coverage decision or make an appeal."

- **Section 6** in this chapter: "Your Part D prescription drugs: How to ask for a coverage decision or make an appeal."

- **Section 7** in this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon."

- **Section 8** in this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (applies to these services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services).

If you're not sure which section you should be using, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (Chapter 2, Section 3, of this booklet has the phone numbers for this program).
SECTION 5. Your medical care: How to ask for a coverage decision or make an appeal

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

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These benefits are described in Chapter 4 of this booklet: "Medical Benefits Chart (what is covered and what you pay)." To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time.

If you have a complaint about a bill when you receive care from an out-of-network provider, the appeals process described will not apply, unless you were directed to go to an out-of-network provider by the plan or one of the network providers for care covered by our plan (for example, an authorized referral).

You should refer to the notice of the service (called the "Medicare Summary Notice") you receive from Original Medicare. The Medicare Summary Notice provides information on how to appeal a decision made by Original Medicare.

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

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

2. We will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by our plan.

3. You have received medical care or services that you believe should be covered by our plan, but we have said we will not pay for this care.

4. You have received and paid for medical care or services that you believe should be covered by our plan, and you want to ask us to reimburse you for this care.

5. You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.
Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care.

Here's what to read in those situations:

- **Chapter 9, Section 7:** "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon."

- **Chapter 9, Section 8:** "How to ask us to keep covering certain medical services if you think your coverage is ending too soon." This section is about three services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services.

For all other situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

**Which of these situations are you in?**

<table>
<thead>
<tr>
<th>If you are in this situation:</th>
<th>This is what you can do:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Do you want to find out whether we will cover the medical care or services you want?</td>
<td>You can ask us to make a coverage decision for you. Go to the next section in this chapter, <strong>Section 5.2</strong>.</td>
</tr>
<tr>
<td>Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?</td>
<td>You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to <strong>Section 5.3</strong> in this chapter.</td>
</tr>
<tr>
<td>Do you want to ask us to pay you back for medical care or services you have already received and paid for?</td>
<td>You can send us the bill. Skip ahead to <strong>Section 5.5</strong> in this chapter.</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Legal Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>When a coverage decision involves your medical care, it is called an &quot;organization determination.&quot;</td>
</tr>
</tbody>
</table>
Step 1: You ask us to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a "fast coverage decision."

<table>
<thead>
<tr>
<th>Legal Terms</th>
</tr>
</thead>
<tbody>
<tr>
<td>A &quot;fast coverage decision&quot; is called an &quot;expedited determination.&quot;</td>
</tr>
</tbody>
</table>

How to request coverage for the medical care you want

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

Generally we use the standard deadlines for giving you our decision

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

- However, we can take up to 14 more calendar days if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing.
- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)

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

- A fast coverage decision means we will answer within 72 hours.
  - However, we can take up to 14 more calendar days if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing.
  - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.) We will call you as soon as we make the decision.
- To get a fast coverage decision, you must meet two requirements:
You can get a fast coverage decision only if you are asking for coverage for medical care you have not yet received. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)

You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.

- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**

- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.**
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)

**Step 2: We consider your request for medical care coverage and give you our answer.**

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

- Generally, for a fast coverage decision, we will give you our answer **within 72 hours**.
  - As explained above, we can take up to **14 more calendar days** under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)
  - If we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells you how to make an appeal.

- **If our answer is yes to part or all of what you requested,** we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision, we will provide the coverage by the end of that extended period.

- **If our answer is no to part or all of what you requested,** we will send you a detailed written explanation as to why we said no.
Deadlines for a "standard" coverage decision

- Generally, for a standard coverage decision, we will give you our answer within **14 days of receiving your request**.
  - We can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing.
  - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)
  - If we do not give you our answer within 14 days (or if there is an extended time period, by the end of that period), you have the right to appeal. Section 5.3 below tells you how to make an appeal.

- If our answer is **yes** to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 14 days after we received your request. If we extended the time needed to make our coverage decision, we will provide the coverage by the end of that extended period.

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

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

- If we say **no**, you have the right to ask us to reconsider, and perhaps change this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.

- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

<table>
<thead>
<tr>
<th>Section 5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)</th>
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<tbody>
<tr>
<td>Legal Terms</td>
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<tr>
<td>An appeal to our plan about a medical care coverage decision is called a plan &quot;reconsideration.&quot;</td>
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</tbody>
</table>
Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a "fast appeal."

What to do:

- To start an appeal, you, your doctor, or your representative must contact us. For details about how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care or Part D prescription drugs."

- If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.
  - If you have someone appealing our decision for you other than your doctor, your appeal must include an "Appointment of Representative" form authorizing this person to represent you. To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's website at [http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf](http://www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf). While we can accept an appeal request without the form, we cannot complete our review until we receive it. If we do not receive the form within 44 days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be sent to the Independent Review Organization for dismissal.

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

- You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

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

If your health requires it, ask for a "fast appeal" (you can make a request by calling us)
A "fast appeal" is also called an "expedited reconsideration."

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

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

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

**Deadlines for a "fast" appeal**

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

**Deadlines for a "standard" appeal**

- If we are using the standard deadlines, we must give you our answer **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. We will give you our decision sooner if your health condition requires us to.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, **we can take up to 14 more calendar days.**
♦ If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see Section 10 in this chapter.)

♦ If we do not give you an answer by the deadline above, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent, outside organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.

- If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 30 days after we receive your appeal.

- If our answer is no to part or all of what you requested, we will send you a written denial notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal.

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

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

**Section 5.4 Step-by-step: How a Level 2 Appeal is done**

If we say no to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the Independent Review Organization reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

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<th>Legal Terms</th>
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<tr>
<td>The formal name for the &quot;Independent Review Organization&quot; is the &quot;Independent Review Entity.&quot; It is sometimes called the &quot;IRE.&quot;</td>
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</table>

Step 1: The Independent Review Organization reviews your appeal.

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
• We will send the information about your appeal to this organization. This information is called your "case file." You have the right to ask us for a copy of your case file. We are allowed to charge you a fee for copying and sending this information to you.

• You have a right to give the Independent Review Organization additional information to support your appeal.

• Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

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

• If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 72 hours of when it receives your appeal.

• However, if the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days.

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

• If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 30 calendar days of when it receives your appeal.

• However, if the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days.

Step 2: The Independent Review Organization gives you their answer.
The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

• If the review organization says yes to part or all of what you requested, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization.

• If this organization says no to part or all of your appeal, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")

• There is a certain dollar value that must be in dispute to continue with the appeals process. For example, to continue and make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.
Step 3: **If your case meets the requirements, you choose whether you want to take your appeal further.**

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

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

If you want to ask us for payment for medical care, start by reading Chapter 7 of this booklet: "Asking us to pay our share of a bill you have received for covered medical services or drugs." Chapter 7 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells you how to send us the paperwork that asks us for payment.

