Health Maintenance Organization (HMO)

Combined Evidence of Coverage and Disclosure Form
for the Basic Plan and the Medicare Managed Care Plan

Effective January 1, 2012

Contracted by the CalPERS Board of Administration
Under the Public Employees' Medical & Hospital Care Act (PEMHCA)

This *Disclosure Form and Evidence of Coverage (Evidence of Coverage),* the *Group Agreement (Agreement)*, and any amendments constitute the contract between Kaiser Foundation Health Plan, Inc., and CalPERS. The *Agreement* is on file and available for review in the office of the CalPERS Health Plan Administration Division, 400 Q St, Sacramento, CA 95811. You may purchase a copy of the *Agreement* from the CalPERS Health Plan Administration Division, P.O. Box 720724, Sacramento, CA 94229-0724, for a reasonable duplicating charge.

It is in your best interest to familiarize yourself with this *Evidence of Coverage.* This *Combined Evidence of Coverage* for the Basic Plan and the Managed Medicare Health Plan is divided into the following sections, which are clearly marked on each page:

- Part One pertains to the Basic Plan;
- Part Two pertains to the Managed Medicare Health Plan, Kaiser Permanente Senior Advantage Plan with Part D;
- Part Three provides information about both the Basic Plan and the Managed Medicare Health Plan.

Health Care Reform

The Patient Protection and Affordable Care Act, as amended by the Health Care and Education Affordability Reconciliation Act of 2010, expands health coverage for various groups and provides mechanisms to lower costs and increase benefits for Americans with health insurance. As federal regulations are released for various measures of the law, CalPERS may need to modify benefits accordingly. For up-to-date information about CalPERS and Health Care Reform, please refer to the Health Care Reform page on CalPERS On-Line at www.calpers.ca.gov.

Help in your language

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

Ayuda en su propio idioma

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

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KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern and Southern California Regions

PART ONE – EVIDENCE OF COVERAGE FOR KAISER PERMANENTE BASIC PLAN

January 1, 2012, through December 31, 2012

Member Service Call Center
800-464-4000 toll free
800-777-1370 (TTY for the hearing/speech impaired) toll free
Weekdays 7 a.m.–7 p.m. and weekends 7 a.m.–3 p.m. (except holidays)
kp.org

BENEFIT CHANGES FOR CURRENT YEAR

The following is a summary of the most important coverage changes and clarifications that we have made to this Basic Plan 2012 *Disclosure Form and Evidence of Coverage (Evidence of Coverage).* Please read this *Evidence of Coverage* for the complete text of these changes, as well as changes not listed in the summary below. In addition, please refer to the "Premiums" section for information about 2012 Premiums.

Please refer to the "Benefits, Copayments, and Coinsurance" section in this *Evidence of Coverage* for benefit descriptions and the amount Members must pay for covered benefits. Benefits are also subject to the "Emergency Services and Urgent Care" and the "Exclusions, Limitations, Coordination of Benefits, and Reductions" sections in Part One of this *Evidence of Coverage*

Acupuncture Services

We have clarified that the Cost Sharing for acupuncture Services (typically prescribed by a Plan Physician only for the treatment of nausea or provided as part of a comprehensive pain management program for the treatment of chronic pain) is the same as the Cost Sharing for a specialty care office visit.

Annual out-of-pocket maximum

The Cost Sharing for Skilled Nursing Facility care will accumulate to the annual out-of-pocket maximum.

Bariatric Surgery

We have clarified that covered Services related to bariatric surgical procedures that you receive, you will pay the Cost Sharing you would pay if the Services were not related to a bariatric surgical procedure.

Emergency Services

We have replaced the term "Emergency Care" with "Emergency Services," and have revised the definitions of "Emergency Services," "Emergency Medical Condition," and "Stabilize." Also, we have revised the definition of "Emergency Medical Condition" in accord with California Assembly Bill 235 to indicate that a mental health condition is an Emergency Medical Condition when it meets the requirements of the definition under the Patient Protection and Affordable Care Act (PPACA), or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to himself or herself or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

Exclusions

We have made the following revisions in the "Exclusions" section:

- We have clarified that when a service is excluded, it is excluded regardless of whether the services are within the scope of a provider's license or certificate
- We have revised the exclusion for services performed by unlicensed people for clarity. Services performed by unlicensed people are services that are performed safely and effectively by people who do not require

licenses or certificates by the state to provide health care services and where the Member's condition does not require that the services be provided by a licensed health care provider

- We have added an exclusion for massage therapy

Eyeglasses and contact lenses following cataract surgery

Eyeglass and contact lenses following cataract surgery are covered as described in the "Vision Services" section at Plan Medical Offices or Plan Optical Sales Offices when prescribed by *any physician or optometrist*. Previously, the *EOC* said that lenses must be prescribed by a Plan Physician or Plan Optometrist. A prescription from a Plan Physician or Plan Optometrist is required for special contact lenses to treat aphakia and aniridia.

Non-health care items and services

We have clarified that for Services to be covered, the Services must be one of the following:

- Health care items and services for preventive care
- Health care items and services for diagnosis, assessment, or treatment
- Health education covered under "Health Education" in this "Benefits and Cost Sharing" section
- Other health care items and services

We have also clarified non-health care items and services are excluded, and have provided the following examples of non-health care services and items:

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

Prescription Drugs

The copayment amounts for brand-name prescription drugs obtained at a Plan Pharmacy or through our mail order service are as follows:

- Plan Pharmacy:
  - $20 Copayment for up to a 30-day supply

- $40 Copayment for a 31- to 60-day supply
- $60 Copayment for a 61- to 100-day supply

- Mail-order service:
  - $20 Copayment for up to a 30-day supply
  - $40 Copayment for a 31- to 100-day supply

Prosthetic and Orthotic devices

The copayment or coinsurance amount for external prosthetic and orthotic devices, and ostomy and urological supplies, is now listed in the Benefit Summary.

Referrals

We have clarified that a Plan Physician must provide a referral before a Member can receive physical, occupational, or speech therapy.

Service Area ZIP codes

We are now listing all the ZIP codes that are in the Kaiser Permanente Service Area. For each county, we have indicated whether all ZIP codes in that county are inside the service area or if only the ZIP codes listed are inside our service area. A ZIP code must be listed for that county to be in the Kaiser Permanente Service Area.

Testicular implants

We have revised the cosmetic services exclusion to clarify that we cover testicular implants that are associated with reconstructive surgery, if a Plan Physician determines they are necessary to improve function, or create a normal appearance, to the extent possible.

Vision Services

We have made the following revisions for clarity:

- The exclusion for eye surgery has been modified to clarify that non-surgical vision correction procedures are also excluded
- We have clarified that we only cover one pair of eyeglasses or contact lenses after any cataract surgery that includes insertion of an intraocular lens

BASIC PLAN BENEFIT SUMMARY

Service	You Pay
Professional Services (Plan Provider office visits)	
Most primary and specialty care consultations and exams	$15 per visit
Routine physical maintenance exams	No charge
Well-child preventive exams (through age 23 months)	No charge
Family planning counseling	$15 per visit
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	No charge
Eye exams for refraction	No charge
Hearing exams	No charge
Urgent care consultations and exams	$15 per visit
Physical, occupational, and speech therapy	$15 per visit
Outpatient Services	
Outpatient surgery and certain other outpatient procedures	$15 per procedure
Allergy injections (including allergy serum)	No charge
Biofeedback	$15 per visit
Most immunizations (including vaccines)	No charge
Most X-rays and lab tests	No charge
Health education:	
Most individual health education counseling	$15 per visit
Covered health education programs	No charge
Hospitalization Services	
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
Emergency Health Coverage	
Emergency Department visits	$50 per visit
Note: This Copayment does not apply if you are held for observation in a hospital unit outside the Emergency Department or if admitted directly to the hospital as an inpatient for covered Services (see "Hospitalization Services" for inpatient Copayment)	
Ambulance Services	
Ambulance Services	No charge
Prescription Drug Coverage	
Most covered outpatient items in accord with our drug formulary guidelines:	
Generic items from a Plan Pharmacy	$5 for up to a 30-day supply, $10 for a 31- to 60-day supply, or $15 for a 61- to 100-day supply
Generic refills from our mail-order service	$5 for up to a 30-day supply or $10 for a 31- to 100-day supply
Brand-name items from a Plan Pharmacy	$20 for up to a 30-day supply, $40 for a 31- to

Service	You Pay
Brand-name refills from our mail-order service	60-day supply, or $60 for a 61- to 100-day supply $20 for up to a 30-day supply or $40 for a 31- to 100-day supply
Durable Medical Equipment	
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	No charge
Mental Health Services	
Inpatient psychiatric hospitalization	No charge
Outpatient mental health evaluation and treatment:	$15 per individual visit $7 per group visit
Chemical Dependency Services	
Inpatient detoxification	No charge
Individual outpatient chemical dependency consultations and treatment	$15 per visit
Group outpatient chemical dependency treatment	$5 per visit
Home Health Services	
Home health care	No charge
Other	
Hearing aid(s) every 36 months	Amount in excess of $1,000 Allowance
Skilled Nursing Facility care (up to 100 days per benefit period)	No charge
External prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge
All covered Services related to infertility treatment	50% Coinsurance
Hospice care	No charge
Eyeglasses and contact lenses following cataract surgery, in accord with Medicare guidelines	No charge

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

INTRODUCTION

Part One and Part Three of this *Evidence of Coverage* describe the health care coverage of the "Basic Plan" provided under the *Group Agreement (Agreement)* between Health Plan (Kaiser Foundation Health Plan, Inc., Northern California Region and Southern California Region) and your Group (CalPERS). For benefits provided under any other Health Plan program, refer to that plan's evidence of coverage.

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

When you join Kaiser Permanente, you are enrolling in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), which we call your "Home Region." The Service Area of each Region is described in the "Definitions" section in Part Three of this *Evidence of Coverage*. The coverage information in this *Evidence of Coverage* applies when you obtain care in your Home Region. When you visit the other California Region, you may receive care as described in "Visiting Other Regions" in the "How to Obtain Services" section.

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

Term of this *Evidence of Coverage*

This *Evidence of Coverage* is for the period January 1, 2012, through December 31, 2012, unless amended. Your Health Benefits Officer (or, if you are retired, the CalPERS Health Account Services Section) can tell you whether this *Evidence of Coverage* is still in effect and give you a current one if this *Evidence of Coverage* has expired or been amended.

About Kaiser Permanente

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

We provide covered Services to Members using Plan Providers located in your Home Region's Service Area, which is described in the "Definitions" section in Part Three of this *Evidence of Coverage*. You must receive all covered care from Plan Providers inside your Home Region's Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Durable medical equipment as described under "Durable Medical Equipment for Home Use"

in the “Benefits, Copayments, and Coinsurance” section

- Emergency ambulance Services as described under “Ambulance Services” in the “Benefits, Copayments, and Coinsurance” section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the “Emergency Services and Urgent Care” section
- Home health care as described under “Home Health Care” in the “Benefits, Copayments, and Coinsurance” section
- Eyeglasses and contact lenses prescribed by Non–Plan Providers as described under "Vision Services" in the "Benefits and Cost Sharing" section
- Hospice care as described under “Hospice Care” in the “Benefits, Copayments, and Coinsurance” section
- Ostomy and urological supplies as described under “Ostomy and Urological Supplies” in the “Benefits, Copayments, and Coinsurance” section
- Prosthetic and orthotic devices as described under “Prosthetic and Orthotic Devices” in the “Benefits, Copayments, and Coinsurance” section

PREMIUMS, ELIGIBILITY, AND ENROLLMENT

Premiums

Your Group is responsible for paying Premiums, except that you are responsible for paying Premiums as described in the "Continuation of Membership" section if you have Cal-COBRA coverage under this *Evidence of Coverage*. If you are responsible for any contribution to the Premiums that your Group pays, your Group will tell you the amount and how to pay your Group (through payroll deduction, for example).

State employees and annuitants

The Premiums listed below will be reduced by the amount the state of California contributes toward the cost of your health benefit plan. These contribution amounts are subject to change as a result of collective bargaining agreements or legislative action. Any such change will be accomplished by the State Controller or affected retirement system without any action on your part. For current contribution information, contact your Health Benefits Officer (or, if you are retired, the CalPERS Health Account Services Section).

State employees and annuitants	Monthly Premiums
Self only	$559.11
Self and one Dependent	$1,118.22
Self and two or more Dependents	$1,453.69

Contracting agency employees and annuitants

The Premiums listed below will be reduced by the amount your contracting agency contributes toward the cost of your health benefit plan. This amount varies among contracting agencies. For assistance on calculating your net contribution, contact your Health Benefits Officer (or, if you are retired, the CalPERS Health Account Services Section). There are five geographic pricing areas.

The Premiums that apply to you are based on your CalPERS address of record.

Bay Area pricing area. If you live or work in these counties: Alameda, Amador, Contra Costa, Marin, Napa, Nevada, San Francisco, San Joaquin, San Mateo, Santa Clara, Santa Cruz, Solano, Sonoma, Sutter, Yolo, and Yuba, the monthly Premiums are:

Bay Area	Monthly Premiums
Self only	$610.44
Self and one Dependent	$1,220.88
Self and two or more Dependents	$1,587.14

Sacramento pricing area. If you live or work in these counties: El Dorado, Placer or Sacramento, the monthly Premiums are:

Sacramento	Monthly Premiums
Self only	$562.69
Self and one Dependent	$1,125.38
Self and two or more Dependents	$1,462.99

Other Northern California counties pricing area. If you live or work in these counties: Alpine, Butte, Calaveras, Colusa, Del Norte, Glenn, Humboldt, Lake, Lassen, Mariposa, Mendocino, Merced, Modoc, Mono, Monterey, Plumas, San Benito, Shasta, Sierra, Siskiyou, Stanislaus, Tehama, Trinity, and Tuolumne, the monthly Premiums are:

Other Northern California counties	Monthly Premiums
Self only	$616.14
Self and one Dependent	$1,232.28
Self and two or more	

Dependents	$1,601.96

Los Angeles pricing area. If you live or work in Los Angeles, San Bernardino, or Ventura counties, the monthly Premiums are:

Los Angeles area	**Monthly Premiums**
Self only	$465.63
Self and one Dependent	$931.26
Self and two or more Dependents	$1,210.64

Other Southern California counties pricing area. If you live or work in these counties: Fresno, Imperial, Inyo, Kern, Kings, Madera, Orange, Riverside, San Diego, San Luis Obispo, Santa Barbara, and Tulare, the monthly Premiums are:

Other Southern California counties	**Monthly Premiums**
Self only	$512.76
Self and one Dependent	$1,025.52
Self and two or more Dependents	$1,333.18

Out of State pricing area. If you live or work outside California, the monthly Premiums are:

Out of State	**Monthly Premiums**
Self only	$816.47
Self and one Dependent	$1,632.94
Self and two or more Dependents	$2,122.82

Eligibility

To enroll and to continue enrollment, you must meet all of the eligibility requirements described in this "Eligibility" section. The CalPERS Health Program enrollment and eligibility requirements are determined in accord with the Public Employees' Medical & Hospital Care Act (PEMHCA) and the Health Insurance Portability and Accountability Act (HIPAA). For an explanation of specific enrollment and eligibility criteria, please consult your Health Benefits Officer (or, if you are retired, the CalPERS Health Account Services Section).

Information pertaining to eligibility, enrollment, termination of coverage, and conversion rights can be obtained through the CalPERS Web site at **www.calpers.ca.gov** or by calling CalPERS. Also, please refer to the *CalPERS Health Program Guide* for information about eligibility. It is your responsibility to stay informed about your coverage. If you have any questions, contact your:

- Health Benefits Officer in your agency
  - If you are retired, the CalPERS Health Account Services Section, Attn: Enrollment Administration, P.O. Box 942714, Sacramento, CA 94229-2714. Fax number: 916-795-1277
  - CalPERS Customer Service and Outreach Division toll free at: **888-CalPERS** (**888-225-7377**) TTY users call 800-735-2929 or 916-795-3240

Group Eligibility Requirements

You must meet CalPERS eligibility requirements. Active employees should contact their Health Benefits Officer (or, if you are retired, the CalPERS Health Account Services Section) to learn about your Group health care options.

Service Area Eligibility Requirements

The "Definitions" section in Part Three of this *Evidence of Coverage* describes your Home Region's Service Area and how it may change.

Active employees (and annuitants who are currently working and enrolled in the Basic Plan) must live or work inside his or her Home Region's Service Area at the time they enroll. If after enrollment the Subscriber no longer lives or

works inside your Home Region's Service Area, the Subscriber can continue membership unless (1) he or she lives inside or moves to the service area of another Region and does not work inside his or her Home Region Service Area, or (2) your Group does not allow continued enrollment of Subscribers who do not live or work inside his or her Home Region Service Area (please contact your Health Benefits Officer, or if you are retired, the CalPERS Health Account Services Section, to learn about your Group health care options).

Dependent children of the Subscriber or of the Subscriber's Spouse may live anywhere inside or outside his or her Home Region Service Area. Other Dependents may live anywhere, except that they are not eligible to enroll or to continue enrollment if they live in or move to the service area of another Region.

If you are not eligible to continue enrollment because you live in or move to the service area of another Region, please contact your Health Benefits Officer (or, if you are retired, the CalPERS Health Account Services Section) to learn about your Group health care options:

Regions outside California. You may be able to enroll in the new service area if there is an agreement between CalPERS and that Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same. For the purposes of this eligibility rule, the service areas of the Regions outside California may change on January 1 of each year and are currently the District of Columbia and parts of Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington.

Our Northern and Southern California Regions' Service Areas. When you join Kaiser Permanente, you are enrolling in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), which we call your "Home Region." The Service Area of each Region is described in the "Definitions" section in Part Three of this *Evidence of Coverage*. The coverage information in this *Evidence of Coverage* applies when you obtain care in your Home Region. When you visit the other California Region, you may receive care as described in "Visiting Other Regions" in the "How to Obtain Services" section.

Members with Medicare

In accord with the Public Employees' Medical & Hospital Care Act (PEMHCA), if you are or become Medicare-eligible and do not enroll in Medicare Part B and a CalPERS Medicare health plan, CalPERS health coverage for you and all your enrolled Dependents will be terminated.

If you become eligible for Medicare Part B and are retired, you must enroll in Kaiser Permanente Senior Advantage with Part D, if you are eligible as described in Part Two of this *Evidence of Coverage,* to continue Kaiser Permanente membership.