**Asking for reimbursement is asking for a coverage decision from us**

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 in this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service; see Chapter 4, "Medical Benefits Chart (what is covered and what you pay)." We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: "Using our plan's coverage for your medical services").

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

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

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

To make this appeal, follow the process for appeals that we describe in Section 5.3 of this chapter. Go to this part for step-by-step instructions. When you are following these instructions, please note:

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

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

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

Section 6.1 This section tells what to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a member of our plan include coverage for many prescription drugs. Please refer to our plan's Kaiser Permanente 2015 Abridged Formulary or Kaiser Permanente 2015 Comprehensive Formulary. To be covered, the drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3, for more information about a medically accepted indication.)

- This section is about your Part D drugs only. To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time.
- For details about what we mean by Part D drugs, the Kaiser Permanente 2015 Abridged Formulary and Kaiser Permanente 2015 Comprehensive Formulary, rules and restrictions on coverage, and cost information, see Chapter 5 ("Using our plan's coverage for your Part D prescription drugs") and Chapter 6 ("What you pay for your Part D prescription drugs").
Part D coverage decisions and appeals
As discussed in Section 4 of this chapter, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs.

Legal Terms
An initial coverage decision about your Part D drugs is called a "coverage determination."

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

- You ask us to make an exception, including:
  - Asking us to cover a Part D drug that is not on our Kaiser Permanente 2015 Comprehensive Formulary.
  - Asking us to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get).
  - Asking to pay a lower cost-sharing amount for a covered nonpreferred drug.

- You ask us whether a drug is covered for you and whether you meet the requirements for coverage. For example, when your drug is on our Kaiser Permanente 2015 Comprehensive Formulary, but we require you to get approval from us before we will cover it for you.
  - Please note: If your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision.

- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment.

If you disagree with a coverage decision we have made, you can appeal our decision.
This section tells you both how to ask for coverage decisions and how to request an appeal. Use the chart below to help you determine which part has information for your situation:

**Which of these situations are you in?**

<table>
<thead>
<tr>
<th>Do you need a drug that isn't on our Drug List or need us to waive a rule or restriction on a drug we cover?</th>
<th>Do you want us to cover a drug on our Drug List and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need?</th>
<th>Do you want to ask us to pay you back for a drug you have already received and paid for?</th>
<th>Have we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for?</th>
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</thead>
<tbody>
<tr>
<td>You can ask us to make an exception. (This is a type of coverage decision.) <strong>Start with Section 6.2 in this chapter.</strong></td>
<td>You can ask us for a coverage decision. <strong>Skip ahead to Section 6.4 in this chapter.</strong></td>
<td>You can ask us to pay you back. (This is a type of coverage decision.) <strong>Skip ahead to Section 6.4 in this chapter.</strong></td>
<td>You can make an appeal. (This means you are asking us to reconsider.) <strong>Skip ahead to Section 6.5 in this chapter.</strong></td>
</tr>
</tbody>
</table>

**Section 6.2 What is an exception?**

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

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

1. **Covering a Part D drug for you that is not on our Kaiser Permanente 2015 Comprehensive Formulary.** (We call it the "Drug List" for short.)

<table>
<thead>
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<th><strong>Legal Terms</strong></th>
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<tr>
<td>Asking for coverage of a drug that is not on the Drug List is sometimes called asking for a <em>formulary exception.</em></td>
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</table>
• If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the cost-sharing amount that applies to drugs in the brand-name tier. You cannot ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

2. Removing a restriction on our coverage for a covered drug. There are extra rules or restrictions that apply to certain drugs on our Kaiser Permanente 2015 Abridged Formulary and Kaiser Permanente 2015 Comprehensive Formulary (for more information, go to Chapter 5 and look for Section 4).

Legal Terms

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

• The extra rules and restrictions on coverage for certain drugs include:
  ♦ Getting plan approval in advance before we will agree to cover the drug for you. (This is sometimes called "prior authorization.")
  ♦ For some drugs, there are restrictions on the amount of the drug you can have.

• If we agree to make an exception and waive a restriction for you, you can ask for an exception to the copayment or coinsurance amount we require you to pay for the drug.

3. Changing coverage of a drug to a lower cost-sharing tier. Every drug on our Drug List is in one of three cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you will pay as your share of the cost of the drug.

Legal Terms

| Asking to pay a lower price for a covered nonpreferred drug is sometimes called asking for a "tiering exception." |

• If your drug is in Tier 2 you can ask us to cover it at the cost-sharing amount that applies to drugs in Tier 1. This would lower your share of the cost for the drug.

Section 6.3 Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting an exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.
Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception.

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

- If we approve your request for an exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition.

- If we say no to your request for an exception, you can ask for a review of our decision by making an appeal. Section 6.5 tells you how to make an appeal if we say no.

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

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**Section 6.4 Step-by-step: How to ask for a coverage decision, including an exception**

**Step 1:** You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a "fast coverage decision." You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

**What to do:**

- **Request the type of coverage decision you want.** Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care or Part D prescription drugs." Or if you are asking us to pay you back for a drug, go to the section called "Where to send a request asking us to pay for our share of the cost for medical care or a drug you have received."

- **You or your doctor or someone else who is acting on your behalf** can ask for a coverage decision. Section 4 in this chapter tells you how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf.

- **If you want to ask us to pay you back for a drug,** start by reading Chapter 7 of this booklet: "Asking us to pay our share of a bill you have received for covered medical services or drugs." Chapter 7 describes the situations in which you may need to ask for reimbursement. It also tells you how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for.

- **If you are requesting an exception, provide the "supporting statement."** Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the
statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See Sections 6.2 and 6.3 for more information about exception requests.

- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

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

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

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours.

- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision only if you are asking for a drug you have not yet received. (You cannot get a fast coverage decision if you are asking us to pay you back for a drug you have already bought.)
  - You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.

- **If your doctor or other prescriber tells us that your health requires a "fast coverage decision,"** we will automatically agree to give you a fast coverage decision.

- **If you ask for a fast coverage decision on your own** (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision.
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell you how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells you how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see Section 10 in this chapter.)
Step 2: **We consider your request and we give you our answer.**

*Deadlines for a "fast coverage decision"*

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

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

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

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

- We must give you our answer **within 14 calendar days** after we receive your request.
  - If we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent organization. Later in this
section, we talk about this review organization and explain what happens at Appeal Level 2.

- If our answer is *yes* to part or all of what you requested, we are also required to make payment to you within 14 calendar days after we receive your request.
- If our answer is *no* to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how to appeal.

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

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

### Section 6.5 Step-by-step: How to make a Level 1 Appeal

**(how to ask for a review of a coverage decision made by our plan)**

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<tr>
<td>An appeal to our plan about a Part D drug coverage decision is called a plan &quot;redetermination.&quot;</td>
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**Step 1:** **You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a "fast appeal."**

**What to do:**

- **To start your appeal, you (or your representative or your doctor or other prescriber) must contact us.**
  - For details about how to reach us by phone, fax, mail, or on our website for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care or Part D prescription drugs."

- **If you are asking for a standard appeal, make your appeal by submitting a written request.**

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

- **We must accept any written request**, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website.

- **You must make your appeal request within 60 calendar days from the date on the written notice** we sent to tell you our answer to your request for a coverage decision. If you
miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.

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

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

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<td>A &quot;fast appeal&quot; is also called an &quot;expedited redetermination.&quot;</td>
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- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal."
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in Section 6.4 of this chapter.

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

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

*Deadlines for a "fast" appeal*

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

- If we are using the standard deadlines, we must give you our answer **within 7 calendar days after we receive your appeal**. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for a "fast" appeal.

- If we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell you about this review organization and explain what happens at Level 2 of the appeals process.

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

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

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

- If we say **no** to your appeal, you then choose whether to accept this decision or continue by making another appeal.

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

### Section 6.6  Step-by-step: How to make a Level 2 Appeal

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

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<tr>
<td>The formal name for the &quot;Independent Review Organization&quot; is the &quot;Independent Review Entity.&quot; It is sometimes called the &quot;IRE.&quot;</td>
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Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case.

- If we say no to your Level 1 Appeal, the written notice we send you will include instructions about how to make a Level 2 Appeal with the Independent Review Organization. These instructions will tell you who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization.

- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." You have the right to ask us for a copy of your case file. We are allowed to charge you a fee for copying and sending this information to you.

- You have a right to give the Independent Review Organization additional information to support your appeal.

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

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us.

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it.

**Deadlines for "fast" appeal at Level 2**

- If your health requires it, ask the Independent Review Organization for a "fast appeal."

- If the review organization agrees to give you a fast appeal, the review organization must give you an answer to your Level 2 Appeal within 72 hours after it receives your appeal request.

- If the Independent Review Organization says yes to part or all of what you requested, we must provide the drug coverage that was approved by the review organization within 24 hours after we receive the decision from the review organization.

**Deadlines for "standard" appeal at Level 2**

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal within 7 calendar days after it receives your appeal.

- If the Independent Review Organization says yes to part or all of what you requested:
  - If the Independent Review Organization approves a request for coverage, we must provide the drug coverage that was approved by the review organization within 72 hours after we receive the decision from the review organization.
If the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive the decision from the review organization.

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

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

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details about how to do this are in the written notice you got after your second appeal.
- The Level 3 Appeal is handled by an administrative law judge. Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

**SECTION 7. How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon**

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see Chapter 4 of this booklet: "Medical Benefits Chart (what is covered and what you pay)."

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

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

**Section 7.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights**

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

- **Read this notice carefully and ask questions if you don't understand it.** It tells you about your rights as a hospital patient, including:
  - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
  - Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
  - Where to report any concerns you have about quality of your hospital care.
  - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

**Legal Terms**

The written notice from Medicare tells you how you can "request an immediate review." Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 7.2 below tells you how you can request an immediate review.)

- **You must sign the written notice** to show that you received it and understand your rights.
  - You or someone who is acting on your behalf must sign the notice. (Section 4 in this chapter tells you how you can give written permission to someone else to act as your representative.)
  - Signing the notice shows only that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice does not mean you are agreeing on a discharge date.

- **Keep your copy** of the signed notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
**Section 7.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date**

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

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet) or 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048. You can also see it online at http://www.cms.gov/BNI/12_HospitalDischargeAppealNotices.asp.

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

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

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<td>A &quot;fast review&quot; is also called an &quot;immediate review.&quot;</td>
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**What is the Quality Improvement Organization?**

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

- The written notice you received (An Important Message from Medicare About Your Rights) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization before you leave the hospital and no later than your planned discharge date. (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
  - If you meet this deadline, you are allowed to stay in the hospital after your discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
  - If you do not meet this deadline, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you receive after your planned discharge date.

- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 7.4.

Ask for a "fast review":

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

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<td>A &quot;fast review&quot; is also called an &quot;immediate review&quot; or an &quot;expedited review.&quot;</td>
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Step 2: The Quality Improvement Organization conducts an independent review of your case.

What happens during this review?

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

- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.

- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives you your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.
Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

What happens if the answer is yes?

• If the review organization says yes to your appeal, we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.

• You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See Chapter 4 of this booklet.)

What happens if the answer is no?

• If the review organization says no to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

• If the review organization says no to your appeal and you decide to stay in the hospital, then you may have to pay the full cost of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

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

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

Section 7.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

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

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

**Step 2:** The Quality Improvement Organization does a second review of your situation.
- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

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

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

*If the review organization says no:*
- It means they agree with the decision they made on your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

**Step 4:** If the answer is no, you will need to decide whether you want to take your appeal further by going on to Level 3.
- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

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

You can appeal to us instead
As explained above in Section 7.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before
you leave the hospital and no later than your planned discharge date.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

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

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

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

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<td>A &quot;fast review&quot; (or &quot;fast appeal&quot;) is also called an <strong>expedited appeal</strong>.</td>
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**Step 1: Contact us and ask for a "fast review."**

- For details about how to contact us, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care or Part D prescription drugs."
- **Be sure to ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

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

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

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

- **If we say yes to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
- **If you stayed in the hospital after your planned discharge date,** then you may have to pay the full cost of hospital care you received after the planned discharge date.
Step 4: If we say no to your fast appeal, your case will automatically be sent on to the next level of the appeals process.

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

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

If we say no to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the Independent Review Organization reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

Legal Terms

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

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

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeals process. Section 10 in this chapter tells you how to make a complaint.)

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

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say *no* to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

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

**Section 8.1** *This section is about three services only: Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services*

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

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 12, "Definitions of important words.")
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 12, "Definitions of important words.")

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information about your covered services, including your share of the cost and any limitations to coverage that may apply, see Chapter 4 of this booklet: "Medical Benefits Chart (what is covered and what you pay)."

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, **we will stop paying our share of the cost for your care.**

If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.
Section 8.2 We will tell you in advance when your coverage will be ending

• **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice.
  ♦ The written notice tells you the date when we will stop covering the care for you.
  ♦ The written notice also tells you what you can do if you want to ask us to change this decision about when to end your care, and keep covering it for a longer period of time.

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**Legal Terms**

In telling you what you can do, the written notice is telling how you can request a "fast-track appeal." Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 8.3 below tells you how you can request a fast-track appeal.)