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

required by the Centers for Medicare & Medicaid Services and upon your request.

Enrollment

To enroll in this Plan, use form CalPERS HBD-12. Your agency Health Benefits Officer (or, if you are retired, the CalPERS Health Account Services Section) can provide both the form and assistance in completing it.

Also, if you choose to use your work address as the ZIP code when you enroll, you must complete the "CalPERS Employer ZIP code Election Form." To obtain this form, please contact your Health Benefits Officer (or, if you are retired, the CalPERS Health Account Services Section).

Effective date of coverage

Your coverage begins on the date established by CalPERS. Check with your agency Health Benefits Officer (or, if you are retired, the CalPERS Health Account Services Section) if you have questions.

HOW TO OBTAIN SERVICES

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

- Authorized referrals as described under "Getting a Referral" in this "How to Obtain Services" section
- Durable medical equipment as described under "Durable Medical Equipment for Home Use" in the "Benefits, Copayments, and Coinsurance" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits, Copayments, and Coinsurance" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Home health care as described under "Home Health Care" in the "Benefits, Copayments, and Coinsurance" section
- Eyeglasses and contact lenses prescribed by Non–Plan Providers as described under "Vision Services" in the "Benefits and Cost Sharing" section
- Hospice care as described under "Hospice Care" in the "Benefits, Copayments, and Coinsurance" section
- Ostomy and urological supplies as described under "Ostomy and Urological Supplies" in the "Benefits, Copayments, and Coinsurance" section
- Prosthetic and orthotic devices as described under "Prosthetic and Orthotic Devices" in the "Benefits, Copayments, and Coinsurance" section

As a Member, you are enrolled in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), called your Home Region. The coverage information in this *Evidence of Coverage* applies when you obtain care in your Home Region.

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

Routine Care

If you need the following Services, you should schedule an appointment:

- Preventive care (Services to help keep you healthy or to prevent illness)
- Periodic follow-up care (regularly scheduled follow-up care, such as visits to monitor a chronic condition)
- Other care that is not Urgent Care

To make a non-urgent appointment, please refer to *Your Guidebook* for appointment telephone numbers, or go to our Web site at **kp.org** to request an appointment online.

Urgent Care

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

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

Not Sure What Kind of Care You Need?

Sometimes it's difficult to know what kind of care you need, so we have licensed health care professionals available to assist you by phone 24 hours a day, seven days a week. Here are some of the ways they can help you:

- They can answer questions about a health concern, and instruct you on self-care at home if appropriate
- They can advise you about whether you should get medical care, and how and where to get care (for example, if you are not sure whether your condition is an Emergency Medical Condition, they can help you decide whether you need Emergency Care or Urgent Care, and how and where to get that care)
- They can tell you what to do if you need care and a Plan Medical Office is closed

You can reach one of these licensed health care professionals by calling the appointment or advice telephone number listed in *Your Guidebook*. When you call, a trained support person may ask you questions to help determine how to direct your call.

Your Personal Plan Physician

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

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

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

Getting a Referral

Referrals to Plan Providers

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

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

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

Medical Group authorization procedure for certain referrals

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

- **Durable medical equipment.** If your Plan Physician prescribes durable medical equipment, he or she will submit a written referral to the Plan Hospital's durable medical equipment coordinator, who will authorize the durable medical equipment if he or she determines that your durable medical equipment coverage includes the item and that the item is listed on our formulary for your condition. If the item doesn't appear to meet our durable medical equipment formulary guidelines, then the durable medical equipment coordinator will contact the Plan Physician for additional information. If the durable medical equipment request still doesn't appear to meet our durable medical equipment formulary guidelines, it will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our durable medical equipment formulary, please refer to "Durable Medical Equipment for Home Use" in the "Benefits, Copayments, and Coinsurance" section
- **Home health care.** If your Plan Physician makes a written referral for at least eight continuous hours of home health nursing or other care, the Medical Group's designee Plan Physician or committee will authorize the Services if the designee determines that they are Medically Necessary and that they are not the types of Services that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training
- **Ostomy and urological supplies.** If your Plan Physician prescribes ostomy or urological supplies, he or she will submit a written referral to the Plan Hospital's designated coordinator, who will authorize the item if he or she determines that it is covered and the item is listed on our soft goods formulary for your condition. If the item doesn't appear to meet our soft goods formulary guidelines, then the coordinator will contact the Plan Physician for additional information. If the request still doesn't appear to meet our soft goods formulary guidelines, it will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our soft goods formulary, please refer to "Ostomy and Urological Supplies" in the "Benefits, Copayments, and Coinsurance" section
- **Services not available from Plan Providers.** If your Plan Physician decides that you require covered Services not available from Plan Providers, he or she will recommend to the Medical Group that you be referred to a Non–Plan Provider inside or outside your Home Region's Service Area. The appropriate Medical Group designee will authorize the Services if he or she determines that they are Medically Necessary and are not available from a Plan Provider. Referrals to Non–Plan Physicians will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your Plan Physician what Services have been authorized
- **Transplants.** If your Plan Physician makes a written referral for a transplant, the Medical Group's regional transplant advisory committee or board (if one exists) will authorize the Services if it determines that they are Medically Necessary. In cases where no transplant committee or board exists, the Medical Group will refer you to physician(s) at a transplant center, and the Medical Group

will authorize the Services if the transplant center's physician(s) determine that they are Medically Necessary. Note: A Plan Physician may provide or authorize a corneal transplant without using this Medical Group transplant authorization procedure

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

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

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

Copayments and Coinsurance. The Copayments and Coinsurance for these referral Services are the Copayments and Coinsurance required for Services provided by a Plan Provider as described in the "Benefits, Copayments, and Coinsurance" section.

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

Completion of Services from Non–Plan Providers

New Member. If you are currently receiving Services from a Non–Plan Provider in one of the cases listed below under "Eligibility" and your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective, you may be eligible for limited coverage of that Non–Plan Provider's Services.

Terminated provider. If you are currently receiving covered Services in one of the cases listed below under "Eligibility" from a Plan Hospital or a Plan Physician (or certain other providers) when our contract with the provider ends (for reasons other than medical disciplinary cause or criminal activity), you may be eligible for limited coverage of that terminated provider's Services.

Eligibility. The cases that are subject to this completion of Services provision are:

- Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration. We may cover these Services until the acute condition ends
- We may cover Services for serious chronic conditions until the earlier of (1) 12 months from your effective date of coverage if you are a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the first day after a course of treatment is complete when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non–Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
  - it persists without full cure
  - it worsens over an extended period of time
  - it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Care for children under age 3. We may cover completion of these Services until the earlier of (1) 12 months from the child's effective date of coverage if the child is a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the child's third birthday
- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of your effective date of coverage if you are a new Member or within 180 days of the termination date of the terminated provider

To qualify for this completion of Services coverage, all of the following requirements must be met:

- Your Health Plan coverage is in effect on the date you receive the Service
- For new Members, your prior plan's coverage of the provider's Services has ended or will end when your coverage with us becomes effective
- You are receiving Services in one of the cases listed above from a Non–Plan Provider on your effective date of coverage if you are a new Member, or from the terminated Plan Provider on the provider's termination date
- For new Members, when you enrolled in Health Plan, you did not have the option to continue with your previous health plan or to choose another plan (including an out-of-network option) that would cover the Services of your current Non–Plan Provider
- The provider agrees to our standard contractual terms and conditions, such as conditions pertaining to payment and to providing Services inside your Home Region's Service Area
- The Services to be provided to you would be covered Services under this *Evidence of Coverage* if provided by a Plan Provider
- You request completion of Services within 30 days (or as soon as reasonably possible) from your effective date of coverage if you are a new Member or from the termination date of the Plan Provider

Copayments and Coinsurance. The Copayments and Coinsurance for completion of Services are the Copayments and Coinsurance required for Services provided by a Plan Provider as described in the "Benefits, Copayments, and Coinsurance" section.

More information. For more information about this provision, or to request the Services or a copy of our "Completion of Covered Services" policy, please call our Member Service Call Center.

Second Opinions

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

Here are some examples of when a second opinion is Medically Necessary:

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

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

Copayments and Coinsurance. The Copayments and Coinsurance for these referral Services are the Copayments and Coinsurance required for Services provided by a Plan Provider as described in the "Benefits, Copayments, and Coinsurance" section.

Contracts with Plan Providers

How Plan Providers are paid

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

Financial liability

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

Termination of a Plan Provider's contract

If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered care you receive from that provider until we

make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements. You may be eligible to receive Services from a terminated provider; please refer to "Completion of Services from Non–Plan Providers" under "Getting a Referral" in this "How to Obtain Services" section.

Provider groups and hospitals. If you are assigned to a provider group or hospital whose contract with us terminates, or if you live within 15 miles of a hospital whose contract with us terminates, we will give you written notice at least 60 days before the termination (or as soon as reasonably possible).

Visiting Other Regions

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

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

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

Your ID Card

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

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

Getting Assistance

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

Member Services

Most Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, our Member Service Call Center representatives are available to assist you weekdays from 7 a.m. to 7 p.m. and weekends from 7 a.m. to 3 p.m. (except holidays) toll free at 800-464-4000 or 800-777-1370 (TTY for the deaf, hard of hearing, or speech impaired). For your convenience, you can also contact us through our website at **kp.org**.

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

Interpreter services

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

EMERGENCY SERVICES AND URGENT CARE

Emergency Services

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

Post-Stabilization Care

Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that this condition is Stabilized. We cover Post-Stabilization Care from a Non–Plan Provider, including inpatient care at a Non–Plan Hospital, only if we provide prior authorization for the care or if otherwise required by applicable law ("prior authorization" means that we must approve the Service in advance).

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

Be sure to ask the Non–Plan Provider to tell you what care (including any transportation) we have authorized because we will not cover unauthorized Post-Stabilization Care or related transportation provided by Non–Plan Providers.

We understand that extraordinary circumstances can delay your ability to call us to request authorization for Post-Stabilization Care from a Non–Plan Provider, for example, if a young child is without a parent or guardian present, or you are unconscious. In these cases, you must call us as soon as reasonably possible. Please keep in mind that anyone can call us for you. We do not cover any care you receive from Non–Plan Providers after your Emergency Medical Condition is Stabilized unless we authorize it, so if you don’t call as soon as reasonably possible, you increase the risk that you will have to pay for this care.

Copayments and Coinsurance

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

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

Services not covered under this "Emergency Services" section

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

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

Urgent Care

Inside the Service Area

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

Out-of-Area Urgent Care

If you have an Urgent Care need due to an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy), we cover Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health from a Non–Plan Provider if all of the following are true:

- You receive the Services from Non–Plan Providers while you are temporarily outside your Home Region's Service Area
- You reasonably believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to your Home Region's Service Area

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

Copayments and Coinsurance

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

- Please refer to "Outpatient Care" for the Copayments and Coinsurance for Urgent Care consultations and exams
- The Copayments and Coinsurance for other covered Urgent Care is the Copayments and Coinsurance that you would pay if the Services were not Urgent Care. For example, if the Urgent Care you receive includes an X-ray, your Copayments and Coinsurance for the X-ray would be the Copayments and

Coinsurance for an X-ray listed under "Outpatient Imaging, Laboratory, and Special Procedures"

Services not covered under this "Urgent Care" section

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

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

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider as described in this "Emergency Services and urgent Care: section, or emergency ambulance Services described under "Ambulance Services" in the "Benefits, Copayments, and Coinsurance" section, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us. Also, you may be required to pay and file a claim for any Services prescribed by a Non–Plan Provider as part of covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care even if you receive the Services from a Plan Provider, such as a Plan Pharmacy.

We will reduce any payment we make to you or the Non-Plan Provider by the applicable Copayments and Coinsurance.

How to file a claim

To file a claim for payment or reimbursement, this is what you need to do:

- As soon as possible, send us a completed claim form. You can get a claim form by visiting our website at kp.org or by calling our Member Service Call Center toll free at 1-800-464-4000 or 1-800-390-3510 (TTY users call 1-800-777-1370). One of our representatives will be happy to assist you if you need help completing our claim form
- If you have paid for Services, you must include any bills and receipts from the Non–Plan Provider with your claim form
- To request that we pay a Non–Plan Provider for Services, you must include any bills from the Non–Plan Provider with your claim form. If the Non–Plan Provider states that they will submit the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. If you later receive any bills from the Non–Plan Provider for covered Services (other than bills for your Copayment and Coinsurance amount), please call our Member Service Call Center toll free at 1-800-390-3510 for assistance
- The completed claim form and any bills or receipts must be mailed to the following address as soon as possible after receiving the care:

  For Northern California Members:
  Kaiser Foundation Health Plan, Inc.
  Claims Department
  P.O. Box 12923
  Oakland, CA 94604-2923

  For Southern California Members:
  Kaiser Foundation Health Plan, Inc.
  Claims Department
  P.O. Box 7004
  Downey, CA 90242-7004

If we ask you to provide information or complete a document in connection with your claim, you must send it to our Claims Department at the

address above. For example, we might request that you provide completed claim forms, consents for the release of medical records, assignments, claims for any other benefits to which you may be entitled, or verification of your travel or itinerary.

We will send you our written decision within 45 business days after we receive the claim unless we request additional information from you or the Non–Plan Provider. If we request additional information, we will send our written decision no later than 45 business days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in the letter, we will make our decision based on the information we have. If our decision is not fully in your favor, we will tell you the reasons and how to file a grievance as described under "Grievances" in the "Dispute Resolution" section.

BENEFITS, COPAYMENTS, AND COINSURANCE

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

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
  - health care items and services for preventive care
  - health care items and services for diagnosis, assessment, or treatment
  - other health care items and services
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except where specifically noted to the contrary in the sections listed below for the following Services:
  - emergency ambulance Services as described under "Ambulance Services" in this "Benefits, Copayments, and Coinsurance" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- You receive the Services from Plan Providers inside your Home Region's Service Area, except where specifically noted to the contrary in the sections listed below for the following Services:
  - authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
  - durable medical equipment as described under "Durable Medical Equipment for Home Use" in the "Benefits, Copayments, and Coinsurance" section
  - emergency ambulance Services as described under "Ambulance Services" in the "Benefits, Copayments, and Coinsurance" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
  - home health care as described under "Home Health Care" in the "Benefits, Copayments, and Coinsurance" section
  - hospice care as described under "Hospice Care" in this "Benefits, Copayments, and Coinsurance" section
  - ostomy and urological supplies as described under "Ostomy and Urological Supplies" in the "Benefits, Copayments, and Coinsurance" section
  - prosthetic and orthotic devices as described under "Prosthetic and Orthotic Devices" in the "Benefits, Copayments, and Coinsurance" section
- The Medical Group has given prior authorization for the Services if required under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

The only Services we cover under this *Evidence of Coverage* are those that this "Benefits, Copayments, and Coinsurance" section says that we cover, subject to exclusions and limitations described in this "Benefits, Copayments, and Coinsurance" section and to all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. The "Exclusions, Limitations, Coordination of Benefits, and Reductions" section describes exclusions, limitations, reductions, and

coordination of benefits provisions that apply to all Services that would otherwise be covered. When an exclusion or limitation applies only to a particular benefit, it is listed in the description of that benefit in this "Benefits, Copayments, and Coinsurance" section. Also, please refer to:

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

Copayments and Coinsurance

At the time you receive covered Services, you must pay the Copayments or Coinsurance in effect on that date, except as follows:

- If you are receiving covered inpatient hospital or Skilled Nursing Facility Services on the effective date of this *Evidence of Coverage*, you pay the Copayments or Coinsurance in effect on your admission date until you are discharged if the Services were covered under your prior Health Plan evidence of coverage and there has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Copayments or Coinsurance in effect on the date you receive the Services
- For items ordered in advance, you pay the Copayment or Coinsurance 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 or Coinsurance before 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
- Before starting or continuing a course of infertility Services, you may be required to pay initial and subsequent deposits toward your Copayment or Coinsurance for some or all of the entire course of Services, along with any past-due infertility-related Copayment or Coinsurance. Any unused portion of your deposit will be returned to you. When a deposit is not required, you must pay the Copayment or Coinsurance for the procedure, along with any past-due infertility-related Copayment or Coinsurance, before you can schedule an infertility procedure
- If you are receiving more than one Service from a provider, or Services from more than one provider, you may be required to pay separate Copayments or Coinsurance amounts for each Service and each provider. For example, if you receive both preventive Services in the same visit, you may have to pay separate Copayments or Coinsurance for each Service received during the visit. Similarly, if your physician requests the assistance of another provider during a procedure, you may have to pay separate Copayments or Coinsurance amounts for the Services provided by each provider. If you have questions about Copayments and Coinsurance, please contact our Member Service Call Center.
- In some cases, we may agree to bill you for your Copayments and Coinsurance amounts.

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

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

Annual out-of-pocket maximum

There is a limit to the total amount of Copayments and Coinsurance you must pay under this *Evidence of Coverage* in a calendar year for all of the covered Services listed below that you receive in the same calendar year.

The limit is one of the following amounts:

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

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

Payments that count toward the maximum. The Copayments and Coinsurance you pay for the following Services apply toward the annual out-of-pocket maximum except that Copayments and Coinsurance you pay for Services covered under “Infertility Services” in this “Benefits, Copayments, and Coinsurance” section do not apply to the annual out-of-pocket maximum:

- Diabetic testing supplies and equipment and insulin-administration devices
- Emergency Department visits
- Outpatient surgery
- Services performed during an office visit (including professional Services such as dialysis treatment, health education counseling and programs, and physical, occupational, and speech therapy)
- Skilled Nursing Facility care

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

Preventive Care Services

We cover a variety of preventive care Services, which are Services that do one or more of the following:

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

This “Preventive Care Services” section lists examples of preventive care Services, but it does not explain coverage. For example, we cover a preventive care Service that is an outpatient laboratory Service only if it is covered as described under the "Outpatient Imaging, Laboratory, and Special Procedures" section, subject to the "Exclusions, Limitations, Coordination of Benefits and Reductions" section.

The following preventive care Services are provided as described in other parts of this "Benefits, Copayments, and Coinsurance" section and all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section:

- Eye exams for refraction and preventive vision screenings
- Family planning counseling and programs
- Flexible sigmoidoscopies and colonoscopies
- Health education counseling and programs
- Hearing exams and screenings
- Immunizations (including vaccines) administered in a Plan Medical Office
- Preventive counseling, such as STD preventions counseling
- Routine preventive imaging services, such as the following:
  - abdominal aortic aneurysm screening
  - bone density scans
- Routine physical maintenance exams, including well-woman exams
- Routine preventive retinal photography screenings
- Scheduled prenatal care exams and first postpartum follow-up consultation and exam
- Tuberculosis tests
- Well-child preventive care exams (0–23 months)
- The following routine preventive laboratory tests and screenings:
  - cervical cancer screenings
  - cholesterol tests (lipid panel and profile)
  - diabetes screening (fasting blood glucose tests)
  - fecal occult blood tests
  - HIV tests
  - prostate specific antigen tests
  - certain sexually transmitted diseases (STD) tests

If you receive both preventive and non-preventive Services in the same visit, you may have to pay separate Copayments and Coinsurance amounts for each Service received during that visit. For example, if you go in for a preventive exam, and your physician diagnoses you with an infection, you may have to pay separate Copayments and Coinsurance amount for both the preventive exam and for the Services performed to diagnose a condition.

For preventive screening tests and vaccines that Plan Physicians recommend for generally healthy people, please refer to "Preventive Screenings and Vaccines" in the appendix to this *Evidence of Coverage*. For more information about preventive care guidelines, as well as recommended lifestyle practices, please refer to *Your Guidebook to Kaiser Permanente Services*, or visit our website at **kp.org**.

Outpatient Care

We cover the following outpatient care subject to the Copayment or Coinsurance indicated:

- Primary and specialty care consultations, exams and treatment (other than those described below in this "Outpatient Care" section): **a $15 Copayment per visit**
- Routine preventive physical maintenance exams, including well-woman exams: **no charge**
- Well-child preventive exams for Members through age 23 months: **no charge**
- Family planning counseling, or to obtain internally implanted time-release contraceptives, or intrauterine devices (IUDs) prescribed in accord with our drug formulary guidelines: **a $15 Copayment per visit**
- After confirmation of pregnancy, the normal series of regularly scheduled preventive

prenatal care exams and the first postpartum follow-up consultation and exam: **no charge**

- Alcohol and substance abuse screenings: **no charge**
- Developmental screenings to diagnose and assess potential development delays: **no charge**
- Immunizations (including vaccines) administered to you in a Plan Medical Office: **no charge**
- Flexible sigmoidoscopies: **no charge**
- Colonoscopies: **no charge**
- Allergy injection(including allergy serum): **no charge**
- Outpatient surgery and other outpatient procedures: **a $15 Copayment per procedure**
- Voluntary termination of pregnancy: **a $15 Copayment per procedure**
- Physical, occupational, and speech therapy: **a $15 Copayment per visit**
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program: **a $15 Copayment per day**
- Acupuncture Services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain): **a $15 Copayment per visit**
- Urgent Care consultations and exams: **a $15 Copayment per visit**
- Emergency Department visits: **a $50 Copayment per visit**. The Emergency Department Copayment does not apply if you are admitted directly to the hospital as an inpatient for covered Services or if you are admitted for observation in a hospital unit outside the Emergency Department
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside your Home Region's Service Area when care can best be provided in your home as determined by a Plan Physician: **no charge**
- Blood, blood products, and their administration: **no charge**
- Administered drugs (drugs, injectables, radioactive materials used for therapeutic purposes, and allergy test and treatment materials) prescribed in accord with our drug formulary guidelines, if administration or observation by medical personnel is required and they are administered to you in a Plan Medical Office or during home visits: **no charge**
- Some types of outpatient consultations and exams may be available as group appointments, which we cover at **a $7 Copayment per visit**

Services not covered under this "Outpatient Care" section

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

- Bariatric Surgery
- Chemical Dependency Services
- Dental and Orthodontic Services
- Dialysis Care
- Durable Medical Equipment for Home Use
- Health Education
- Hearing Services
- Home Health Care
- Hospice Care
- Infertility Services
- Mental Health Services
- Ostomy and Urological Supplies
- Outpatient Imaging, Laboratory, and Special Procedures

- Outpatient Prescription Drugs, Supplies, and Supplements
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Transplant Services
- Vision Services

Hospital Inpatient Care

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

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

Services not covered under this "Hospital Inpatient Care" section

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

- Bariatric Surgery
- Chemical Dependency Services
- Dental and Orthodontic Services
- Dialysis Care
- Hospice Care
- Infertility Services
- Mental Health Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Skilled Nursing Facility Care
- Transplant Services

Ambulance Services

Emergency

We cover at **no charge** emergency Services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency

response system where available) if one of the following is true:

- You reasonably believe that you have an Emergency Medical Condition and you reasonably believe that your condition requires the clinical support of ambulance transport services
- Your treating physician determines that you must be transported to another facility because your emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

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

Nonemergency

Inside your Home Region's Service Area, we cover nonemergency ambulance and psychiatric transport van Services at **no charge** if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to or from covered Services.

Ambulance Services exclusion

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

Bariatric Surgery

We cover hospital inpatient care related to bariatric surgical procedures (including room and board, imaging, laboratory, special procedures, and Plan Physician Services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

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

For covered Services related to bariatric surgical procedures that you receive, you will pay the **Copayments and Coinsurance you would pay if the Services were not related to a bariatric surgical procedure**.

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

- Transportation for you to and from the facility up to $130 per round trip for a maximum of three trips (one pre-surgical visit, the surgery, and one follow-up visit), including any trips for which we provided reimbursement under any other evidence of coverage offered by your Group
- Transportation for one companion to and from the facility up to $130 per round trip for a maximum of two trips (the surgery and one follow-up visit), including any trips for which

we provided reimbursement under any other evidence of coverage offered by your Group

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

Services not covered under this "Bariatric Surgery" section

Coverage for the following Services is described under these headings in this "Benefits, Copayments, and Coinsurance" section:

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

Chemical Dependency Services

Inpatient detoxification

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

Outpatient chemical dependency care

We cover the following Services for treatment of chemical dependency:

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

You pay the following for these covered Services:

- Individual chemical dependency consultations and treatment: **a $15 Copayment per visit**
- Group chemical dependency treatments: **a $5 Copayment per visit**

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

Transitional residential recovery Services

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

Services not covered under this "Chemical Dependency Services" section

Coverage for the following Services is described under these headings in this “Benefits, Copayments, and Coinsurance” section:

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

Chemical dependency Services exclusion

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

Dental and Orthodontic Services

We do not cover most dental and orthodontic Services, but we do cover some dental and orthodontic Services as described in this "Dental and Orthodontic Services" section.

Dental Services for radiation treatment

We cover dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck at **a $15 Copayment per visit** if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental anesthesia

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

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

We do not cover any other Services related to the dental procedure, such as the dentist's Services.

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

Dental and orthodontic Services for cleft palate

We cover dental extractions, dental procedures necessary to prepare the mouth for an extraction, and orthodontic Services, if they meet all of the following requirements:

- The Services are an integral part of a reconstructive surgery for cleft palate that we are covering under "Reconstructive Surgery" in this "Benefits, Copayments, and Coinsurance" section
- A Plan Provider provides the Services or the Medical Group authorizes a referral to a Non-Plan Provider who is a dentist or orthodontist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section)

You pay the following for these dental and orthodontic Services for cleft palate:

- Office visits: **no charge**
- Hospital inpatient care: **no charge**
- Outpatient surgery and other outpatient procedures: **a $15 Copayment per visit**

Services not covered under this "Dental and Orthodontic Services" section

Coverage for the following Services is described under these headings in this "Benefits, Copayments, and Coinsurance" section:

- Outpatient imaging, laboratory, and special procedures (refer to "Outpatient Imaging, Laboratory, and Special Procedures")
- Outpatient administered drugs (refer to "Outpatient Care"), except that we cover outpatient administered drugs under "Dental anesthesia" in this "Dental and Orthodontic Services" section
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Dialysis Care

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

- The Services are provided inside your Home Region's Service Area
- You satisfy all medical criteria developed by the Medical Group and by the facility providing the dialysis
- A Plan Physician provides a written referral for care at the facility

After you receive appropriate training at a dialysis facility we designate, we also cover equipment, and medical supplies required for home hemodialysis and home peritoneal dialysis inside your Home Region's Service Area at **no charge.** Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or purchase the equipment and supplies, and we select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when we are no longer covering them.

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

- Inpatient dialysis care: **no charge**
- One routine office consultation or exam per month with the multidisciplinary nephrology team: **no charge**
- All other consultations or exams: **a $15 Copayment per visit**
- Hemodialysis treatment at a Plan Facility: **no charge**

Services not covered under this "Dialysis Care" section

Coverage for the following Services is described under these headings in this "Benefits, Copayments, and Coinsurance" section:

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

Dialysis Care exclusions

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

Durable Medical Equipment for Home Use

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

Coverage is limited to the standard item of equipment that adequately meets your medical needs. Covered durable medical equipment, (including repair or replacement of covered equipment, unless due to loss or misuse), is provided at **no charge**. We decide whether to rent

or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.

Durable medical equipment for diabetes

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

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

About our durable medical equipment formulary

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

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

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

Coverage for the following Services is described under these headings in this "Benefits, Copayments, and Coinsurance" section:

- Dialysis equipment and supplies required for home hemodialysis and home peritoneal dialysis (refer to "Dialysis Care")
- Diabetes urine-testing supplies and insulin-administration devices other than insulin pumps (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Durable medical equipment related to the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")

Durable medical equipment for home use exclusions

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

Health Education

We cover a variety of health education counseling programs, and materials that your

personal Plan Physician or other Plan Providers provide during a visit covered under another part of this "Benefits, Copayments and Coinsurance" section.

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

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

You pay the following for these covered Services:

- Covered health education programs, which may include programs provided online and counseling over the phone: **no charge**
- Individual counseling during an office visit related to smoking cessation: **no charge**
- Individual counseling during an office visit related to diabetes management: **a $15 Copayment per visit**
- Other covered individual counseling when the office visit is solely for health education: **a $15 Copayment per visit**
- Health education provided during an outpatient consultation or exam covered in another part of this "Benefits, Copayments and Coinsurance" section: **no additional Copayment or Coinsurance beyond the Copayment and Coinsure required in that other part of this "Benefits, Copayments, and Coinsurance" section**
- Covered health education materials: **no charge**

Hearing Services

We cover the following:

- Routine preventive hearing screenings: **no charge**
- Hearing exams to determine the need for hearing correction: **no charge**
- Hearing tests to determine the appropriate hearing aid: **no charge**
- A **$1,000 Allowance** toward the purchase price of hearing aid(s) every 36 months when prescribed by a Plan Physician or by a Plan Provider who is an audiologist. We will cover hearing aids for both ears only if both aids are required to provide significant improvement that is not obtainable with only one hearing aid. We will not provide the Allowance if we have provided an Allowance toward (or otherwise covered) a hearing aid for that ear within the previous 36 months. Also, the Allowance can only be used at the initial point of sale. If you do not use all of your Allowance at the initial point of sale, you cannot use it later
- Visits to verify that the hearing aid conforms to the prescription: **no charge**
- Visits for fitting, counseling, adjustment, cleaning, and inspection after the warranty is exhausted: **no charge**

We select the provider or vendor that will furnish the covered hearing aid. Coverage is limited to the types and models of hearing aids furnished by the provider or vendor.

Services not covered under this "Hearing Services" section

Coverage for the following Services is described under these headings in this “Benefits, Copayments, and Coinsurance” section:

- Services related to the ear or hearing other than those described in this section (refer to

the applicable heading in this "Benefits, Copayments, and Coinsurance" section)

- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")

Hearing Services exclusions

- Internally implanted hearing aids
- Replacement parts and batteries, repair of hearing aids, and replacement of lost or broken hearing aids (the manufacturer warranty may cover some of these)

Home Health Care

"Home health care" means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists. We cover home health care at **no charge** only if all of the following are true:

- You are substantially confined to your home (or a friend's or relative's home)
- Your condition requires the Services of a nurse, physical therapist, occupational therapist, or speech therapist (home health aide Services are not covered unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide)
- A Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home and that the Services can be safely and effectively provided in your home
- The Services are provided inside California

The Medical Group must authorize any home health nursing or other care of at least eight continuous hours, in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section (that authorization procedure does not apply to home health nursing or other care of less than eight continuous hours).

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

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

Home health care exclusions

Care of a type that an unlicensed family member or other layperson could provide safely and effectively in the home setting after receiving appropriate training. This care is excluded even if we would cover the care if it were provided by a qualified medical professional in a hospital or a Skilled Nursing Facility

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

Hospice Care

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

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

- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The Services are provided inside your Home Region's Service Area or inside California but within 15 miles or 30 minutes from your Home Region's Service Area (including a friend's or relative's home even if you live there temporarily)
- The Services are provided by a licensed hospice agency that is a Plan Provider
- The Services are necessary for the palliation and management of your terminal illness and related conditions

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

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, or speech therapy for purposes of symptom control or to enable you to maintain activities of daily living
- Respiratory therapy
- Medical social services
- Home health aide and homemaker services
- Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from Plan Pharmacies. Certain drugs are limited to a maximum 30-day supply in any 30-day period (please call our Member Service Call Center for the current list of these drugs)
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling
- The following care during periods of crisis when you need continuous care to achieve palliation or management of acute medical symptoms:
  - nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home
  - short-term inpatient care required at a level that cannot be provided at home

Infertility Services

We cover the following Services related to involuntary infertility at **50% Coinsurance**:

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

Services not covered under this "Infertility Services" section

Coverage for the following Services is described under these headings in this "Benefits, Copayments, and Coinsurance" section:

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

Infertility Services exclusions

- Services to reverse voluntary, surgically induced infertility

- Semen and eggs (and Services related to their procurement and storage)

Mental Health Services

We cover Services specified in this "Mental Health Services" section only when the Services are for the diagnosis or treatment of Mental Disorders.

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

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

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

Outpatient mental health Services

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

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

You pay the following for these covered Services:

- Individual mental health evaluation and treatment: **a $15 Copayment per visit**
- Group mental health treatment: **a $7 Copayment per visit**

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

Inpatient psychiatric hospitalization and intensive psychiatric treatment programs

Inpatient psychiatric hospitalization. We cover inpatient psychiatric hospitalization in a Plan Hospital. Coverage includes room and board, drugs, and Services of Plan Physicians and other Plan Providers who are licensed health care professionals acting within the scope of their license. We cover these Services at **no charge**.

Intensive psychiatric treatment programs. We cover at **no charge** the following intensive psychiatric treatment programs at a Plan Facility:

- Short-term hospital-based intensive outpatient care (partial hospitalization)
- Short-term multidisciplinary treatment in an intensive outpatient psychiatric treatment program
- Short-term treatment in a crisis residential program in licensed psychiatric treatment facility with 24-hour-a-day monitoring by clinical staff for stabilization of an acute psychiatric crisis
- Psychiatric observation for an acute psychiatric crisis

Services not covered under this "Mental Health Services" section

Coverage for the following Services is described under these headings in this “Benefits, Copayments, and Coinsurance” section:

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

Ostomy and Urological Supplies

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

About our soft goods formulary

Our soft goods formulary includes the list of ostomy and urological supplies that have been approved by our Soft Goods Formulary Executive Committee for our Members. Our Soft Goods Formulary Executive Committee is responsible for reviewing and revising the soft goods formulary. Our soft goods formulary is periodically updated to keep pace with changes in medical technology and clinical practice.

To find out whether a particular ostomy or urological supply is included in our soft goods formulary, please call our Member Service Call Center.

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

Ostomy and urological supplies exclusion

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Special Procedures

We cover the following Services at the Copayment or Coinsurance indicated only when prescribed as part of care covered under other headings in this “Benefits, Copayments, and Coinsurance” section:

- Diagnostic and therapeutic imaging, such as X-rays, mammograms, and ultrasound: **no charge** except that certain imaging procedures are covered at **a $15 Copayment per procedure** if they are provided in an outpatient or ambulatory surgery center or in a

hospital operating room, or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort.

- Preventive imaging, such as preventive mammograms, aortic aneurysm screenings, and bone density screenings: **no charge**
- Nuclear medicine: **no charge**
- Laboratory tests (including tests for specific genetic disorders for which genetic counseling is available):
  - laboratory tests to monitor the effectiveness of dialysis: **no charge**
  - fecal occult blood tests: **no charge**
  - routine preventive laboratory tests and screenings, such as preventive cervical cancer screenings, prostate specific antigen tests, cholesterol tests (lipid panel and profile), diabetes screening (fasting blood glucose tests), certain sexually transmitted disease (STD) tests, and HIV tests: **no charge**
  - all other laboratory tests: **no charge**
- Routine preventive retinal photography screenings: **no charge**
- All other diagnostic procedures provided by Plan Providers who are not physicians (such as EKGs and EEGs): **no charge** except that certain diagnostic procedures are covered at **a $15 Copayment per procedure** if they are provided in an outpatient or ambulatory surgery center or in a hospital operating room, or if they are provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort
- Radiation therapy: **no charge**
- Ultraviolet light treatments: **no charge**

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

Coverage for the following Services is described under these headings in this “Benefits, Copayments, and Coinsurance” section:

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

Outpatient Prescription Drugs, Supplies, and Supplements

We cover outpatient drugs, supplies, and supplements specified in this “Outpatient Prescription Drugs, Supplies, and Supplements” section when prescribed as follows and obtained through a Plan Pharmacy or our mail-order service:

- Items prescribed by Plan Physicians in accord with our drug formulary guidelines
- Items prescribed by the following Non–Plan Providers unless a Plan Physician determines that the item is not Medically Necessary or the drug is for a sexual dysfunction disorder:
  - Dentists if the drug is for dental care
  - Non–Plan Physicians if the Medical Group authorizes a written referral to the Non–Plan Physician (in accord with “Medical Group authorization procedure for certain referrals” under “Getting a Referral” in the “How to Obtain Services” section) and the drug, supply, or supplement is covered as part of that referral
  - Non–Plan Physicians if the prescription was obtained as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the “Emergency Services and Urgent Care” section (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described under “Payment and Reimbursement” in the

"Emergency Services and Urgent Care" section)

How to obtain covered items

You must obtain covered drugs, supplies, and supplements from a Plan Pharmacy or through our mail-order service unless the item is covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section.

Please refer to *Your Guidebook* for the locations of Plan Pharmacies in your area.