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

• **You must sign the written notice to show that you received it.**
  ♦ You or someone who is acting on your behalf must sign the notice. (Section 4 tells you how you can give written permission to someone else to act as your representative.)
  ♦ Signing the notice shows only that you have received the information about when your coverage will stop. **Signing it does not mean you agree** with us that it's time to stop getting the care.

---

Section 8.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

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

• **Follow the process.** Each step in the first two levels of the appeals process is explained below.

• **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 10 in this chapter tells you how to file a complaint.)

• **Ask for help if you need it.** If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your
State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 in this chapter).

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

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

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

How can you contact this organization?
- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?
- Ask this organization to do an independent review of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.
- You must contact the Quality Improvement Organization to start your appeal no later than noon of the day after you receive the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 8.5 in this chapter.

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

What happens during this review?
- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
By the end of the day the reviewers informed us of your appeal, you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

### Legal Terms

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

**Step 3:** Within one full day after they have all the information they need, the reviewers will tell you their decision.

**What happens if the reviewers say yes to your appeal?**

- If the reviewers say yes to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see Chapter 4 of this booklet).

**What happens if the reviewers say no to your appeal?**

- If the reviewers say no to your appeal, then **your coverage will end** on the date we have told you. We will stop paying our share of the costs of this care.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after this date when your coverage ends, **then you will have to pay the full cost of this care yourself.**

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

- This first appeal you make is "Level 1" of the appeals process. If reviewers say no to your Level 1 Appeal, and you choose to continue getting care after your coverage for the care has ended, then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

### Section 8.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.
Here are the steps for Level 2 of the appeals process:

Step 1: **You contact the Quality Improvement Organization again and ask for another review.**
- **You must ask for this review within 60 days** after the day when the Quality Improvement Organization said *no* to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: **The Quality Improvement Organization does a second review of your situation.**
- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

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

**What happens if the review organization says yes to your appeal?**
- **We must reimburse you** for our share of the costs of care you have received since the date when we said your coverage would end. **We must continue providing coverage** for the care for as long as it is medically necessary.
- You must continue to pay your share of the costs and there may be coverage limitations that apply.

**What happens if the review organization says no?**
- It means they agree with the decision we made to your Level 1 Appeal and will not change it.
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by a judge.

Step 4: **If the answer is no, you will need to decide whether you want to take your appeal further.**
- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

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

You can appeal to us instead
As explained above in Section 8.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline
for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.

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

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

Here are the steps for a Level 1 Alternate Appeal:

<table>
<thead>
<tr>
<th>Legal Terms</th>
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</thead>
<tbody>
<tr>
<td>A &quot;fast review&quot; (or &quot;fast appeal&quot;) is also called an <em>expedited appeal</em>.</td>
</tr>
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</table>

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

- For details about how to contact us, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care or Part D prescription drugs."
- **Be sure to ask for a "fast review."** This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

**Step 2: We do a "fast" review of the decision we made about when to end coverage for your services.**

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending our plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our plan and ask for a "fast review," we are allowed to decide whether to agree to your request and give you a "fast review." But in this situation, the rules require us to give you a fast response if you ask for it.)

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

- **If we say yes to your fast appeal**, it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say no to your fast appeal**, then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
• If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end, then you will have to pay the full cost of this care yourself.

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

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

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

If we say no to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the Independent Review Organization reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

<table>
<thead>
<tr>
<th>Legal Terms</th>
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<tbody>
<tr>
<td>The formal name for the &quot;Independent Review Organization&quot; is the &quot;Independent Review Entity.&quot; It is sometimes called the &quot;IRE.&quot;</td>
</tr>
</tbody>
</table>

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

• We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying no to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeals process. Section 10 in this chapter tells you how to make a complaint.)

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

• The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.

• Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

• If this organization says yes to your appeal, then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these
could limit how much we would reimburse or how long we would continue to cover your services.

- **If this organization says no to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say no to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge.
- Section 9 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

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**SECTION 9. Taking your appeal to Level 3 and beyond**

**Section 9.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals**

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

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

**Level 3 Appeal:** A judge who works for the federal government will review your appeal and give you an answer. This judge is called an "administrative law judge."

- **If the administrative law judge says yes to your appeal,** the appeals process may or may not be over. We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you.
If we decide not to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the judge's decision.

If we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute.

- **If the administrative law judge says no to your appeal, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

**Level 4 Appeal:** The Appeals Council will review your appeal and give you an answer. The Appeals Council works for the federal government.

- **If the answer is yes, or if the Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over.** We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you.
  - If we decide not to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Appeals Council's decision.
  - If we decide to appeal the decision, we will let you know in writing.

- **If the answer is no or if the Appeals Council denies the review request, the appeals process may or may not be over.**
  - If you decide to accept this decision that turns down your appeal, the appeals process is over.
  - If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what to do next if you choose to continue with your appeal.

**Level 5 Appeal:** A judge at the Federal District Court will review your appeal.

- This is the last step of the administrative appeals process.
Section 9.2 Levels of Appeal 3, 4, and 5 for Part D Drug Appeals

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

If the value of the drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: A judge who works for the federal government will review your appeal and give you an answer. This judge is called an "administrative law judge."

• **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the administrative law judge within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision.

• **If the answer is no, the appeals process may or may not be over.**
  ♦ If you decide to accept this decision that turns down your appeal, the appeals process is over.
  ♦ If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal.

Level 4 Appeal: The Appeals Council will review your appeal and give you an answer. The Appeals Council works for the federal government.

• **If the answer is yes, the appeals process is over.** What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the Appeals Council within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision.

• **If the answer is no, the appeals process may or may not be over.**
  ♦ If you decide to accept this decision that turns down your appeal, the appeals process is over.
  ♦ If you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you
to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what to do next if you choose to continue with your appeal.

**Level 5 Appeal:** A judge at the **Federal District Court** will review your appeal.

- This is the last step of the appeals process.

Making complaints

**SECTION 10. How to make a complaint about quality of care, waiting times, customer service, or other concerns**

If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 in this chapter.

**Section 10.1 What kinds of problems are handled by the complaint process?**

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

If you have a complaint regarding a service provided by a hospital or skilled nursing facility that is not part of our network, follow the complaint process established by Original Medicare. However, if you have a complaint involving a network hospital or skilled nursing facility (or you were directed to go to an out-of-network hospital or skilled nursing facility by our plan or one of the network providers), you will follow the instructions contained in this section. This is true even if you received a Medicare Summary Notice indicating that a claim was processed but not covered by Original Medicare. Furthermore, if you have a complaint regarding an emergency service or urgently needed care, or the cost-sharing for hospital or skilled nursing facility services, you will follow the instructions contained in this section.

Here are examples of the kinds of problems handled by the complaint process.

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

- **Quality of your medical care**
  - Are you unhappy with the quality of care you have received (including care in the hospital)?