Refills. You may be able to order refills from a Plan Pharmacy, our mail-order service, or through our website at **kp.org/rxrefill**. A Plan Pharmacy or *Your Guidebook* can give you more information about obtaining refills, including the options available to you for obtaining refills. For example, a few Plan Pharmacies don't dispense refills and not all drugs can be mailed through our mail-order service. Please check with your local Plan Pharmacy if you have a question about whether or not your prescription can be mailed or obtained from a Plan Pharmacy. Items available through our mail-order service are subject to change at any time without notice.

Outpatient drugs, supplies, and supplements

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

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

Copayments and Coinsurance for outpatient drugs, supplies, and supplements. The Copayments and Coinsurance for these items are as follows:

- Generic items:
  - **a $5 Copayment** for up to a 30-day supply, **a $10 Copayment** for a 31- to 60-day supply, or **a $15 Copayment** for a 61- to 100-day supply at a Plan Pharmacy
  - **a $5 Copayment** for up to a 30-day supply or **a $10 Copayment** for a 31- to 100-day supply through our mail-order service
  - drugs prescribed for the treatment of sexual dysfunction disorders: **50 % Coinsurance** for up to a 100-day supply at a Plan Pharmacy or through our mail order service
  - drugs prescribed for the treatment of infertility: **50% Coinsurance** for up to a 100-day supply at a Plan Pharmacy or through our mail order service
- Brand-name items and compounded products:
  - **a $20 Copayment** for up to a 30-day supply, **a $40 Copayment** for a 31- to 60-day supply, or **a $60 Copayment** for a 61- to 100-day supply at a Plan Pharmacy
  - **a $20 Copayment** for up to a 30-day supply or **a $40 Copayment** for a 31- to 100-day supply through our mail-order service
  - drugs prescribed for the treatment of sexual dysfunction disorders: **50 % Coinsurance** for up to a 100-day supply at a Plan Pharmacy or through our mail order service
  - drugs prescribed for the treatment of infertility: **50% Coinsurance** for up to a 100-day supply at a Plan Pharmacy or through our mail order service

- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria) and elemental dietary enteral formula when used as a primary therapy for regional enteritis: **no charge** for up to a
  30-day supply
- Emergency contraceptive pills: **no charge**
- Hematopoietic agents for dialysis: **no charge** for up to a 30-day supply
- Continuity drugs (if this *Evidence of Coverage* is amended to exclude a drug that we have been covering and providing to you under this *Evidence of Coverage*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the U.S. Food and Drug Administration): **50% Coinsurance** for up to a 30-day supply in a 30-day period

Note: If Charges for the drug, supply, or supplement are less than the Copayment, you will pay the lesser amount.

Certain intravenous drugs, supplies, and supplements

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

Note: Injectable drugs, insulin, and drugs for the diagnosis and treatment of infertility are not covered under this paragraph (instead, refer to the "Outpatient drugs, supplies, and supplements" paragraph).

Diabetes urine-testing supplies and insulin-administration devices

We cover ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing at **no charge** for up to a 100-day supply.

We cover the following insulin-administration devices at **a $5 Copayment** for up to a 100-day supply: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear).

Day supply limit

The prescribing physician or dentist determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, Plan Physicians determine the amount of an item that constitutes a Medically Necessary 30-, 60-, or 100-day supply for you. Upon payment of the Copayments and Coinsurance specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section, you will receive the supply prescribed up to the day supply limit also specified in this section. The day supply limit is either a 30-day supply in a 30-day period or a 100-day supply in a 100-day period. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantities that exceed the day supply limit. Note: We cover episodic drugs prescribed for the treatment of sexual dysfunction disorders up to a maximum of 8 doses in any 30-day period or 27 doses in any 100-day period.

The pharmacy may reduce the day supply dispensed at the Copayment or Coinsurance specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your Plan Pharmacy can tell you if a drug you take is one of these drugs).

About our drug formulary

Our drug formulary includes the list of drugs that have been approved by our Pharmacy and Therapeutics Committee for our Members. Our Pharmacy and Therapeutics Committee, which is primarily composed of Plan Physicians, selects drugs for the drug formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature. The Pharmacy and Therapeutics Committee meets quarterly to consider additions and deletions based on new information or drugs that become available.

If you would like to request a copy of our drug formulary, please call our Member Service Call Center. Note: The presence of a drug on our drug formulary does not necessarily mean that your Plan Physician will prescribe it for a particular medical condition.
Our drug formulary guidelines allow you to obtain nonformulary prescription drugs (those not listed on our drug formulary for your condition) if they would otherwise be covered and a Plan Physician determines that they are Medically Necessary. If you disagree with your Plan Physician's determination that a nonformulary prescription drug is not Medically Necessary, you may file a grievance as described in the "Dispute Resolution" section. Also, our formulary guidelines may require you to participate in a behavioral intervention program approved by the Medical Group for specific conditions and you may be required to pay for the program.

Services not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section

Coverage for the following Services is described under these headings in this "Benefits, Copayments, and Coinsurance" section:

- Diabetes blood-testing equipment and their supplies, and insulin pumps and their supplies (refer to "Durable Medical Equipment for Home Use")
- Durable medical equipment used to administer drugs (refer to "Durable Medical Equipment for Home Use")
- Outpatient administered drugs (refer to "Outpatient Care")
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Care" and "Skilled Nursing Facility Care")
- Drugs prescribed for pain control and symptom management of the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")

Outpatient prescription drugs, supplies, and supplements exclusions

- Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging
- Compounded products unless the drug is listed on our drug formulary or one of the ingredients requires a prescription by law
- Drugs prescribed to shorten the duration of the common cold

Prosthetic and Orthotic Devices

For Members who live inside California, we cover the prosthetic and orthotic devices specified in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

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

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

Internally implanted devices

We cover prosthetic and orthotic devices, such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if they are implanted during a surgery that we are covering under another section of this "Benefits, Copayment and Coinsurance" section. We cover these devices at **no charge**.

External devices

We cover the following external prosthetic and orthotic devices at **no charge**:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary and up to three brassieres required to hold a prosthesis every 12 months
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect
- Other covered prosthetic and orthotic devices:
  - prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity
  - rigid and semi-rigid orthotic devices required to support or correct a defective body part
  - covered special footwear when custom made for foot disfigurement due to disease, injury, or developmental disability

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

Coverage for the following Services is described under these headings in this “Benefits, Copayments, and Coinsurance” section:

- Eyewear following cataract surgery (refer to “Vision Services”)
- Contact lenses to treat aniridia or aphakia (refer to “Outpatient Care”).
- Hearing aids other than internally implanted devices described in this section (refer to “Hearing Services”)

Prosthetic and orthotic devices exclusions

- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Except as otherwise described above in this “Prosthetic and Orthotic Devices” section, nonrigid supplies, such as elastic stockings and wigs
- Comfort, convenience, or luxury equipment or features
- Shoes or arch supports, even if custom-made, except footwear described above in this “Prosthetic and Orthotic Devices” section for diabetes-related complications and foot disfigurement

Reconstructive Surgery

We cover the following reconstructive surgery Services:

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

You pay the following for covered reconstructive surgery Services:

- Consultations and exams: **a $15 Copayment per visit**
- Outpatient surgery: **a $15 Copayment per procedure**
- Hospital inpatient care (including room and board, drugs, and Plan Physician Services): **no charge**

Services not covered under this "Reconstructive Surgery" section

Coverage for the following Services is described under these headings in this “Benefits, Copayments, and Coinsurance” section

- Dental and orthodontic Services that are an integral part of reconstructive surgery for cleft palate (refer to “Dental and Orthodontic Services”)
- Outpatient imaging and laboratory (refer to “Outpatient Imaging, Laboratory, and Special Procedures”)
- Outpatient prescription drugs (refer to “Outpatient Prescription Drugs, Supplies, and Supplements”)
- Outpatient administered drugs (refer to “Outpatient Care”)
- Prosthetics and orthotics (refer to “Prosthetic and Orthotic Devices”)

Reconstructive surgery exclusions

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

Services Associated with Clinical Trials

We cover Services associated with cancer clinical trials if all of the following requirements are met:

- You are diagnosed with cancer
- You are accepted into a phase I, II, III, or IV clinical trial for cancer
- Your treating Plan Physician, or your treating Non–Plan Physician if the Medical Group authorizes a written referral to the Non–Plan Physician for treatment of cancer (in accord with “Medical Group authorization procedure for certain referrals” under “Getting a Referral” in the “How to Obtain Services” section), recommends participation in the clinical trial after determining that it has a meaningful potential to benefit you
- The Services would be covered under this *Evidence of Coverage* if they were not provided in connection with a clinical trial
- The clinical trial has a therapeutic intent, and its end points are not defined exclusively to test toxicity
- The clinical trial involves a drug that is exempt under federal regulations from a new drug application, or the clinical trial is approved by: one of the National Institutes of Health, the U.S. Food and Drug

Administration (in the form of an investigational new drug application), the U.S. Department of Defense, or the U.S. Department of Veterans Affairs

For covered Services related to a clinical trial, you will pay the **Copayments and Coinsurance you would pay if the Services were not related to a clinical trial**.

Services associated with clinical trials exclusions

- Services that are provided solely to satisfy data collection and analysis needs and are not used in your clinical management
- Services that are customarily provided by the research sponsors free of charge to enrollees in the clinical trial

Skilled Nursing Facility Care

Inside your Home Region's Service Area, we cover at **no charge** up to 100 days per benefit period (including any days we covered under any other evidence of coverage offered by your Group) of skilled inpatient Services in a Plan Skilled Nursing Facility. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care. A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility, receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required.

We cover the following Services:

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

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

Coverage for the following Services is described under these headings in this "Benefits, Copayments, and Coinsurance" section:

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

Transplant Services

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

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

- If either the Medical Group or the referral facility determines that you do not satisfy its

respective criteria for a transplant, we will only cover Services you receive before that determination is made

- Health Plan, Plan Hospitals, the Medical Group, and Plan Physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with our guidelines for Services for living transplant donors, we provide certain donation-related Services for a donor, or an individual identified by the Medical Group as a potential donor, whether or not the donor is a Member. These Services must be directly related to a covered transplant for you, which may include certain Services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Our guidelines for donor Services are available by calling our Member Service Call Center

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

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

Services not covered under this "Transplant Services" section

Coverage for the following Services is described under these headings in this “Benefits, Copayments, and Coinsurance” section:

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

Vision Services

We cover the following:

- Routine preventive vision screenings: **no charge**
- Eye exams for refraction to determine the need for vision correction and to provide a prescription for eyeglass lenses: **no charge**

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

- Up to two Medically Necessary contact lenses, fitting, and dispensing per eye every 12 months (including lenses we covered under any other evidence of coverage offered by your Group) to treat aniridia (missing iris): **no charge**
- Up to six Medically Necessary aphakic contact lenses, fitting, and dispensing per eye per calendar year (including lenses we covered under any other evidence of coverage offered by your Group) to treat aphakia (absence of the crystalline lens of the eye) for Members through age 9: **no charge**

Eyeglasses and contact lenses following cataract surgery. In accord with Medicare guidelines, we provide at **no charge** one pair of eyeglasses or contact lenses after each cataract surgery that includes insertion of an intraocular lens at Plan Medical Offices or Plan Optical Sales Offices when prescribed by a physician or optometrist. Also, we provide corrective lenses and frames (and replacements) needed after a cataract removal without a lens implant. If the eyewear you purchase costs more than what Medicare covers for someone who has Original

Medicare (also known as "Fee-for-Service Medicare"), you pay the difference

Services not covered under this "Vision Services" section

Coverage for the following Services is described under other headings in this "Benefits, Copayments, and Coinsurance" section:

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

Vision Services exclusions

- Industrial frames
- Services for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism
- Eyeglass lenses and frames (except for eyewear following cataract surgery, as described under this "Vision Services" section)
- Contact lenses, including fitting and dispensing (except for contact lenses to treat aphakia or aniridia, and contact lenses following cataract surgery, as described under this "Vision Services" section)
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Low vision devices

EXCLUSIONS, LIMITATIONS, COORDINATION OF BENEFITS, AND REDUCTIONS

Exclusions

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

Certain exams and Services

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

Conception by artificial means

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

Cosmetic Services

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

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

Custodial care

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

This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice, skilled Nursing Facility, or inpatient hospital care.

Dental and Orthodontic Services

Dental and orthodontic Services such as X-rays, appliances, implants, Services provided by dentists or orthodontists, dental Services following accidental injury to teeth, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment.

This exclusion does not apply to Services covered under "Dental and Orthodontic Services" in the "Benefits, Copayments, and Coinsurance" section.

Disposable supplies

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

This exclusion does not apply to disposable supplies covered under "Durable Medical Equipment for Home Use," "Home Health Care," "Hospice Care," "Ostomy and Urological Supplies," and "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits, Copayments, and Coinsurance" section.

Experimental or investigational Services

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

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

This exclusion does not apply to any of the following.

- Experimental or investigational Services when an investigational application has been filed with the U.S. Food and Drug Administration (FDA) and the manufacturer or other source makes the Services available to you or Kaiser Permanente through an FDA-authorized procedure, except that we do not cover Services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol
- Services covered under "Services Associated with Clinical Trials" in the "Benefits, Copayments, and Coinsurance" section

Please refer to the "Dispute Resolution" section for information about Independent Medical Review related to denied requests for experimental or investigational Services.

Hair loss or growth treatment

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

Intermediate care

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

Items and services that are not health care items and services

For example, we do not cover:

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

Massage therapy

Oral nutrition

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

This exclusion does not apply to any of the following:

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

Residential care

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

Routine foot care items and services

Routine foot care items and services that are not Medically Necessary.

Services not approved by the U.S. Food and Drug Administration

Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other Services that by law require U.S. 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.

This exclusion does not apply to any of the following:

- Services covered under the "Emergency Services and Urgent Care" section that you receive outside the U.S.
- Experimental or investigational Services when an investigational application has been filed with the FDA and the manufacturer or other source makes the Services available to you or Kaiser Permanente through an FDA-authorized procedure, except that we do not cover Services that are customarily provided by research sponsors free of charge to enrollees in a clinical trial or other investigational treatment protocol
- Services covered under "Services Associated with Clinical Trials" in the "Benefits, Copayments, and Coinsurance" section

Please refer to the "Dispute Resolution" section for information about Independent Medical Review related to denied requests for experimental or investigational Services.

Services performed by unlicensed people

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

Services related to a noncovered Service

When a Service is not covered, all Services related to the noncovered Service are excluded, except for Services we would otherwise cover to treat complications of the noncovered Service. For example, if you have a noncovered cosmetic surgery, we would not cover Services you receive in preparation for the surgery or for follow-up

care. If you later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and we would cover any Services that we would otherwise cover to treat that complication.

Surrogacy

Services for anyone in connection with a surrogacy arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. A surrogacy arrangement is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child. Please refer to "Surrogacy arrangements" under "Reductions" in this "Exclusions, Limitations, Coordination of Benefits, and Reductions" section for information about your obligations to us in connection with a surrogacy arrangement, including your obligation to reimburse us for any Services we cover.

Transgender surgery

Travel and lodging expenses

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

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

Limitations

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

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

Coordination of Benefits

The Services covered under this *Evidence of Coverage* are subject to coordination of benefits rules.

Coverage other than Medicare coverage

If you have medical or dental coverage under another plan, we will coordinate benefits with the other coverage under the coordination of benefits rules of the California Department of Managed Health Care. Those rules are incorporated into this *Evidence of Coverage*.

If both the other coverage and we cover the same Service, the other coverage and we will see that up to 100 percent of your covered medical expenses are paid for that Service. The coordination of benefits rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." The secondary coverage may reduce its payment to take into account payment by the primary

coverage. You must give us any information we request to help us coordinate benefits.

If your coverage under this *Evidence of Coverage* is secondary, we may be able to establish a Benefit Reserve Account for you. You may draw on the Benefit Reserve Account during a calendar year to pay for your out-of-pocket expenses for Services that are partially covered by either your other coverage or us during that calendar year. If you are entitled to a Benefit Reserve Account, we will provide you with detailed information about this account.

If you have any questions about coordination of benefits, please call our Member Service Call Center.

Medicare coverage

If you have Medicare coverage, we will coordinate benefits with the Medicare coverage under Medicare rules. Medicare rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." You must give us any information we request to help us coordinate benefits. Please call our Member Service Call Center to find out which Medicare rules apply to your situation, and how payment will be handled.

Reductions

Employer responsibility

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

Government agency responsibility

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

Injuries or illnesses alleged to be caused by third parties

If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered Services, you must pay us Charges for those Services, except that the amount you must pay will not exceed the maximum amount allowed under California Civil Code Section 3040.

Note: This “Injuries or illnesses alleged to be caused by third parties” section does not affect your obligation to pay Copayments and Coinsurance for these Services, but we will credit any such payments toward the amount you must pay us under this paragraph.

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

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

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

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

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

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

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

If you have Medicare, Medicare law may apply with respect to Services covered by Medicare.

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers ordinarily charge to the general public ("General Fees"). However, these contracts may allow the providers to recover all or a portion of the difference between the fees paid by Kaiser Permanente and their General Fees by means of a lien claim under California Civil Code Sections 3045.1-3045.6 against a judgment or settlement that you receive from or on behalf of a third party. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

Medicare benefits

Your benefits are reduced by any benefits you have under Medicare except for Members whose Medicare benefits are secondary by law.

Surrogacy arrangements

If you enter into a surrogacy arrangement, you must pay us Charges for covered Services you receive related to conception, pregnancy, or delivery in connection with that arrangement ("Surrogacy Health Services"), except that the amount you must pay will not exceed the compensation you are entitled to receive under the surrogacy arrangement. A surrogacy arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

Note: This "Surrogacy arrangements" section does not affect your obligation to pay Copayments and Coinsurance for these Services, but we will credit any such payments toward the amount you must pay us under this paragraph.

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or your chosen payee under the surrogacy arrangement,

regardless of whether those payments are characterized as being for medical expenses.

To secure our rights, we will also have a lien on those payments. Those payments shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

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

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

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

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

U.S. Department of Veterans Affairs

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

Workers' compensation or employer's liability benefits

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

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

DISPUTE RESOLUTION

Grievances

We are committed to providing you with quality care and with a timely response to your concerns. You can discuss your concerns with our Member Services representatives at most Plan Facilities, or you can call our Member Service Call Center.