- **Respecting your privacy**
Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?

- **Disrespect, poor customer service, or other negative behaviors**
  - Has someone been rude or disrespectful to you?
  - Are you unhappy with how our Member Services has treated you?
  - Do you feel you are being encouraged to leave our plan?

- **Waiting times**
  - Are you having trouble getting an appointment, or waiting too long to get it?
  - Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by Member Services or other staff at our plan?
  - Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room.

- **Cleanliness**
  - Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?

- **Information you get from our plan**
  - Do you believe we have not given you a notice that we are required to give?
  - Do you think written information we have given you is hard to understand?

**Timeliness (these types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)**

The process of asking for a coverage decision and making appeals is explained in Sections 4–9 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint.
- If you believe our plan is not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and our plan is told that we must cover or reimburse you for certain medical services or drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.
Section 10.2 The formal name for "making a complaint" is "filing a grievance"

**Legal Terms**

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

Section 10.3 Step-by-step: Making a complaint

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

- **Usually calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. Call toll-free 1-888-777-5536 (TTY 711), seven days a week, 8 a.m. to 8 p.m.

- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to your complaint in writing. We will also respond in writing when you make a complaint by phone if you request a written response or your complaint is related to quality of care.

- **If you have a complaint, we will try to resolve your complaint over the phone.** If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. Your grievance must explain your concern, such as why you are dissatisfied with the services you received. Please see Chapter 2 for whom you should contact if you have a complaint.

  - You must submit your grievance to us (orally or in writing) within 60 calendar days of the event or incident. We must address your grievance as quickly as your health requires, but no later than 30 calendar days after receiving your complaint. We may extend the time frame to make our decision by up to 14 calendar days if you ask for an extension, or if we justify a need for additional information and the delay is in your best interest.

  - You can file a fast grievance about our decision not to expedite a coverage decision or appeal, or if we extend the time we need to make a decision about a coverage decision or appeal. We must respond to your fast grievance within 24 hours.

- **Whether you call or write, you should contact Member Services right away.**

- **If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal,"** we will automatically give you a "fast" complaint. If you have a "fast" complaint, it means we will give you an answer **within 24 hours.**
Legal Terms

What this section calls a "fast complaint" is also called an "expedited grievance."

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.

- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint.

- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 10.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about quality of care, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization.** If you prefer, you can make your complaint about the quality of care you received directly to this organization (without making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.

- **Or you can make your complaint to both at the same time.** If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 10.5 You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your
complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call **1-800-MEDICARE** (**1-800-633-4227**). TTY/TDD users can call **1-877-486-2048**.
CHAPTER 10. Ending your membership in our plan

SECTION 1. Introduction ................................................................. 205
Section 1.1 This chapter focuses on ending your membership in our plan .................. 205

SECTION 2. When can you end your membership in our plan? ......................... 205
Section 2.1 You can end your membership at any time .......................................... 205
Section 2.2 Where can you get more information about when you can end your group membership? .............................................................. 205

SECTION 3. How do you end your membership in our plan? ......................... 206
Section 3.1 To end your membership, you must ask us in writing .............................. 206

SECTION 4. Until your membership ends, you must keep getting your medical services and drugs through our plan ................................. 207
Section 4.1 Until your membership ends, you are still a member of our plan ................ 207

SECTION 5. We must end your membership in our plan in certain situations ............ 208
Section 5.1 When must we end your membership in our plan? .............................. 208
Section 5.2 We cannot ask you to leave our plan for any reason related to your health ... 209
Section 5.3 You have the right to make a complaint if we end your membership in our plan ........................................................................................................ 209
SECTION 1. Introduction

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

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

- **You might leave our plan because you have decided that you want to leave.**
  - You can disenroll from our plan at any time. Section 2 tells you more about when you can end your membership in our plan.
  - The process for voluntarily ending your membership varies depending on what type of new coverage you are choosing. Section 3 tells you how to end your membership in each situation.
- **There are also limited situations where you do not choose to leave, but we are required to end your membership.** Section 5 tells you about situations when we must end your membership.

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

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

**Section 2.1 You can end your membership at any time**

You can disenroll from this plan at any time. You may switch to Original Medicare, or if you have a special enrollment period, you may enroll in a Medicare Advantage or another Medicare prescription drug plan. If you have Medicare prescription drug coverage through our plan, your Medicare prescription drug coverage will also end. Your membership will usually end on the last day of the month in which we receive your request to change your plan.

**Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See Chapter 6, Section 9, for more information about the late enrollment penalty.

**Section 2.2 Where can you get more information about when you can end your group membership?**

If you have any questions or would like more information about when you can end your group membership:
• Contact your group's benefits administrator.
• You can call Member Services (phone numbers are printed on the back cover of this booklet).
• You can find the information in the Medicare & You 2015 handbook.
  ♦ Everyone with Medicare receives a copy of Medicare & You each fall. Those new to Medicare receive it within a month after first signing up.
  ♦ You can also download a copy from the Medicare website (http://www.medicare.gov). Or you can order a printed copy by calling Medicare at the number below.
• You can contact Medicare at 1-800-MEDICARE (1-800-633-4227), 24 hours a day, 7 days a week. TTY users should call 1-877-486-2048.

SECTION 3. How do you end your membership in our plan?

Section 3.1 To end your membership, you must ask us in writing

You may end your membership in our plan at any time during the year and change to Original Medicare. To end your membership, you must make a request in writing to us. Your membership will end on the last day of the month in which we receive your request. Contact us if you need more information on how to do this. If you have drug coverage through our plan and you leave our plan during the year, you will have the opportunity to join a Medicare prescription drug plan when you leave. You must notify your employer to coordinate another coverage and/or to change any premium sharing arrangements you may have.

The table below explains how you should end your membership in our plan.

<table>
<thead>
<tr>
<th>If you would like to switch from our plan to:</th>
<th>This is what you should do:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Another Medicare health plan.</td>
<td>• Enroll in the Medicare health plan.</td>
</tr>
<tr>
<td></td>
<td>• You will automatically be disenrolled from our plan when your new plan's coverage begins.</td>
</tr>
<tr>
<td>• Original Medicare with a separate Medicare prescription drug plan.</td>
<td>• Send us a written request to disenroll. Contact Member Services if you need more information on how to do this (phone numbers are printed on the back cover of this booklet). Then contact the Medicare prescription drug plan that you want to enroll in and ask to be enrolled.</td>
</tr>
<tr>
<td></td>
<td>• You can also contact Medicare at 1-800-MEDICARE</td>
</tr>
</tbody>
</table>
### If you would like to switch from our plan to:

<table>
<thead>
<tr>
<th>This is what you should do:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(1-800-633-4227)</strong>, 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call <strong>1-877-486-2048</strong>.</td>
</tr>
<tr>
<td><strong>You will be disenrolled from our plan when your coverage in Original Medicare begins. If you join a Medicare prescription drug plan, that coverage should begin at this time as well.</strong></td>
</tr>
</tbody>
</table>

- **Original Medicare without a separate Medicare prescription drug plan.**

**Note:** If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. See Chapter 6, Section 9, for more information about the late enrollment penalty.

- Send us a written request to disenroll. Contact Member Services if you need more information about how to do this (phone numbers are printed on the back cover of this booklet).

- You can also contact Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week, and ask to be disenrolled. TTY users should call **1-877-486-2048**.

- **You will be disenrolled from our plan when your coverage in Original Medicare begins.**

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

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

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

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

If you use out-of-network providers to obtain medical services, the services are covered under Original Medicare. You will be responsible for Original Medicare's cost-sharing for such services, with the exception of emergency and urgently needed care. If you get prescription drugs from an out-of-network provider, you will be responsible for the cost of the drug.

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

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

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

- If you do not stay continuously enrolled in Part B. Members must stay continuously enrolled in Medicare Part B.
- If you move out of our service area or you are away from our service area for more than 90 days.
  ♦ If you move or take a long trip for more than 90 days, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. Phone numbers for Member Services are printed on the back cover of this booklet.
- If you become incarcerated (go to prison), we will disenroll you from our Part D optional supplemental benefit and you will lose prescription drug coverage.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage, we may disenroll you from our Part D optional supplemental benefit and you will lose prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you let someone else use your membership card to get medical care. We cannot make you leave our plan for this reason unless we get permission from Medicare first.
  ♦ If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.
• If you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our Part D optional supplemental benefit and you will lose prescription drug coverage.

**Where can you get more information?**

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

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

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

We are not allowed to ask you to leave our plan for any reason related to your health.

### What should you do if this happens?

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

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

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can make a complaint about our decision to end your membership. You can also look in Chapter 9, Section 10, for information about how to make a complaint.
CHAPTER 11. Legal notices

SECTION 1. Notice about governing law................................................................. 211
SECTION 2. Notice about nondiscrimination...................................................... 211
SECTION 3. Notice about Medicare Secondary Payer subrogation rights........ 211
SECTION 4. Administration of this *Evidence of Coverage* .................................. 211
SECTION 5. Applications and statements........................................................................................................ 211
SECTION 6. Assignment......................................................................................... 212
SECTION 7. Attorney and advocate fees and expenses..................................... 212
SECTION 8. Coordination of benefits................................................................... 212
SECTION 9. Employer responsibility..................................................................... 212
SECTION 10. *Evidence of Coverage* binding on members............................... 212
SECTION 11. Government agency responsibility............................................... 213
SECTION 12. Member nonliability......................................................................... 213
SECTION 13. No waiver ......................................................................................... 213
SECTION 14. Notices............................................................................................ 213
SECTION 15. Overpayment recovery................................................................. 213
SECTION 16. Third party liability......................................................................... 213
SECTION 17. U.S. Department of Veterans Affairs............................................. 214
SECTION 18. Workers' compensation or employer's liability benefits............ 214
SECTION 19. Important information from the Commonwealth of Virginia regarding your insurance.......................................................... 215
### SECTION 1. Notice about governing law

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

### SECTION 2. Notice about nondiscrimination

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

### SECTION 3. Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Kaiser Permanente Medicare Plus, as a Medicare Cost Plan sponsor, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

### SECTION 4. Administration of this *Evidence of Coverage*

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

### SECTION 5. Applications and statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this *Evidence of Coverage*. 
SECTION 6. Assignment

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

SECTION 7. 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.

SECTION 8. Coordination of benefits

As described in Chapter 1 (Section 7) "How other insurance works with our plan," if you have other insurance, you are required to use your other coverage in combination with your coverage as a Medicare Plus member to pay for the care you receive. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you. You will get your covered care as usual from network providers, and the other coverage you have will simply help pay for the care you receive.

If your other coverage is the primary payer, it will often settle its share of payment directly with us, and you will not have to be involved. However, if payment owed to us by a primary payer is sent directly to you, you are required by Medicare law to give this primary payment to us. For more information about primary payments in third party liability situations, see Section 16, and for primary payments in workers' compensation cases, see Section 18.

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

SECTION 9. Employer responsibility

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

SECTION 10. Evidence of Coverage binding on members

By electing coverage or accepting benefits under this Evidence of Coverage, all members legally capable of contracting, and the legal representatives of all members incapable of contracting, agree to all provisions of this Evidence of Coverage.
SECTION 11. Government agency responsibility

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

SECTION 12. Member nonliability

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

SECTION 13. No waiver

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

SECTION 14. Notices

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

SECTION 15. Overpayment recovery

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

SECTION 16. Third party liability

As stated in Chapter 1, Section 7, third parties who cause you injury or illness (and/or their insurance companies) usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue these primary payments. If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered services, you must pay us "Plan Charges" for those services. Note: This Section 16 does not affect your obligation to pay cost-sharing for these services, but we will credit any such payments toward the amount you must pay us under this section. Please refer to Chapter 12 for the definition of "Plan Charges."
To the extent permitted or required by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney, but we will be subrogated only to the extent of the total of Plan Charges for the relevant services.

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

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

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
Attention: Other Party Liability and Recovery Dept.
2101 East Jefferson Street, Rockville, Maryland 20852

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

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

SECTION 17. U.S. Department of Veterans Affairs

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

SECTION 18. Workers' compensation or employer's liability benefits

As stated in Chapter 1, Section 7, workers' compensation usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue primary payments under workers' compensation or employer's liability law. You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered services even if it is unclear...
whether you are entitled to a Financial Benefit, but we may recover the value of any covered services from the following sources:

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

SECTION 19. Important information from the Commonwealth of Virginia regarding your insurance

We are subject to regulation in this Commonwealth by the State Corporation Commission Bureau of Insurance pursuant to Title 38.2 and by the Virginia Department of Health pursuant to Title 32.1.

In the event you need to contact someone about this insurance for any reason, please contact your agent. If no agent was involved in the sale of this insurance, or if you have additional questions, you may contact Kaiser Permanente at the following address and telephone number:

Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc.
P.O. Box 6831
2101 East Jefferson Street
Rockville MD 20849-6831
301-468-6000 or 1-800-777-7902

We recommend that you familiarize yourself with our customer satisfaction and appeals processes as described in Chapter 9: "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)" and make use of it before taking any other action.