You can file a grievance for any issue. Here are some examples of reasons you might file a grievance:

- You are not satisfied with the quality of care you received
- You received a written denial of Services that require prior authorization from the Medical Group or a "Notice of Non-Coverage" and you want us to cover the Services
- A Plan Physician has said that Services are not Medically Necessary and you want us to cover the Services
- You were told that Services are not covered and you believe that the Services should be covered
- You received care from a Non–Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services) and you want us to pay for the care
- We did not decide fully in your favor on a claim for Services described in the "Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits, Copayments, and Coinsurance" section and you want to appeal our decision
- You are dissatisfied with how long it took to get Services, including getting an appointment, in the waiting room, or in the exam room
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility

Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about Services you received. You must submit your grievance orally or in writing within 180 days of the date of the incident that caused your dissatisfaction as follows:

- If we did not decide fully in your favor on a claim for Services described in the "Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits, Copayments and Coinsurance" section and you want to appeal our decision, you can submit your grievance in one of the following ways:
  - to the Claims Department at the following address:

    For Northern California Members:
    Kaiser Foundation Health Plan, Inc.
    Special Services Unit
    P.O. Box 23280
    Oakland, CA 94623

    For Southern California Members:
    Kaiser Foundation Health Plan, Inc.
    Special Services Unit
    P.O. Box 7136
    Pasadena, CA 91109

  - by calling our Member Service Call Center at 1-800-464-4000 or 1-800-390-3510 (TTY users call 1-800-777-1370)
- For all other issues, you can submit your grievance in one of the following ways:
  - to the Member Services Department at a Plan Facility (please refer to *Your Guidebook* for addresses)

- by calling our Member Service Call Center at 1-800-464-4000 (TTY users call 1-800-777-1370)
- through our website at **kp.org**

We will send you a confirmation letter within five days after we receive your grievance. We will send you our written decision within 30 days after we receive your grievance. If we do not approve your request, we will tell you the reasons and about additional dispute resolution options. Note: If we resolve your issue to your satisfaction by the end of the next business day after we receive your grievance orally, by fax, or through our website, and a Member Services representative notifies you orally about our decision, we will not send you a confirmation letter or a written decision unless your grievance involves a coverage dispute, a dispute about whether a Service is Medically Necessary, or an experimental or investigational treatment.

Expedited grievance

You or your physician may make an oral or written request that we expedite our decision about your grievance if it involves an imminent and serious threat to your health, such as severe pain or potential loss of life, limb, or major bodily function. We will inform you of our decision within 72 hours (orally or in writing).

If the request is for a continuation of an expiring course of treatment and you make the request at least 24 hours before the treatment expires, we will inform you of our decision within 24 hours.

You or your physician must request an expedited decision in one of the following ways and you must specifically state that you want an expedited decision:

- Call our Expedited Review Unit toll free at 888-987-7247 (TTY users call 800-777-1370), which is available Monday through Saturday from 8:30 a.m. to 5 p.m. After hours, you may leave a message and a representative will return your call the next business day
- Send your written request to:

  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 23170
  Oakland, CA 94623-0170
- Fax your written request to our Expedited Review Unit toll free at 888-987-2252
- Deliver your request in person to your local Member Services Department at a Plan Facility

If we do not approve your request for an expedited decision, we will notify you and we will respond to your grievance within 30 days. If we do not approve your grievance, we will send you a written decision that tells you the reasons and about additional dispute resolution options.

Note: If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the California Department of Managed Health Care directly at any time at 1-888-HMO-2219 (TDD 1-877-688-9891) without first filing a grievance with us.

Supporting Documents

It is helpful for you to include any information that clarifies or supports your position. You may want to include supporting information with your grievance, such as medical records or physician opinions. When appropriate, we will request medical records from Plan Providers on your behalf. If you have consulted with a Non–Plan Provider and are unable to provide copies of relevant medical records, we will contact the provider to request a copy of your medical records. We will ask you to send or fax us a written authorization so that we can request your records. If we do not receive the information we

request in a timely fashion, we will make a decision based on the information we have.

Who May File

The following persons may file a grievance:

- You may file for yourself
- You may appoint someone as your authorized representative by completing our authorization form. Authorization forms are available from your local Member Services Department at a Plan Facility or by calling our Member Service Call Center. Your completed authorization form must accompany the grievance
- You may file for your Dependent under age 18, except that he or she must appoint you as his or her authorized representative if he or she has the legal right to control release of information that is relevant to the grievance
- You may file for your ward if you are a court-appointed guardian, except that he or she must appoint you as his or her authorized representative if he or she has the legal right to control release of information that is relevant to the grievance
- You may file for your conservatee if you are a court-appointed conservator
- You may file for your principal if you are an agent under a currently effective health care proxy, to the extent provided under state law
- Your physician may request an expedited grievance as described under "Expedited grievance" in this "Dispute Resolution" section

Department of Managed Health Care Complaints

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan toll free at **800-464-4000** (TTY users call **800-777-1370**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(888-HMO-2219)** and a TDD line **(877-688-9891)** for the hearing and speech impaired. The department's Internet website **http://www.hmohelp.ca.gov** has complaint forms, IMR application forms and instructions online.

Independent Medical Review (IMR)

If you qualify, you or your authorized representative may have your issue reviewed through the Independent Medical Review (IMR) process managed by the California Department of Managed Health Care. The Department of Managed Health Care determines which cases qualify for IMR. This review is at no cost to you. If you decide not to request an IMR, you may give up the right to pursue some legal actions against us.

You may qualify for IMR if all of the following are true:

- One of these situations applies to you:
  - you have a recommendation from a provider requesting Medically Necessary Services

- you have received Emergency Services, emergency ambulance Services, or Urgent Care from a provider who determined the Services to be Medically Necessary
- you have been seen by a Plan Provider for the diagnosis or treatment of your medical condition

- Your request for payment or Services has been denied, modified, or delayed based in whole or in part on a decision that the Services are not Medically Necessary
- You have filed a grievance and we have denied it or we haven't made a decision about your grievance within 30 days (or three days for expedited grievances). The Department of Managed Health Care may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function

You may also qualify for IMR if the Service you requested has been denied on the basis that it is experimental or investigational as described under "Experimental or investigational denials".

If the Department of Managed Health Care determines that your case is eligible for IMR, it will ask us to send your case to the Department of Managed Health Care's Independent Medical Review organization. The Department of Managed Health Care will promptly notify you of its decision after it receives the Independent Medical Review organization's determination. If the decision is in your favor, we will contact you to arrange for the Service or payment.

Experimental or investigational denials

If we deny a Service because it is experimental or investigational, we will send you our written explanation within five days of making our decision. We will explain why we denied the Service and provide additional dispute resolution options. Also, we will provide information about your right to request Independent Medical Review if we had the following information when we made our decision:

- Your treating physician provided us a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy we cover than the therapy being requested. "Life-threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival. "Seriously debilitating" means diseases or conditions that cause major irreversible morbidity
- If your treating physician is a Plan Physician, he or she recommended a treatment, drug, device, procedure, or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Plan Physician in certifying his or her recommendation
- You (or your Non–Plan Physician who is a licensed, and either a board-certified or board-eligible, physician qualified in the area of practice appropriate to treat your condition) requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The physician's certification included a statement of the evidence relied upon by the physician in certifying his or her recommendation. We do not cover the Services of the Non–Plan Provider

Note: You can request IMR for experimental or investigational denials at any time without first filing a grievance with us.

CalPERS Final Administrative Determination

If you do not achieve resolution of your complaint through the grievance process described under "Grievances", "Department of Managed Health Care Complaints" or "Independent Medical Review (IMR)," you have additional dispute resolution options, depending on the nature of the complaint.

Eligibility issues

Issues of eligibility must be referred directly to CalPERS. Contact the CalPERS Health Account Services Section at Attn: Enrollment Administration, P.O. Box 942714, Sacramento, CA 94229-2714, fax number 916-795-1277, or telephone the CalPERS Customer Service and Outreach Division toll free at 888-CalPERS (888-**225-7377).**

Coverage issues

If you have a coverage issue and are dissatisfied with the outcome of our grievance process or if you have been in the process for 30 days or more, you may request review by the Department of Managed Health Care (as described under "Department of Managed Health Care Complaints"), or you may submit the matter to binding arbitration (or Small Claims Court if applicable). A coverage issue concerns the denial of Services substantially based on a finding that a Service is excluded as a covered benefit under this *Evidence of Coverage*. Coverage issues do not include a Plan Provider's decision about a disputed Service. However, you must choose between the Department of Managed Health Care and binding arbitration. You may not take the same issue to both the CalPERS Board and use one of the other dispute resolution procedures.

Independent Medical Review (IMR)

If you are dissatisfied with the outcome of the independent medical review process described under the "Independent Medical Review (IMR)" section, you may request an administrative hearing through the CalPERS Board of Administration, or you may submit the matter to binding arbitration (or Small Claims Court if applicable).

CalPERS administrative hearing process

You may request an administrative hearing of your dispute if we deny your grievance or if the Department of Managed Health Care denies your IMR request. However, your written request must be submitted to CalPERS within 30 days of the date of our denial letter or the Department of Managed Health Care's determination of findings.

During the hearing, evidence and testimony will be presented to an Administrative Law Judge. As an alternative to this hearing, you may have recourse through binding arbitration (or Small Claims Court if applicable). However, you must choose between the Administrative Hearing and binding arbitration (or Small Claims Court if applicable). You may not take the same issue through both procedures. You may withdraw your request from CalPERS at any time, and proceed to binding arbitration (or Small Claims Court if applicable).

To request an administrative review, please contact CalPERS Health Plan Administration Division, Attn: Health Appeals Coordinator at P.O. Box 1953, Sacramento, CA 95812-1953, fax number 916-795-1513, or telephone the CalPERS Customer Service and Outreach Division toll free at **888-CalPERS** (**888-225-7377**).

Binding Arbitration

For all claims subject to this "Binding Arbitration" section, both Claimants and

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

Scope of arbitration

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

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

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

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

"Kaiser Permanente Parties" include:

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

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

Initiating arbitration

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

Serving Demand for Arbitration

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

For Northern California Members:
Kaiser Foundation Health Plan, Inc.
Legal Department
1950 Franklin St, 17th Floor
Oakland, CA 94612

For Southern California Members:
Kaiser Foundation Health Plan, Inc.
Legal Department
393 E. Walnut St
Pasadena, CA 91188

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

Filing fee

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

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

Number of arbitrators

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

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

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

Payment of arbitrators' fees and expenses

Health Plan will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the *Rules for Kaiser Permanente Member*

Arbitrations Overseen by the Office of the Independent Administrator ("Rules of Procedure"). In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

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

Costs

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

Rules of Procedure

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

General provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondents served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after the earlier of (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

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

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

TERMINATION OF MEMBERSHIP

Your Group is required to inform the Subscriber of the date your membership terminates. The guidelines that determine the termination of coverage from the CalPERS Health Program are governed in accord with the Public Employees' Medical & Hospital Care Act (PEMHCA). For an explanation of specific eligibility criteria and termination requirements, please consult your Health Benefits Officer (or, if you are retired, the CalPERS Health Account Services Section). Your *CalPERS Health Program Guide* also includes eligibility and termination information and can be ordered through the CalPERS Web site or by calling CalPERS.

Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2012, your last minute of coverage was at 11:59 p.m. on December 31, 2011). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Services you receive after your membership terminates.

Health Plan and Plan Providers have no further liability or responsibility under this *Evidence of Coverage* after your membership terminates, except as provided under "Payments after Termination" in this "Termination of Membership" section, or if your coverage terminates for one of the reasons listed below and you are receiving covered Services as an acute care hospital inpatient on the termination date, we will continue to cover your hospital Services until you are discharged. We will cover only 91 days of continuous hospitalization after the termination date if one of the following is true:

- Your membership terminated due to a change from one CalPERS-sponsored plan to another (if you are still hospitalized on the 92nd day, your coverage under the newly chosen CalPERS-sponsored plan will take effect)
- Your membership terminated for a reason other than termination of your Group's *Agreement* with us or voluntary termination by the Subscriber

Termination Due to Loss of Eligibility

If you meet the eligibility requirements described under "Eligibility" in the "Premiums, Eligibility, and Enrollment" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership will end at 11:59 p.m. on the last day of that month. For example, if you become ineligible on December 5, 2011, your termination date is January 1, 2012 and your last minute of coverage is at 11:59 p.m. on December 31, 2011.

Termination of *Agreement*

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

Termination for Cause

If you commit one of the following acts, we will ask CalPERS to approve termination of your membership in accord with Section 22841 of the California Government Code:

- You behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for our other members.
- You commit theft from Health Plan, from a Plan Provider, or at a Plan Facility

- You intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider. Some examples of fraud include:
  - misrepresenting eligibility information about you or a Dependent
  - presenting an invalid prescription or physician order
  - misusing a Kaiser Permanente ID card (or letting someone else use it)
  - giving us incorrect or incomplete material information
  - failing to notify us of changes in family status or Medicare coverage that may affect your eligibility or benefits

If CalPERS approves termination of your membership, CalPERS will send written notice to the Subscriber.

If we terminate your membership for cause, you will not be allowed to enroll in Health Plan in the future. We may also report criminal fraud and other illegal acts to the authorities for prosecution.

Termination of a Product or all Products

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

HIPPA Certificates of Creditable Coverage

The Health Insurance Portability and Accountability Act (HIPAA) requires employers or health plans to issue a "Certificates of Creditable Coverage" to Members whose coverage terminates. The certificate documents health care coverage and you can use it to prove prior creditable health care coverage if you seek new coverage after your membership terminates. When your membership terminates, or at any time upon request, we will mail the certificate to the Subscriber unless your Group has an agreement with us to mail the certificates. If you have any questions, please contact your Group's Health Benefits Officer (or, if you are retired, the CalPERS Health Account Services Section.

Payments after Termination

If we terminate your membership for cause, we will:

- Refund any amounts we owe your Group for Premiums paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Emergency Services and Urgent Care" and "Dispute Resolution" sections. We will deduct any amounts you owe Health Plan or Plan Providers from any payment we make to you

State Review of Membership Termination

If you believe that we terminated your membership because of your ill health or your need for care, you may request a review of the termination by the California Department of Managed Health Care (please see "Department of Managed Health Care Complaints" in the "Dispute Resolution" section).

CONTINUATION OF MEMBERSHIP

If your membership under this *Evidence of Coverage* ends, you may be eligible to maintain Health Plan membership without a break in coverage under this *Evidence of Coverage* (Group coverage) or you may be eligible to convert to an individual (nongroup) plan.

Continuation of Group Coverage

If at any time you become entitled to continuation of Group coverage such as Cal-COBRA, please examine your coverage options carefully before declining this coverage. You should be aware that companies selling individual health insurance typically require a review of your medical history that could result in higher premiums or you could be denied coverage entirely.

Note: Medical history does not impact premiums or eligibility for our Individual–Conversion Plan and HIPAA Individual Plan described under "Conversion from Group Membership to an Individual Plan" in this "Continuation of Membership" section. However, the individual plan premiums and coverage will be different from the premiums and coverage under your Group plan.

COBRA

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

If your Group is subject to COBRA and you are eligible for COBRA coverage, in order to enroll you must submit a COBRA election form to your Group within the COBRA election period. Please ask your Health Benefits Officer (or, if you are retired, the CalPERS Health Account Services Section) for details about COBRA coverage, such as how to elect coverage, how much you must pay for coverage, when coverage and Premiums may change, and where to send your Premium payments.

As described in "Conversion from Group Membership to an Individual Plan" in this "Continuation of Membership" section, you may be able to convert to an individual (nongroup) plan if you don't apply for COBRA coverage, or if you enroll in COBRA and your COBRA coverage ends. Also, if you enroll in COBRA and exhaust the time limit for COBRA coverage, you may be able to continue Group coverage under state law as described under "Cal-COBRA" in this "Continuation of Group Coverage" section.

Cal-COBRA

If you are eligible for Cal-COBRA, you can continue coverage as described in this "Cal-COBRA" section if you apply for coverage in compliance with Cal-COBRA law and pay applicable Premiums.

Eligibility and effective date of coverage for Cal-COBRA after COBRA. If your group is subject to COBRA and your COBRA coverage ends, you may be able to continue Group coverage effective the date your COBRA coverage ends if all of the following are true:

- Your effective date of COBRA coverage was on or after January 1, 2003
- You have exhausted the time limit for COBRA coverage and that time limit was 18 or 29 months
- You do not have Medicare

You must request an enrollment application by calling our Member Service Call Center within

60 days of the date of when your COBRA coverage ends.

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

Cal-COBRA enrollment and Premiums. Within 10 days of your request for an enrollment application, we will send you our application, which will include Premiums and billing information. You must return your completed application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later).

If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay the bill within 45 days after the date we issue the bill. The first Premium payment will include coverage from your Cal-COBRA effective date through our current billing cycle. You must send us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

After that first payment, monthly Premium payments are due on or before the last day of the month preceding the month of coverage. The Premiums will not exceed 110 percent of the applicable Premiums charged to a similarly situated individual under the Group benefit plan except that Premiums for disabled individuals after 18 months of COBRA coverage will not exceed 150 percent instead of 110 percent.

Changes to Cal-COBRA coverage and Premiums. Your Cal-COBRA coverage is the same as for any similarly situated individual under your Group's *Agreement*, and your Cal-COBRA coverage and Premiums will change at the same time that coverage or Premiums change in your Group's *Agreement*. Your Group's coverage and Premiums will change on the renewal date of its *Agreement* (January 1), and may also change at other times if your Group's *Agreement* is amended. Your monthly invoice will reflect the current Premiums that are due for Cal-COBRA coverage, including any changes. For example, if your Group makes a change that affects Premiums retroactively, the amount we bill you will be adjusted to reflect the retroactive adjustment in Premiums. Your Health Benefits Officer (or, if you are retired, the CalPERS Health Account Services Section) can tell you whether this *Evidence of Coverage* is still in effect and give you a current one if this *Evidence of Coverage* has expired or been amended. You can also request one from our Member Service Call Center.

Cal-COBRA open enrollment or termination of another health plan. If you previously elected Cal-COBRA coverage through another health plan available through your Group, you may be eligible to enroll in Kaiser Permanente during your Group's annual open enrollment period, or if your Group terminates its agreement with the health plan you are enrolled in. You will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA. Please ask your Group for information about health plans available to you either at open enrollment or if your Group terminates a health plan's agreement, please contact the CalPERS Health Account Services Section, Attn: Enrollment Administration, P.O. Box 942714, Sacramento, CA 94229-2714, fax number 916-795-1277, or telephone the CalPERS Customer Service and Outreach Division toll free at **888-CalPERS** (**888-225-7377**).