If you have been unable to contact or obtain satisfaction from the company or your agent, you may contact the Virginia State Corporation Commission's Bureau of Insurance at:

State Corporation Commission
Bureau of Insurance
P.O. Box 115
Richmond VA 23218
804-371-9741 or 1-800-552-7945

Written correspondence is preferable so that a record of your inquiry is maintained. When contacting your agent, Kaiser Permanente, or the Bureau of Insurance, have your policy number available.
CHAPTER 12. Definitions of important words

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

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Annual Enrollment Period – A set time each fall when members can change their health or drug plans. The Annual Enrollment Period is from October 15 until December 7. (As a member of a Medicare Cost Plan, you can switch to Original Medicare at any time. But you can only join a new Medicare health or drug plan during certain times of the year, such as the Annual Enrollment Period.)

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for a drug, item, or service you think you should be able to receive. Chapter 9 explains appeals, including the process involved in making an appeal.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measure your use of hospital and skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Brand-Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand-name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand-name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit when you pay a low copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4,700 in covered drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare. Chapter 2 explains how to contact CMS.
**Coinsurance** – An amount you may be required to pay as your share of the cost for services or prescription drugs. Coinsurance is usually a percentage (for example, 20% of Plan Charges).

**Comprehensive Outpatient Rehabilitation Facility (CORF)** – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

**Coordination of Benefits (COB)** – Coordination of Benefits is a provision used to establish the order in which claims are paid when you have other insurance. If you have Medicare and other health insurance or coverage, each type of coverage is called a "payer." When there is more than one payer, there are "coordination of benefits" rules that decide which one pays first. The "primary payer" pays what it owes on your bills first, and then sends the rest to the "secondary payer" to pay. If payment owed to us is sent directly to you, you are required under Medicare law to give the payment to us. In some cases, there may also be a third payer. See Chapter 1 (Section 7) and Chapter 11 (Section 8) for more information.

**Copayment** – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is usually a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit or prescription drug.

**Cost-Sharing** – Cost-sharing refers to amounts that a member has to pay when services or drugs are received. However, in some cases, you may not pay all applicable cost-sharing at the time you receive the services, and we will send you a bill later for the cost-sharing. For example, if you receive nonpreventive care during a scheduled preventive care visit, we may bill you later for the cost-sharing applicable to the nonpreventive care. For items ordered in advance, you pay the copayment 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 copayment when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription. Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services or drugs are covered; (2) any fixed "copayment" amount that a plan requires when a specific service or drug is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service or drug that a plan requires when the service or drug is received. A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment.

**Cost-Sharing Tier** – Every drug on the list of covered drugs is in one of three cost-sharing tiers. In general, the higher the cost-sharing tier, the higher your cost for the drug.

**Coverage Determination** – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you are required to pay for the prescription. In general, if you take your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under your plan, that isn't a coverage determination. You need to call or write to your plan to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.
Covered Drugs – The term we use to mean all of the Medicare Part D prescription drugs covered by our plan.

Covered Services – The general term we use to mean all of the health care services and items that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily Cost-Sharing Rate – A "daily cost-sharing rate" may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you are required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in your plan is 30 days, then your "daily cost-sharing rate" is $1 per day. This means you pay $1 for each day's supply when you fill your prescription.

Deductible – The amount you must pay for health care or prescriptions before our plan begins to pay.

Disenroll or Disenrollment – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription. The dispensing fee covers costs such as the pharmacist's time to prepare and package the prescription.

Durable Medical Equipment – Certain medical equipment that is ordered by your doctor for medical reasons. Examples are walkers, wheelchairs, or hospital beds.

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

Emergency Care – Covered services that are (1) rendered by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.
**Emergency Medical Condition** – Either: (1) a medical or psychiatric condition that manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could reasonably expect the absence of immediate medical attention to result in serious jeopardy to your health or body functions or organs, or (2) active labor when there isn't enough time for safe transfer to a plan hospital (or designated hospital) before delivery or if transfer poses a threat to your (or your unborn child's) health and safety.

**Evidence of Coverage (EOC) and Disclosure Information** – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

**Exception** – A type of coverage determination that, if approved, allows you to get a drug that is not on your plan sponsor's formulary (a formulary exception), or get a nonpreferred drug at the preferred cost-sharing level (a tiering exception).

**Excluded Drug** – A drug that is not a "covered Part D drug," as defined under 42 U.S.C. Section 1395w-102(e).

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

**Formulary** – A list of Medicare Part D drugs covered by our plan.

**Generic Drug** – A prescription drug that is approved by the Food and Drug Administration (FDA) as having the same active ingredient(s) as the brand-name drug. Generally, a "generic" drug works the same as a brand-name drug and usually costs less.

**Grievance** – A type of complaint you make about us or one of our network providers or pharmacies, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

**Group** – The entity with which we have entered into the Agreement that includes this Evidence of Coverage.

**Group Health Cooperative (GHC)** – When you are outside our service area, you can get medically necessary health care and ongoing care for chronic conditions from designated providers in another Kaiser Permanente region's service area or GHC service area. GHC is located in parts of Washington and Northern Idaho. For more information, please refer to Chapter 3, Section 2.2, and you may visit GHC's website at ghc.org/about_gh/index.jhtml.

**Home Health Aide** – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (for example, bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.
Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Medical Benefits Chart in Chapter 4. We cover home health care in accord with Medicare guidelines. Home health care can include services from a home health aide if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services do not include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice Care – A special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending upon the situation, this care may be given in the home, a hospice facility, a hospital, or a nursing home. Care from a hospice is meant to help patients in the last months of life by giving comfort and relief from pain. The focus is on care, not cure. For more information on hospice care, visit www.medicare.gov, and under "Search Tools," choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or call 1-800-MEDICARE (1-800-633-4227). TTY users should call 1-877-486-2048.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Income Related Monthly Adjustment Amount (IRMAA) – If your income is above a certain limit, you will pay an income-related monthly adjustment amount in addition to your plan premium. For example, individuals with income greater than $85,000 and married couples with income greater than $170,000 must pay a higher Medicare Part B (medical insurance) and Medicare prescription drug coverage premium amount. This additional amount is called the income-related monthly adjustment amount. Less than 5% of people with Medicare are affected, so most people will not pay a higher premium.

Initial Coverage Limit – The maximum limit of coverage under the Initial Coverage Stage.

Initial Coverage Stage – This is the stage before your total drug expenses have reached $4,700, including amounts you've paid and what our plan has paid on your behalf.

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

Inpatient Hospital Care – Health care that you get during an inpatient stay in an acute care general hospital.

Kaiser Foundation Health Plan (Health Plan) – Kaiser Foundation Health Plan of the Mid-Atlantic States, Inc, is a nonprofit corporation and a Medicare Cost Plan. This Evidence of Coverage sometimes refers to Health Plan as "we" or "us."