In order for you to switch from another health plan and continue your Cal-COBRA coverage with us, we must receive your enrollment

application during your Group's open enrollment period, or within 63 days of receiving the Group's termination notice described under "Group responsibilities". To request an application, please call our Member Service Call Center. We will send you our enrollment application and you must return your completed application before open enrollment ends or within 63 days of receiving the termination notice described under "Group responsibilities". If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay the bill within 45 days after the date we issue the bill. You must send us the Premium payment by the due date on the bill to be enrolled in Cal-COBRA.

Termination for nonpayment of Cal-COBRA Premiums. If we do not receive the full amount of your Family's Premium payment on or before the last day of the month preceding the month of coverage, we will terminate the membership of everyone in your Family effective on the last day of the month for which we received a full Premium payment. This retroactive period will not exceed 60 days before the date we mail you a notice confirming termination of membership. If we do not receive full Premium payment on or before the last day of the month preceding the month of coverage, we will send a Notice of Termination (notice of nonreceipt of payment) to the Subscriber in accord with "Notices" in the "Miscellaneous Provisions" section. We will mail this notice at least 15 days before any termination of coverage and it will include the following information:

- A statement that we have not received full Premium payment and that we will terminate the memberships of everyone in your Family for nonpayment if we do not receive the required Premiums within 15 days after the date we mailed the notice confirming termination of membership
- The date and time when the memberships of everyone in your Family will end if we do not receive the Premiums

We will terminate your Family's memberships if we do not receive payment within 15 days of the date we mailed the Notice of Termination (notice of nonreceipt of payment). We will mail a notice confirming termination of membership, which will inform you of the following:

- That we have terminated the memberships of everyone in your Family for nonpayment of Premiums
- The date and time when the memberships of everyone in your Family ended
- Information explaining whether or not you can reinstate your memberships

Reinstatement of your membership after termination for nonpayment of Cal-COBRA Premiums. If we terminate your membership for nonpayment of Premiums, we will permit reinstatement of your membership twice during any 12-month period if we receive the amounts owed within 15 days of the date the notice confirming termination of membership was mailed to you. We will not reinstate your membership if you do not obtain reinstatement of your terminated membership within the required 15 days, or if we terminate your membership for nonpayment of Premiums more than twice in a 12-month period.

Termination of Cal-COBRA coverage. Cal-COBRA coverage continues only upon payment of applicable monthly Premiums to us at the time we specify, and terminates on the earliest of:

- The date your Group's *Agreement* with us terminates (you may still be eligible for Cal-COBRA through another Group health plan)
- The date you get Medicare
- The date your coverage begins under any other group health plan that does not contain any exclusion or limitation with respect to any pre-existing condition you may have (or that does contain such an exclusion or limitation, but it has been satisfied)
- The date that is 36 months after your original COBRA effective date (under this or any other plan)
- The date your membership is terminated for nonpayment of Premiums as described under "Termination for nonpayment of Cal-COBRA Premiums" in this "Continuation of Membership" section

Note: If the Social Security Administration determined that you were disabled at any time during the first 60 days of COBRA coverage, you must notify your Group within 60 days of receiving the determination from Social Security. Also, if Social Security issues a final determination that you are no longer disabled in the 35th or 36th month of Group continuation coverage, your Cal-COBRA coverage will end the later of: (1) expiration of 36 months after your original COBRA effective date, or (2) the first day of the first month following 31 days after Social Security issued its final determination. You must notify us within 30 days after you receive Social Security's final determination that you are no longer disabled.

Group responsibilities. If your Group's agreement with a health plan is terminated, your Group is required to provide written notice at least 30 days before the termination date to the persons whose Cal-COBRA coverage is terminating. This notice must inform Cal-COBRA beneficiaries that they can continue Cal-COBRA coverage by enrolling in any health benefit plan offered by your Group. It must also include information about benefits, Premiums, payment instructions, and enrollment forms (including instructions on how to continue Cal-COBRA coverage under the new health plan). Your Group is required to send this information to the person's last known address, as provided by the prior health plan. Health Plan is not obligated to provide this information to qualified beneficiaries if your Group fails to provide the notice. These persons will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA.

Uniformed Services Employment and Reemployment Rights Act (USERRA)

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this *Evidence of Coverage* for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form

to your Group within 60 days after your call to active duty. Please contact your Group to find out how to elect USERRA coverage and how much you must pay your Group.

Coverage for a disabling condition

If you became Totally Disabled while you were a Member under your Group's *Agreement* with us and while the Subscriber was employed by your Group, and your Group's *Agreement* with us terminates and is not renewed, we will cover Services for your totally disabling condition until the earliest of the following events occurs:

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

Your coverage will be subject to the terms of this *Evidence of Coverage* including Copayments and Coinsurance, but we will not cover Services for any condition other than your totally disabling condition.

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

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

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

Leave of Absence

If you qualify for continuing group membership by completion of HBD Form 21, you should contact your Health Benefits Officer who will help you make the necessary changes in your enrollment while you are on a leave of absence.

If you are paying your monthly premiums using the coupon payment book, please send your payment to the following address:

Kaiser Permanente
P.O. Box 7004
Anaheim, CA 92850-7004

If you receive a billing statement for your monthly premiums, please send your payment to the following address:

Kaiser Permanente
P.O. Box 7027
Anaheim, CA 92850-7027

Please note that it is very important to make the necessary enrollment changes and establish your account before you begin making monthly payments. Contact your Health Benefits Officer to make the necessary enrollment changes prior to your leave of absence. If you have additional questions, please call our Member Service Call Center.

Conversion from Group Membership to an Individual Plan

After your Group notifies us to terminate your membership, we will send a termination letter to the Subscriber's address of record. The letter will include information about options that may be available to you to remain a Health Plan member.

Kaiser Permanente Conversion Plan

If you want to remain a Health Plan member, one option that may be available is an individual plan called "Kaiser Permanente Individual–Conversion Plan." You may be eligible to enroll in our Individual–Conversion Plan if you no longer meet the eligibility requirements described under "Eligibility" in the "Premiums, Eligibility, and Enrollment" section. Also, if you enroll in Group continuation coverage through COBRA, Cal-COBRA, or USERRA you may be eligible to enroll in our Individual–Conversion Plan when your Group continuation coverage ends. The premiums and coverage under our Individual–Conversion Plan are different from those under this *Evidence of Coverage.*

To be eligible for our Individual–Conversion Plan, there must be no lapse in your coverage and we must receive your enrollment application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later). To request an application, please call our Member Service Call Center.

If we approve your enrollment application, we will send you billing information within 30 days after we receive your application. You must pay the bill within 45 days after the date we issue the bill. Because your coverage under our Individual–Conversion Plan begins when your Group coverage ends (including Group continuation coverage), your first payment to us will include coverage from when your Group coverage ended through our current billing cycle. You must send us the premium payment by the due date on the bill to be enrolled in our Individual–Conversion Plan.

You may not convert to our Individual–Conversion Plan if any of the following is true:

- You continue to be eligible for coverage through your Group (but not counting COBRA, Cal-COBRA, or USERRA coverage)
- Your membership ends because your Group's *Agreement* with us terminates and it is replaced by another plan within 15 days of the termination date
- We terminated your membership under "Termination for Cause" in the "Termination of Membership" section
- You live in the service area of a Region outside California, except that the Subscriber's or the Subscriber's Spouse's otherwise-eligible children may be eligible to be covered Dependents even if they live in (or move to) the service area of a Region outside California (please refer to the "Eligibility" in the "Premiums, Eligibility, and Enrollment" section for more information)

HIPAA and other individual plans

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) protects health care coverage for workers and their families when they change or lose their jobs. If you lose group health care coverage and meet certain criteria, you are entitled to purchase individual (nongroup) health care coverage from any health plan that sells individual health care coverage.

Every health plan that sells individual health care coverage must offer individual coverage to an eligible person under HIPAA. The health plan cannot reject your application if you are an eligible person under HIPAA, you agree to pay the required premiums, and you live or work inside the plan's service area. To be considered an eligible person under HIPAA you must meet the following requirements:

- You have 18 or more months of creditable coverage without a break of 63 days or more between any of the periods of creditable coverage or since the most recent coverage was terminated

- Your most recent creditable coverage was under a group, government, or church plan (COBRA and Cal-COBRA are considered group coverage)
- You were not terminated from your most recent creditable coverage due to nonpayment of premiums or fraud
- You are not eligible for coverage under a group health plan, Medicare, or Medicaid (Medi-Cal)
- You have no other health care coverage
- You have elected and exhausted any continuation coverage you were offered under COBRA or Cal-COBRA

For more information (including premiums and complete eligibility requirements), please refer to the Kaiser Permanente HIPAA Individual Plan evidence of coverage. To request a copy of the HIPAA Individual Plan evidence of coverage or for information about other individual plans, such as Kaiser Permanente for Individuals and Families plans, please call our Member Service Call Center.

HELPFUL INFORMATION

Your Guidebook to Kaiser Permanente Services (Your Guidebook)

Please refer to Your Guidebook for helpful information about your coverage, such as:

- The types of covered Services that are available from each Plan Facility in your area
- How to use our Services and make appointments
- Hours of operation
- Appointments and advice phone numbers

You can get a copy of Your Guidebook by visiting our website at kp.org or by calling our Member Service Call Center.

How to Reach Us

Appointments

If you need to make an appointment, please call us or visit our website:

Call	The appointment phone number at a Plan Facility (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for phone numbers)
Web-site	**kp.org** for routine (non-urgent) appointments with your personal Plan Physician or another Primary Care Physician

Not sure what kind of care you need?

If you need advice on whether to get medical care, or how and when to get care, we have licensed health care professionals available to assist you by phone 24 hours a day, 7 days a week:

Call	The appointment or advice phone number at a Plan Facility (refer to *Your Guidebook* or the facility directory on our website at **kp.org** for phone numbers)

Member Services

If you have questions or concerns about your coverage, how to obtain Services, or the facilities where you can receive care, you can reach us by calling, writing, or visiting our website:

Call	**1-800-464-4000** **1-800-390-3510** (TTY) Weekdays 7 a.m. to 7 p.m., and weekends 7 a.m. to 3 p.m. (except holidays)
Write	Member Services Department at a Plan Facility (refer to *Your Guidebook to Kaiser Permanente Services* for addresses)
Web-site	**kp.org**

Authorization for Post-Stabilization Care

If you need to request authorization for Post-Stabilization Care as described under "Emergency Services and Urgent Care" section, please call us:

Call	**1-800-225-8883** or the notification telephone number on your Kaiser Permanente ID card **711 (TTY)** Call any time

Help with Claims Forms for Emergency Services, Post-Stabilization, and Out-of-Area Urgent Care and emergency ambulance Services

If you need a claim form to request payment or reimbursement for Services described in the "Emergency Services and Urgent Care" section

or under "Ambulance Services" in the "Benefits, Copayments and Coinsurance" section, or if you need help completing the form, you can reach us by calling or by visiting our website.

Call	**1-800-464-4000** or **1-800-390-3510** **1-800-777-1370** (TTY) Weekdays 7 a.m. to 7 p.m., and weekends 7 a.m. to 3 p.m. (except holidays)
Web-site	**kp.org**

Submitting Claims for Emergency Services, Post-Stabilization, and Out-of-Area Urgent Care, and emergency ambulance Services

If you need to submit a completed claim form for Services described in the "Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits, Copayments and Coinsurance" section, or if you need to submit other information that we request about your claim, send it to our Claims Department:

Write	*For Northern California Members:* Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 24010 Oakland, CA 94623-1010 *For Southern California Members:* Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 7004 Downey, CA 90242-7004

PAYMENT RESPONSIBILITY

Payment Responsibility

This "Payment Responsibility" section briefly explains who is responsible for payments related to the health care coverage described in this *Evidence of Coverage.* Payment responsibility is more fully described in other parts of the *Evidence of Coverage* as described below:

- Your Group is responsible for paying Premiums, except that you are responsible for paying Premiums to your Group if you have COBRA or paying Premiums to us if you have Cal-COBRA (refer to "Premiums" in the "Premiums, Eligibility, and Enrollment" section and "COBRA" and "Cal-COBRA" under "Continuation of Group Coverage" in the "Continuation of Membership" section)
- Your Group may require you to contribute to Premiums (your Group will tell you the amount and how to pay)
- You are responsible for paying Copayments, and Coinsurance for covered Services (refer to "Benefits, Copayments, and Coinsurance" section)
- If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider, or if you receive emergency ambulance Services, you must pay the provider and file a claim for reimbursement unless the provider agrees to bill us (refer to "Payment and Reimbursement" in the "Emergency Services and" section
- If you receive Services from Non–Plan Providers that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services) and you want us to pay for the care, you must submit a grievance (refer to "Grievances" in the "Dispute Resolution" section)
- If you have coverage with another plan or with Medicare, we will coordinate benefits with the other coverage (refer to "Coordination of Benefits" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- In some situations, you or a third party may be responsible for reimbursing us for covered Services (refer to "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section)
- You are responsible for paying the full price for noncovered Services

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern and Southern California Regions

PART TWO – EVIDENCE OF COVERAGE FOR KAISER PERMANENTE SENIOR ADVANTAGE (HMO)

January 1, 2012, through December 31, 2012

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

BENEFIT CHANGES FOR CURRENT YEAR

The following is a summary of the most important coverage changes and clarifications that we have made to this Kaiser Permanente Senior Advantage 2012 *Disclosure Form and Evidence of Coverage (Evidence of Coverage).* Please read this *Evidence of Coverage* for the complete text of these changes, as well as changes not listed in the summary below. In addition, please refer to the "Premiums" section for information about 2012 Premiums.

Please refer to the "Benefits, Copayments, and Coinsurance" section in this *Evidence of Coverage* for benefit descriptions and the amount Members must pay for covered benefits. Benefits are also subject to the "Emergency, Post-Stabilization, and Urgent Care from Non–Plan Providers" and the "Exclusions, Limitations, Coordination of Benefits, and Reductions" sections in Part Two of this *Evidence of Coverage*.

Acupuncture Services

We have clarified that the Cost Sharing for acupuncture Services (typically prescribed by a Plan Physician only for the treatment of nausea or provided as part of a comprehensive pain management program for the treatment of chronic pain) is the same as the Cost Sharing for a specialty care office visit.

Bariatric Surgery

We have clarified that covered Services related to bariatric surgical procedures that you receive, you will pay the Cost Sharing you would pay if the Services were not related to a bariatric surgical procedure.

Emergency Services

We have replaced the term "Emergency Care" with "Emergency Services," and have revised the definitions of "Emergency Services," "Emergency Medical Condition," and "Stabilize." Also, we have revised the definition of "Emergency Medical Condition" in accord with California Assembly Bill 235 to indicate that a mental health condition is an Emergency Medical Condition when it meets the requirements of the definition under the Patient Protection and Affordable Care Act (PPACA), or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to himself or herself or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

Exclusions

We have made the following revisions in the "Exclusions" section:

- We have clarified that when a service is excluded, it is excluded regardless of whether the services are within the scope of a provider's license or certificate
- We have revised the exclusion for services performed by unlicensed people for clarity. Services performed by unlicensed people are services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the Member's condition does not require that the services be provided by a licensed health care provider
- We have added an exclusion for massage therapy

Eyeglasses and contact lenses
Eyeglass lenses and most contact lenses are covered as described in the "Vision Services" section at Plan Medical Offices or Plan Optical Sales Offices when prescribed by *any physician or optometrist*. Previously, the *EOC* said that lenses must be prescribed by a Plan Physician or Plan Optometrist. A prescription from a Plan Physician or Plan Optometrist is required for special contact lenses to treat aniridia and special contact lenses that provide a significant vision improvement not obtainable with eyeglasses.

Medicare-covered preventive services
For all Kaiser Permanente Senior Advantage and Medicare Cost members the following Medicare-covered preventive services will be covered without any Member cost sharing in accord with Medicare guidelines:

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

Medicare Part D outpatient prescription drug coverage
Effective January 1, 2012, Medicare Part D drug coverage for the Senior Advantage with Part D plan is changing as follows:

- Our Part D formulary will include all drugs that can be covered under Medicare Part D according to Medicare requirements
- Medicare's Coverage Gap Discount Program may provide manufacturer discounts on brand name drugs if (1) you are not already receiving “Extra Help,” (2) Medicare is not secondary for you, and (3) the amount that you and any Medicare Part D plan spend for your covered Part D drugs reaches $2,930 in a calendar year
- The Catastrophic Coverage Stage threshold is increasing from $4,550 to $4,700 per calendar year

Non-health care items and services

We have clarified that for Services to be covered, the Services must be one of the following:

- Health care items and services for preventive care
- Health care items and services for diagnosis, assessment, or treatment
- Health education covered under "Health Education" in this "Benefits and Cost Sharing" section
- Other health care items and services

We have also clarified non-health care items and services are excluded, and have provided the following examples of non-health care services and items:

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

Physical exams

The “Welcome to Medicare Exam” and “Annual Wellness Visits” will be covered at **no charge**.

Prescription Drugs

The copayment amounts for brand-name prescription drugs obtained at a Plan Pharmacy or through our mail order service are as follows:

- Plan Pharmacy:
  - $20 Copayment for up to a 30-day supply
  - $40 Copayment for a 31- to 60-day supply
  - $60 Copayment for a 61- to 100-day supply
- Mail-order service:
  - $20 Copayment for up to a 30-day supply
  - $40 Copayment for a 31- to 100-day supply

Prosthetic and Orthotic devices

The copayment or coinsurance amount for external prosthetic and orthotic devices, and ostomy and urological supplies, is now listed in the Benefit Summary.

Referrals

We have clarified that a Plan Physician must provide a referral before a Member can receive physical, occupational, or speech therapy.

Service Area ZIP codes

We are now listing all the ZIP codes that are in the Kaiser Permanente Service Area. For each county, we have indicated whether all ZIP codes in that county are inside the service area or if only the ZIP codes listed are inside our service area. A ZIP code must be listed for that county to be in the Kaiser Permanente Service Area.

Testicular implants

We have revised the cosmetic services exclusion to clarify that we cover testicular implants that are associated with reconstructive surgery, if a Plan Physician determines they are necessary to improve function, or create a normal appearance, to the extent possible.

Vision Services

We have made the following revisions for clarity:

- The exclusion for eye surgery has been modified to clarify that non-surgical vision correction procedures are also excluded
- We have clarified that we only cover one pair of eyeglasses or contact lenses after any cataract surgery that includes insertion of an intraocular lens

KAISER PERMANENTE SENIOR ADVANTAGE BENEFIT SUMMARY

Service	You Pay
Professional Services (Plan Provider office visits)	
Primary and specialty consultations and exams	$10 per visit
Annual Wellness Visit and the Welcome to Medicare Exam	No charge
Family planning counseling	$10 per visit
Scheduled prenatal care exams and first postpartum follow-up consultation and exam	$10 per visit
Eye exams for refraction and glaucoma screening	$10 per visit
Hearing exams	$10 per visit
Urgent care consultations and exams	$10 per visit
Physical, occupational, and speech therapy	$10 per visit
Outpatient Services	
Outpatient surgery and certain other outpatient procedures	$10 per procedure
Allergy injection (including allergy serum)	$3 per visit
Biofeedback	$10 per visit
Most X-rays, annual mammograms, and laboratory tests	No charge
Health education:	
Most individual health education counseling	$10 per visit
Covered health education programs	No charge
Hospitalization Services	
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
Emergency Health Coverage	
Emergency Department visits	$50 per visit
Note: This Copayment does not apply if you are held for observation in a hospital unit outside the Emergency Department or if admitted to the hospital as an inpatient within 24 hours for the same condition for covered Services (see "Hospitalization Services" for inpatient Copayment).	
Ambulance Services	
Ambulance Services	No charge
Prescription Drug Coverage	
Most covered outpatient items in accord with our drug formulary guidelines:	
Generic items from a Plan Pharmacy	$5 for up to a 30-day supply, $10 for a 31- to 60-day supply, or $15 for a 61- to 100-day supply
Generic refills from our mail-order service	$5 for up to a 30-day supply or $10 for a 31- to 100-day supply
Brand-name items from a Plan Pharmacy	$20 for up to a 30-day supply, $40 for a 31- to 60-day supply, or $60 for a 61- to 100-day supply

Service	You Pay
Brand-name refills from our mail-order service	$20 for up to a 30-day supply or $40 for a 31- to 100-day supply
Durable Medical Equipment	
Covered durable medical equipment for home use in accord with our durable medical equipment formulary guidelines	No charge
Mental Health Services	
Inpatient psychiatric hospitalization	No charge
Outpatient mental health evaluation and treatment	$10 per individual visit $5 per group visit
Chemical Dependency Services	
Inpatient detoxification	No charge
Individual outpatient chemical dependency consultations and treatment	$10 per visit
Group outpatient chemical dependency treatment	$5 per visit
Home Health Services	
Home health care (part-time, intermittent)	No charge
Chiropractic Care	
Chiropractic visits (up to 20 visits per calendar year)	$10 per visit
Other	
Hearing aid(s) every 36 months	Amount in excess of $1,000 Allowance
Skilled Nursing Facility care (up to 100 days per benefit period)	No charge
External prosthetic devices, orthotic devices, and ostomy and urological supplies	No charge
All covered Services related to infertility treatment	$10 per visit
Hospice care for Members without Medicare Part A	No charge
Eyeglasses and contact lenses (every 24 months)	Amount in excess of $175 Allowance
Eyeglasses and contact lenses following cataract surgery, in accord with Medicare guidelines	No charge

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

INTRODUCTION

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

This contract provides Medicare Services (including Medicare Part D prescription drug coverage) through "Kaiser Permanente Senior Advantage with Part D" ("Senior Advantage" or "Managed Medicare Health Plan"), except for hospice care for Members with Medicare Part A, which is covered under Original Medicare.

Senior Advantage is for Members who have Medicare, providing the advantages of combined Medicare and Health Plan benefits. Enrollment in this Senior Advantage plan means that you are automatically enrolled in Medicare Part D.

Part Two and Part Three of this *Evidence of Coverage* describes our Senior Advantage health care coverage of the "Managed Medicare Health Plan" provided under the *Group Agreement (Agreement)* between Health Plan (Kaiser Foundation Health Plan, Inc., Northern California Region and Southern California Region) and your Group (CalPERS). For benefits provided under any other Health Plan program, refer to that plan's evidence of coverage.

When you join Kaiser Permanente, you are enrolling in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), which we call your "Home Region." The Service Area of each Region is described in the "Definitions" section in Part Three of this *Evidence of Coverage*. The coverage information in this *Evidence of Coverage* applies when you obtain care in your Home Region. When you visit the other California Region, you may receive care as described in "Visiting Other Regions" in the "How to Obtain Services" section.

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

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

Term of this *Evidence of Coverage*

This *Evidence of Coverage* is for the period January 1, 2012, through December 31, 2012, unless amended. Benefits, formulary, pharmacy network, Copayments, and Coinsurance may change on January 1, 2013.Your Health Benefits Officer (or, if you are retired, the CalPERS Health Account Services Section) can tell you whether this *Evidence of Coverage* is still in effect and give you a current one if this *Evidence of Coverage* has been amended.

About Kaiser Permanente

Kaiser Permanente provides Services directly to our Members through an integrated medical care program. Health Plan, Plan Hospitals, and the Medical Group work together to provide our Members with quality care. Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital care,

laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in the "Benefits, Copayments, and Coinsurance" section. Plus, our health education programs offer you great ways to protect and improve your health. For preventive screening tests and vaccines that Plan Physicians recommend for generally healthy people, please refer to "Preventive Screenings and Vaccines" in the appendix to this *Evidence of Coverage*. For more information about preventive care guidelines, as well as recommended lifestyle practices, please refer to *Your Guidebook to Kaiser Permanente Services*, or visit our Web site at **kp.org.**

We provide covered Services to Members using Plan Providers located in your Home Region's Service Area, which is described in the "Definitions" section in Part Three of this *Evidence of Coverage*. You must receive all covered care from Plan Providers inside your Home Region's Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Certain care when you visit the service area of another Region as described under "Visiting Other Regions" in the "How to Obtain Services" section
- Chiropractic services as described in the "ASH Plans Chiropractic Services" section in Part Two of this *Evidence of Coverage*, and for Southern California Region Members, chiropractic services as described under "Chiropractic Services" in the "Benefits, Copayments, and Coinsurance" section
- Durable medical equipment as described under "Durable Medical Equipment for Home Use" in the "Benefits, Copayments, and Coinsurance" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits, Copayments, and Coinsurance" section
- Emergency Services, Post-Stabilization Care, and Urgent Care as described in the "Emergency Services and Urgent Care" section
- Home health care as described under "Home Health Care" in the "Benefits, Copayments, and Coinsurance" section
- Ostomy and urological supplies as described under "Ostomy and Urological Supplies" in the "Benefits, Copayments, and Coinsurance" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits, Copayments, and Coinsurance" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits, Copayments, and Coinsurance" section
- Prosthetic and orthotic devices as described under "Prosthetic and Orthotic Devices" in the "Benefits, Copayments, and Coinsurance" section
- Routine Services associated with Medicare-approved clinical trials as described under "Routine Services Associated with Clinical Trials" in the "Benefits, Copayments, and Coinsurance" section

PREMIUMS, ELIGIBILITY, AND ENROLLMENT

Premiums

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

California Residents	Monthly Premiums
Self only	$277.81
Self and one Dependent	$555.62
Self and two or more Dependents	$833.43

Out of State	Monthly Premiums
Self only	$366.87
Self and one Dependent	$733.74
Self and two or more Dependents	$1,100.61

Your contribution

State annuitants. The Premiums listed above will be reduced by the amount the state of California or your contracting agency contributes toward the cost of your health benefit plan. These contribution amounts are subject to change as a result of legislative action. Any such change will be accomplished by the affected retirement system without any action on your part. For current contribution information, contact your Health Benefits Officer (or, if you are retired, the CalPERS Health Account Services Section).

Contracting agency annuitants. The Premiums listed above will be reduced by the amount your contracting agency contributes toward the cost of your health benefit plan. This amount varies among contracting agencies. For assistance on calculating your net contribution, contact your Health Benefits Officer (or, if you are retired, the CalPERS Health Account Services Section).

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

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

If you disagree about paying an extra amount because of your income, you can ask the Social Security Administration to review the decision. To find out more about how to do this, contact the Social Security Administration at 1-800-772-1213 (TTY 1-800-325-0778), 7:00 a.m. to 7:00 p.m., Monday through Friday.

Medicare Part D late enrollment penalty.

You may pay a financial penalty if you did not enroll in a plan offering Medicare Part D drug coverage when you first became eligible for this drug coverage, or you experienced a continuous period of 63 days or more when you didn't have creditable prescription drug coverage. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard

prescription drug coverage.) The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your Initial Enrollment Period or how many full calendar months you went without creditable prescription drug coverage (this *Evidence of Coverage* is for a Part D plan). Your Group will inform you if the penalty applies to you. However, if you qualify for Extra Help, you may not have to pay a penalty.

If you disagree with your late enrollment penalty, you can ask us to review the decision about your late enrollment penalty. Generally, you must request this review within 60 days from the date on the letter you receive stating you have to pay a late enrollment penalty. Call our Member Service Call Center at the number on the front of this booklet to find out more about how to do this. Note: If you receive Extra Help from Medicare to pay for your Part D prescription drugs, the late enrollment penalty rules do not apply to you. You will not pay a late enrollment penalty, even if you go without "creditable" prescription drug coverage.

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

People with limited income and resources may qualify for Extra Help. Some people automatically qualify for Extra Help and don't need to apply. Medicare mails a letter to people who automatically qualify for Extra Help. You may be able to get Extra Help to pay for your prescription drug premiums and costs. To see if you qualify for getting Extra Help, call:

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

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

What if you believe you have qualified for extra help

If you believe you have qualified for extra help and you believe that you are paying an incorrect Copayment amount when you get your prescription at a Plan Pharmacy, we have established a process that will allow you to either request assistance in obtaining evidence of your proper Copayment level, or, if you already have the evidence, to provide this evidence to us. If you aren't sure what evidence to provide us, please contact our Member Service Call Center. The evidence is often a letter from either your state Medicaid or Social Security office that confirms you are qualified for extra help. You or your appointed representative may need to provide the evidence to a Plan Pharmacy when obtaining covered Part D prescriptions so that we can charge you the appropriate Copayments, or Coinsurance amount until the Centers for Medicare & Medicaid Services updates its records to reflect your current status. Once the Centers for Medicare & Medicaid Services updates its records, you will no longer need to present the evidence to a Plan Pharmacy. In order for the Centers for Medicare & Medicaid

Services to update its records, you must send your evidence to one of the following locations and we will forward your evidence to the Centers for Medicare & Medicaid Services for updating:

Kaiser Foundation Health Plan, Inc.
California Service Center
Attn: Best Available Evidence
P.O. Box 232407
San Diego, CA 92193-2407

Fax it toll free to 866-311-0514

Bring it to a Plan Pharmacy or Member Services office at a Plan Facility listed in Your Guidebook to Kaiser Permanente Services

Note: If you do not have documentation, you can request that our Plan Pharmacy assist you or you may call our Member Service Call Center to assist you.

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 our Plan 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 our Plan 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 our Plan Pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact our Member Service Call Center if you have questions.

Eligibility

To enroll and to continue enrollment, you must meet all of the eligibility requirements described in this "Eligibility" section. The CalPERS Health Program enrollment and eligibility requirements are determined in accord with the Public Employees' Medical & Hospital Care Act (PEMHCA), the Social Security Administration (SSA), and the Centers for Medicare & Medicaid Services. For an explanation of specific enrollment and eligibility criteria, please consult your Health Benefits Officer (or, if you are retired, the CalPERS Health Account Services Section).

Under the Public Employees' Medical & Hospital Care Act (PEMHCA), if you are Medicare-eligible and do not enroll in Medicare Parts A and B and in a CalPERS Medicare health plan, you and your enrolled Dependents will be excluded from coverage under the CalPERS program. If you are eligible and enrolled in Medicare Part B, but are not eligible for Medicare Part A without cost, you will not be required to enroll in a CalPERS Medicare health plan; however, you are still eligible to enroll in Kaiser Permanente Senior Advantage.

Information pertaining to eligibility, enrollment, termination of coverage, and conversion rights can be obtained through the CalPERS Web site at **www.calpers.ca.gov** or by calling CalPERS. Also, please refer to the *CalPERS Health Program Guide* for information about eligibility.

It is your responsibility to stay informed about your coverage. If you have any questions, contact your:

- Health Benefits Officer in your agency
- If you are retired, the CalPERS Health Account Services Section, Attn: Enrollment Administration, P.O. Box 942714, Sacramento, CA 94229-2714. Fax number: 916-795-1277
- CalPERS Customer Service and Outreach Division toll free at 888-CalPERS (888-225-7377) TTY users call 800-735-2929 or 916-795-3240

Senior Advantage eligibility requirements

- You must be entitled to benefits under Medicare Parts A and B or Part B only

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

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

Service Area eligibility requirements

The "Definitions" section in Part Three of this *Evidence of Coverage* describes your Home Region's Service Area and how it may change. You must live in your Home Region's Service Area, unless you have been continuously enrolled in Senior Advantage since December 31, 1998, and lived outside your Home Region's Service Area during that entire time. In which case, you may continue your membership unless you move and are still outside your Home Region's Service Area. The "Service Area" section in Part Three of this *Evidence of Coverage* describes your Home Region's Service Area and how it may change.

Moving from your Home Region's Service Area to our other California Region's Service Area. You must complete a new Senior Advantage Election Form to continue Senior Advantage coverage, if you move from your Home Region's Service Area to the Service Area of our other California Region (the Service Area of both Regions are described in the "Service Area" section). To get a Senior Advantage Election Form, please call our Member Service Call Center toll free at 800-443-0815 (TTY users call 800-777-1370) every day 8 a.m. to 8 p.m.

Moving outside our Northern and Southern California Regions' Service Areas. If you permanently move outside our Northern and Southern California Regions' Service Areas, or you are temporarily absent from your Home Region's Service Area for a period of more than six months in a row, you must notify us and you cannot continue your Senior Advantage membership under this *Evidence of Coverage*. Send your notice to:

For Northern California Members:
Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 232400
San Diego, CA 92193

For Southern California Members:
Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 232407
San Diego, CA 92193

It is in your best interest to notify us as soon as possible because until your Senior Advantage coverage is officially terminated by the Centers for Medicare & Medicaid Services, you will not be covered by us or Original Medicare for any care you receive from Non–Plan Providers, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Certain care when you visit the service area of another Region as described under "Visiting

Other Regions" in the "How to Obtain Services" section

- Chiropractic services as described in the "ASH Plans Chiropractic Services" section in Part Two of this *Evidence of Coverage*, and for Southern California Region Members, chiropractic services as described under "Chiropractic Services" in the "Benefits, Copayments, and Coinsurance" section
- Durable medical equipment as described under "Durable Medical Equipment for Home Use" in the "Benefits, Copayments, and Coinsurance" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits, Copayments, and Coinsurance" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Home health care as described under "Home Health Care" in the "Benefits, Copayments, and Coinsurance" section
- Ostomy and urological supplies as described under "Ostomy and Urological Supplies" in the "Benefits, Copayments, and Coinsurance" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits, Copayments, and Coinsurance" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits, Copayments, and Coinsurance" section
- Prosthetic and orthotic devices as described under "Prosthetic and Orthotic Devices" in the "Benefits, Copayments, and Coinsurance" section
- Routine Services associated with Medicare-approved clinical trials as described under "Routine Services Associated with Clinical Trials" in the "Benefits, Copayments, and Coinsurance" section

Regions outside California. If you move to the service area of another Region outside California, please contact the Health Benefits Officer in your agency (or, if you are retired, the CalPERS Health Account Services Section to learn about your Group health care options. You may be able to enroll in the new service area if there is an agreement between CalPERS and that Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same.

Please call our Member Service Call Center for more information about our other Regions, including their locations in the District of Columbia and parts of Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington.

Note: You may be able to receive certain care if you are visiting a service area in another Region. See "Visiting Other Regions" in the "How to Obtain Services" section for information.

Enrollment

Information pertaining to enrollment can be found in the CalPERS *Health Program Guide*, which is available from the CalPERS Web site at **www.calpers.ca.gov** or by calling CalPERS.

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

Effective date of Senior Advantage coverage

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

your Senior Advantage coverage under this *Evidence of Coverage*.

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

HOW TO OBTAIN SERVICES

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

- Authorized referrals as described under "Getting a Referral" in this "How to Obtain Services" section
- Certain care when you visit the service area of another Region as described under "Visiting Other Regions" in the "How to Obtain Services" section
- Chiropractic services as described in the "ASH Plans Chiropractic Services" section in Part Two of this *Evidence of Coverage*, and for Southern California Region Members, chiropractic services as described under "Chiropractic Services" in the "Benefits, Copayments, and Coinsurance" section
- Durable medical equipment as described under "Durable Medical Equipment for Home Use" in the "Benefits, Copayments, and Coinsurance" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits, Copayments, and Coinsurance" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Home health care as described under "Home Health Care" in the "Benefits, Copayments, and Coinsurance" section
- Ostomy and urological supplies as described under "Ostomy and Urological Supplies" in the "Benefits, Copayments, and Coinsurance" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits, Copayments, and Coinsurance" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits, Copayments, and Coinsurance" section
- Prosthetic and orthotic devices as described under "Prosthetic and Orthotic Devices" in the "Benefits, Copayments, and Coinsurance" section
- Routine Services associated with Medicare-approved clinical trials as described under "Routine Services Associated with Clinical Trials" in the "Benefits, Copayments, and Coinsurance" section

As a Member, you are enrolled in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), called your Home Region. The coverage information in this *Evidence of Coverage* applies when you obtain care in your Home Region.

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

Routine Care

If you need to make a routine care appointment, please refer to *Your Guidebook to Kaiser Permanente Services (Your Guidebook)* for appointment telephone numbers, or go to our website at **kp.org** to request an appointment online. Routine appointments are for medical

needs that aren't urgent (such as routine preventive care and school physicals). Try to make your routine care appointments as far in advance as possible.

Urgent Care

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

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

Our Advice Nurses

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

Your Personal Plan Physician

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

We encourage you to choose a personal Plan Physician. You may choose any available personal Plan Physician. Parents may choose a pediatrician as the personal Plan Physician for their child. Most personal Plan Physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians).

Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal Plan Physicians. For example, some specialists in internal medicine and obstetrics/gynecology who are not designated as Primary Care Physicians may be available as personal Plan Physicians.