Kaiser Permanente 2015 Abridged Formulary and Kaiser Permanente 2015 Comprehensive Formulary (Formulary or "Drug List") – A list of prescription drugs covered by our plan. The drugs on this list are selected by us with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Late Enrollment Penalty – An amount added to the plan premium for Medicare drug coverage if you go without creditable coverage (coverage that is expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more. You pay this higher amount as long as you have a Medicare drug plan. There are some exceptions. For example, if you receive "Extra Help" from Medicare to pay your prescription drug plan costs, the late enrollment penalty rules do not apply to you. If you receive "Extra Help," you do not pay a penalty, even if you go without "creditable" prescription drug coverage.

Low Income Subsidy (LIS) – See "Extra Help."

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for Part A and Part B services covered by our plan. Amounts you pay for any contributions toward your group's monthly premium, your Medicare Part A and Part B premiums, and Part D prescription drugs do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.2, for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6, for information about how to contact Medicaid in your state.

Medical Care or Services – Health care services or items. Some examples of health care items include durable medical equipment, eyeglasses, and drugs covered by Medicare Part A or Part B, but not drugs covered under Medicare Part D.

Medical Group – It is the network of plan providers that our plan contracts with to provide covered services to you. The name of our medical group is The Kaiser Permanente Medical Group, Inc., a for-profit professional corporation.

Medically Accepted Indication – A use of a drug that is either approved by the Food and Drug Administration or supported by certain reference books. See Chapter 5, Section 3, for more information about a medically accepted indication.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a Medicare Cost Plan, a PACE plan, or a Medicare Advantage Plan.
**Medicare Advantage (MA) Plan** – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, a PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. If you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

**Medicare Cost Plan** – A Medicare Cost Plan is a plan operated by a Health Maintenance Organization (HMO) or Competitive Medical Plan (CMP) in accordance with a cost-reimbursed contract under section 1876(h) of the Act.

**Medicare Coverage Gap Discount Program** – A program that provides discounts on most covered Part D brand-name drugs to Part D enrollees who have reached the Coverage Gap Stage and who are not already receiving "Extra Help." Discounts are based on agreements between the federal government and certain drug manufacturers. For this reason, most, but not all, brand-name drugs are discounted.

**Medicare-Covered Services** – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B. (For members who have only Medicare Part B, the plan covers only Part B services.)

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

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

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

**Member (Member of our Plan, or "Plan Member")** – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

**Member Services** – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

**Network Pharmacy** – A network pharmacy is a pharmacy where members of our plan can get their prescription drug benefits. We call them "network pharmacies" because they contract with our plan. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.
Network Physician – Any licensed physician who is a partner or employee of the Medical Group, or any licensed physician who contracts to provide services to our members (but not including physicians who contract only to provide referral services).

Network Provider – "Provider" is the general term we use for doctors, other health care professionals, hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them "network providers" when they have an agreement with our plan to accept our payment as payment in full, and in some cases, to coordinate as well as provide covered services to members of our plan. Our plan pays network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Organization Determination – The Cost plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. The Cost plan's network provider or facility has also made an organization determination when it provides you with an item or service, or refers you to an out-of-network provider for an item or service. Organization determinations are called "coverage decisions" in this booklet. Chapter 9 explains how to ask us for a coverage decision.

Original Medicare ("Traditional Medicare" or "Fee-for-Service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. As explained in this Evidence of Coverage, most drugs you get from out-of-network pharmacies are not covered by our plan unless certain conditions apply (see Chapter 5, Section 2.5, for more information).

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for "Cost-sharing" above. A member's cost-sharing requirement to pay for a portion of services or drugs received is also referred to as the member's "out-of-pocket" cost requirement.

PACE Plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) for as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.
Part C – See "Medicare Advantage (MA) Plan."

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. (See your formulary for a specific list of covered drugs.) Certain categories of drugs were specifically excluded by Congress from being covered as Part D drugs.

Plan Charges – Plan Charges means the following:

• For services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for services provided to members.

• For services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider.

• For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a member for the item if a member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs; the direct and indirect costs of providing Kaiser Permanente pharmacy services to members; and the pharmacy program's contribution to the net revenue requirements of Health Plan).

• For all other services, the payments that Kaiser Permanente makes for the services or, if Kaiser Permanente subtracts cost-sharing from its payment, the amount Kaiser Permanente would have paid if it did not subtract cost-sharing.

Post-Stabilization Care – Medically necessary services related to your emergency medical condition that you receive after your treating physician determines that this condition is clinically stable. You are considered clinically stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

Preferred cost-sharing – Preferred cost-sharing means lower cost-sharing for certain covered Part D drugs at certain network pharmacies.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (nonpreferred) providers.
**Premium** – The periodic payment to Medicare, an insurance company, or a health care plan for health care or prescription drug coverage.

**Primary Care Provider (PCP)** – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1, for information about Primary Care Providers.

**Prior Authorization** – Approval in advance to get services or certain drugs that may or may not be on our formulary. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4. Some drugs are covered only if your doctor or other network provider gets "prior authorization" from us. Covered drugs that need prior authorization are marked in the formulary.

**Quality Improvement Organization (QIO)** – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4, for information about how to contact the QIO for your state.

**Quantity Limits** – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

**Rehabilitation Services** – These services include physical therapy, speech and language therapy, and occupational therapy.

**Service Area** – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (nonemergency) services. Our plan may disenroll you if you permanently move out of our plan's service area.

**Services** – Health care services or items.

**Skilled Nursing Facility (SNF) Care** – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

**Special Needs Plan** – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

**Specialty-Tier Drugs** – Very high-cost drugs approved by the FDA that are on our formulary.

**Standard Cost-sharing** – Standard cost-sharing is cost-sharing other than preferred cost-sharing offered at a network pharmacy.
Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Care – Urgently needed care is care provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed care may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.
**Kaiser Permanente Medicare Plus Member Services**

<table>
<thead>
<tr>
<th>METHOD</th>
<th>Member Services – contact information</th>
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<tbody>
<tr>
<td>CALL</td>
<td>1-888-777-5536</td>
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<tr>
<td></td>
<td>Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.</td>
</tr>
<tr>
<td></td>
<td>Member Services also has free language interpreter services available for non-English speakers.</td>
</tr>
<tr>
<td>TTY</td>
<td>711</td>
</tr>
<tr>
<td></td>
<td>Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.</td>
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<tr>
<td>FAX</td>
<td>301-816-6192</td>
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<tr>
<td>WRITE</td>
<td>Kaiser Permanente Member Services</td>
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<tr>
<td></td>
<td>2101 East Jefferson Street</td>
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<tr>
<td></td>
<td>Rockville, Maryland 20852</td>
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<tr>
<td>WEBSITE</td>
<td>kp.org</td>
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**State Health Insurance Assistance Program**

A State Health Insurance Assistance Program (SHIP) is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. Please refer to Chapter 2, Section 3, for SHIP contact information.