To learn how to select a personal Plan Physician, please refer to *Your Guidebook* or call our Member Service Call Center.

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

Getting a Referral

Referrals to Plan Providers

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

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

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

Medical Group authorization procedure for certain referrals

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

- **Durable medical equipment.** If your Plan Physician prescribes durable medical equipment, he or she will submit a written referral to the Plan Hospital's durable medical equipment coordinator, who will authorize the durable medical equipment if he or she determines that your durable medical equipment coverage includes the item and that the item is listed on our formulary for your condition. If the item doesn't appear to meet our durable medical equipment formulary or Medicare guidelines, then the durable medical equipment coordinator will contact the Plan Physician for additional information. If the durable medical equipment request still doesn't appear to meet our durable medical equipment formulary or Medicare guidelines, it will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our durable medical equipment formulary, please refer to "Durable Medical Equipment for Home Use" in the "Benefits, Copayments, and Coinsurance" section
- **Ostomy and urological supplies.** If your Plan Physician prescribes ostomy or urological supplies, he or she will submit a written referral to the Plan Hospital's designated coordinator, who will authorize the item if he or she determines that it is covered in accord with Medicare guidelines or on our soft goods formulary for your condition. If the item doesn't appear to meet our soft goods formulary guidelines, then the coordinator will contact the Plan Physician for additional information. If the request still doesn't appear to meet our soft goods formulary or Medicare guidelines, it will be submitted to the Medical Group's designee Plan Physician, who will authorize the item if he or she determines that it is Medically Necessary. For more information about our soft goods formulary, please refer to "Ostomy and Urological Supplies" in the "Benefits, Copayments, and Coinsurance" section
- **Services not available from Plan Providers.** If your Plan Physician decides that you require covered Services not available from Plan Providers, he or she will recommend to the Medical Group that you be referred to a Non–Plan Provider inside or outside your Home Region's Service Area. The appropriate Medical Group designee will authorize the Services if he or she determines that they are Medically Necessary and are not available from a Plan Provider. Referrals to Non–Plan Physicians will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. Please ask your Plan Physician what Services have been authorized
- **Transplants**. If your Plan Physician makes a written referral for a transplant, the Medical Group's regional transplant advisory committee or board (if one exists) will authorize the Services if it determines that they are Medically Necessary or covered in accord with Medicare guidelines. In cases where no transplant committee or board exists, the Medical Group will refer you to physician(s) at a transplant center, and the Medical Group will authorize the Services if the transplant center's physician(s) determine that they are Medically Necessary or covered in accord with Medicare guidelines. Note: A Plan Physician may provide or authorize a

corneal transplant without using this Medical Group transplant authorization procedure

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

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

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

Copayments and Coinsurance. The Copayments and Coinsurance for these referral Services are the Copayments and Coinsurance required for Services provided by a Plan Provider as described in the "Benefits, Copayments, and Coinsurance" section.

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

Second Opinions

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

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

- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have concerns about the diagnosis or plan of care

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

Copayments and Coinsurance. The Copayments and Coinsurance for these referral Services are the Copayments and Coinsurance required for Services provided by a Plan Provider as described in the "Benefits, Copayments, and Coinsurance" section.

Contracts with Plan Providers

How Plan Providers are paid

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

Financial liability

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

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

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

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

The conditions that are subject to this continuation of care provision are:

Certain conditions that are either acute, or serious and chronic. We may cover these Services for up to 90 days, or longer if necessary for a safe transfer of care to a Plan Physician or other contracting provider as determined by the Medical Group

A high-risk pregnancy or a pregnancy in its second or third trimester. We may cover these Services through postpartum care related to the delivery, or longer if Medically Necessary for a safe transfer of care to a Plan Physician as determined by the Medical Group

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

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

Visiting Other Regions

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

The 90 day limit does not apply to Members who attends an accredited college or accredited vocational school. The service areas and facilities where you may obtain care outside your Home Region's Service Area may change at any time without notice.

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

Your ID Card

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

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

Your Medicare card

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

Getting Assistance

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

Member Services

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

Member Services representatives at our Plan Facilities and Member Service Call Center can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace your ID

card. These representatives can also help you if you need to file a claim as described in the "Request for Payment" section.

Interpreter services

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

EMERGENCY SERVICES AND URGENT CARE

Emergency Services

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

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

Post-Stabilization Care

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

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

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

Copayment

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

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

Services not covered under this "Emergency Services" section

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

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

Urgent Care

Inside the Service Area

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

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

Out-of-Area Urgent Care

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

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

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

Copayment

The Copayments or Coinsurance for covered Urgent Care is the Copayments or Coinsurance required for Services provided by Plan Providers as described in the "Benefits, Copayments and Coinsurance" section:

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

Services not covered under this "Urgent Care" section

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

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

Payment and Reimbursement

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

To request payment or reimbursement, you must file a claim as described in the "Request for Payment" section.

We will reduce any payment we make to you or the Non–Plan Provider by applicable Copayments and Coinsurance.

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

BENEFITS, COPAYMENTS, AND COINSURANCE

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

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
  - health care items and services for preventive care
  - health care items and services for diagnosis, assessment, or treatment
  - health education covered under "Health Education" in this "Benefits and Cost Sharing" section
  - other health care items and services
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except where specifically noted to the contrary in the sections listed below for the following Services:
  - certain care when you visit the service area of another Region as described under "Visiting Other Regions" in the "How to Obtain Services" section
  - chiropractic services as described in the "ASH Plans Chiropractic Services" section in Part Two of this *Evidence of Coverage*, and for Southern California Region Members, chiropractic services as described under "Chiropractic Services" in this "Benefits, Copayments, and Coinsurance" section
  - emergency ambulance Services as described under "Ambulance Services" in this "Benefits, Copayments, and Coinsurance" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
  - out-of-area dialysis care as described under "Dialysis Care" in this "Benefits, Copayments, and Coinsurance" section
- You receive the Services from Plan Providers inside your Home Region's Service Area, except where specifically noted to the contrary in the sections listed below for the following Services:
  - authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
  - certain care when you visit the service area of another Region as described under "Visiting Other Regions" in the "How to Obtain Services" section
  - chiropractic services as described in the "ASH Plans Chiropractic Services" section in Part Two of this *Evidence of Coverage*, and for Southern California Region Members, chiropractic services as described under "Chiropractic Services" in this "Benefits, Copayments, and Coinsurance" section
  - durable medical equipment as described under "Durable Medical Equipment for Home Use" in the "Benefits, Copayments, and Coinsurance" section
  - emergency ambulance Services as described under "Ambulance Services" in the "Benefits, Copayments, and Coinsurance" section
  - Emergency Services, Post-Stabilization Care, and Urgent Care as described in the "Emergency Services and Urgent Care" section

- home health care as described under "Home Health Care" in the "Benefits, Copayments, and Coinsurance" section
- ostomy and urological supplies as described under "Ostomy and Urological Supplies" in the "Benefits, Copayments, and Coinsurance" section
- out-of-area dialysis care as described under "Dialysis Care" in the "Benefits, Copayments, and Coinsurance" section
- prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits, Copayments, and Coinsurance" section
- prosthetic and orthotic devices as described under "Prosthetic and Orthotic Devices" in the "Benefits, Copayments, and Coinsurance" section
- routine Services associated with Medicare-approved clinical trials as described under "Routine Services Associated with Clinical Trials" in the "Benefits, Copayments, and Coinsurance" section

- The Medical Group has given prior authorization for the Services if required under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

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

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

Copayments and Coinsurance

At the time you receive covered Services, you must pay the Copayments or Coinsurance in effect on that date, except as follows:

- If you are receiving covered inpatient hospital or Skilled Nursing Facility Services on the effective date of this *Evidence of Coverage* you pay the Copayments or Coinsurance in effect on your admission date until you are discharged. If the Services were covered under your prior Health Plan evidence of coverage and there has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Copayments or Coinsurance in effect on the date you receive the Services
- For items ordered in advance, you pay the Copayment or Coinsurance 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 or Coinsurance 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

- Before starting or continuing a course of infertility Services, you may be required to pay initial and subsequent deposits toward your Copayment or Coinsurance for some or all of the entire course of Services, along with any past-due infertility-related Copayment or Coinsurance. Any unused portion of your deposit will be returned to you. When a deposit is not required, you must pay the Copayment or Coinsurance for the procedure, along with any past-due infertility-related Copayment or Coinsurance, before you can schedule an infertility procedure
- If you receive more than one Service from a provider, or Services from more than one provider, you may be required to pay separate Copayments or Coinsurance amounts for each Service and each provider. For example, if you receive both preventive Services and non-preventive Services in the same visit, you may have to pay separate Copayments or Coinsurance for each Service received during that visit. Similarly, if your physician requests the assistance of another provider during a procedure, you may have to pay separate Copayments or Coinsurance amounts for the Services provided by each provider. If you have questions about Copayments and Coinsurance, please contact our Member Service Call Center.
- In some cases, we may agree to bill you for your Copayments and Coinsurance amount.

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

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

Annual out-of-pocket maximum

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

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

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

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

- Dental Services covered by Medicare
- Emergency Department and Out-of-Area Urgent Care visits
- Imaging, laboratory, and special procedures
- Medicare Part B drugs
- Mental health care, including intensive psychiatric treatment programs
- Outpatient surgery
- Routine costs associated with Medicare-approved clinical trials
- Services performed during an office visit (including professional Services such as

dialysis treatment, health education counseling and programs, and physical, occupational, and speech therapy)

- Rehabilitation Services, including care in a Comprehensive Outpatient Rehabilitation Facility

Preventive Care Services

This "Preventive Care Services" section explains the Copayments or Coinsurance for Medicare-covered preventive care Services, but does not otherwise explain coverage. These preventive care Services are subject to all coverage requirements described in other parts of this "Benefits, Copayments and Coinsurance" section and all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. For example, we cover a preventive care Service that is an outpatient laboratory Service only if it is covered as described under the "Outpatient Imaging, Laboratory, and Special Procedures" section, subject to the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section.

We cover the following preventive care Services at **no charge** in accord with Medicare guidelines:

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

There is no Copayment or Coinsurance for the specified preventive care. However, the applicable Copayment or Coinsurance listed elsewhere in the "Benefits, Copayments and Coinsurance" section may apply to any non-preventive Services you receive during or subsequent to a preventive care visit or screening.

Outpatient Care

We cover the following outpatient care subject to the Copayment or Coinsurance indicated:

- Primary and specialty care consultations and exams (other than those described below in this “Outpatient Care” section): **a $10 Copayment per visit**
- Annual Wellness Visit and the Welcome to Medicare Exam in accord with Medicare guidelines: **no charge**
- Family planning counseling, or to obtain internally implanted time-release contraceptives, or intrauterine devices (IUDs) prescribed in accord with our drug formulary guidelines: **a $10 Copayment per visit**
- After confirmation of pregnancy, the normal series of regularly scheduled preventive

prenatal care exams and the first postpartum follow-up consultation and exam: **a $10 Copayment per visit**

- Immunizations (including vaccines) covered by Medicare Part B and administered to you in a Plan Medical Office: **no charge**
- Allergy injections (including allergy serum): **a $3 Copayment per visit**
- Outpatient surgery and other outpatient procedures: **a $10 Copayment per procedure**
- Voluntary termination of pregnancy: **a $10 Copayment per procedure**
- Physical, occupational, and speech therapy in accord with Medicare guidelines: **a $10 Copayment per visit**
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program in accord with Medicare guidelines: **a $10 Copayment per day**
- Acupuncture Services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain): **a $10 Copayment per visit**
- Urgent Care consultations and exams: **a $10 Copayment per visit**
- Emergency Department visits: **a $50 Copayment per visit**. The Emergency Department Copayment does not apply if you are admitted to the hospital as an inpatient within 24 hours for the same condition for covered Services or if you are admitted for observation in a hospital unit outside the Emergency Department
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside your Home Region's Service Area when care can best be provided in your home as determined by a Plan Physician: **no charge**
- Blood, blood products, and their administration: **no charge**
- Administered drugs (drugs, injectables, radioactive materials used for therapeutic purposes, and allergy test and treatment materials) prescribed in accord with our drug formulary guidelines, if administration or observation by medical personnel is required and they are administered to you in a Plan Medical Office or during home visits: **no charge**
- Preventive health screenings, such as screening and tests for colorectal cancer in accord with Medicare guidelines: **no charge**
- Some types of outpatient consultations and exams may be available as group appointments, which we cover at **a $5 Copayment per visit**

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

Services not covered under this "Outpatient Care" section

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

- Bariatric Surgery
- Chemical Dependency Services
- Chiropractic Services
- Dental Services for Radiation Treatment and Dental Anesthesia
- Dialysis Care
- Durable Medical Equipment for Home Use
- Health Education
- Hearing Services

- Home Health Care
- Hospice Care
- Infertility Services
- Mental Health Services
- Ostomy and Urological Supplies
- Outpatient Imaging, Laboratory, and Special Procedures
- Outpatient Prescription Drugs, Supplies, and Supplements
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Routine Services Associated with Clinical Trials
- Transplant Services
- Vision Services

Hospital Inpatient Care

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

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

Services not covered under this "Hospital Inpatient Care" section

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

- Bariatric Surgery
- Chemical Dependency Services
- Dental Services for Radiation Treatment and Dental Anesthesia
- Dialysis Care
- Hospice Care
- Infertility Services
- Mental Health Services

- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Religious Nonmedical Health Care Institution Services
- Routine Services Associated with Clinical Trials
- Skilled Nursing Facility Care
- Transplant Services

Ambulance Services

Emergency

We cover at **no charge** Services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) if one of the following is true:

- You reasonably believe that you have an Emergency Medical Condition and you reasonably believe that your condition requires the clinical support of ambulance transport services
- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

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

Nonemergency

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

Ambulance Services exclusion

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

Bariatric Surgery

We cover hospital inpatient care related to bariatric surgical procedures (including room and board, imaging, laboratory, special procedures, and Plan Physician Services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met:

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

For covered Services related to bariatric surgical procedures that you receive, you will pay the **Copayment and Coinsurance you would pay if the Services were not related to a bariatric surgical procedure**.

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

your home. We will reimburse authorized and documented travel and lodging expenses as follows:

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

Services not covered under this "Bariatric Surgery" section

Coverage for the following Services is described under these headings in this “Benefits, Copayments, and Coinsurance” section:

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

Chemical Dependency Services

Inpatient detoxification

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

Outpatient chemical dependency care

We cover the following Services for treatment of chemical dependency:

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

You pay the following for these covered Services:

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

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

Transitional residential recovery Services

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

Services not covered under this "Chemical Dependency Services" section

Coverage for the following Services is described under these headings in this "Benefits, Copayments, and Coinsurance" section:

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

Chemical dependency Services exclusion

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

Chiropractic Services

Manual manipulation covered by Medicare

Manual manipulation of the spine is covered at **a $10 Copayment per visit** to correct subluxation, in accord with Medicare guidelines, but only if the manipulation is performed for Southern California Region Members by an American Specialty Health Plans (ASH Plans) Participating Chiropractor (no referral required), or when prescribed or authorized by a Plan Physician and performed by a Plan or network osteopath or chiropractor for Northern California Region Members.

Additional chiropractic coverage

Please see the "ASH Plans Chiropractic Services" section in Part Two of this *Evidence of Coverage* for information about chiropractic services we cover through American Specialty Health Plans (ASH Plans).

Dental Services for Radiation Treatment and Dental Anesthesia

Dental Services for radiation treatment

We cover services in accord with Medicare guidelines, including dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck at **a $10 Copayment per visit** if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental anesthesia

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

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

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

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

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

Coverage for the following Services is described under these headings in this "Benefits, Copayments, and Coinsurance" section:

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

Dialysis Care

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

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

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

Out-of-area dialysis care

We cover dialysis (kidney) Services that you get at a Medicare-certified dialysis facility when you are temporarily outside your Home Region's Service Area. If possible, before you leave the Service Area, please let us know where you are going so we can help arrange for you to have maintenance dialysis while outside your Home Region's Service Area.
Note: The procedure for obtaining reimbursement for out-of-area dialysis care is described in the "Request for Payment" section.

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

- Inpatient dialysis care: **no charge**
- One routine office consultation or exam per month with the multidisciplinary nephrology team: **no charge**
- All other consultations or exams: **a $10 Copayment per visit**
- Hemodialysis treatment: **no charge**

Services not covered under this "Dialysis Care" section

Coverage for the following Services is described under these headings in this "Benefits, Copayments, and Coinsurance" section:

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

Dialysis Care exclusions

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

Durable Medical Equipment for Home Use

Inside your Home Region's Service Area, we cover durable medical equipment for use in your home (or another location used as your home as defined by Medicare) in accord with our durable medical equipment formulary and Medicare

guidelines. However, we will cover DME described in this section if you were enrolled in Senior Advantage on December 31, 1998, and you lived inside California, but outside your Home Region's Service Area, and you continue to live at the same address. Durable medical equipment for home use is an item that is intended for repeated use, primarily and customarily used to serve a medical purpose, generally not useful to a person who is not ill or injured, and appropriate for use in the home.

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

Durable medical equipment for diabetes

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

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

About our durable medical equipment formulary

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

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

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

Coverage for the following Services is described under these headings in this "Benefits, Copayments, and Coinsurance" section:

- Dialysis equipment and supplies required for home hemodialysis and home peritoneal dialysis (refer to "Dialysis Care")
- Diabetes urine testing supplies and insulin-administration devices other than insulin pumps (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Durable medical equipment related to the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")

Durable medical equipment for home use exclusions

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

Health Education

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

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

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

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

You pay the following for these covered Services:

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

Hearing Services

We cover the following:

- Routine preventive hearing screenings: **no charge**
- Hearing exams to determine the need for hearing correction: **a $10 Copayment per visit**

- Hearing tests to determine the need for hearing correction: **a $10 Copayment per visit**
- Hearing tests to determine the appropriate hearing aid: **no charge**
- A **$1,000 Allowance** toward the purchase price of hearing aid(s) every 36 months when prescribed by a Plan Physician or by a Plan Provider who is an audiologist. We will cover hearing aids for both ears only if both aids are required to provide significant improvement that is not obtainable with only one hearing aid. We will not provide the Allowance if we have provided an Allowance toward (or otherwise covered) a hearing aid for that ear within the previous 36 months. Also, the Allowance can only be used at the initial point of sale. If you do not use all of your Allowance at the initial point of sale, you cannot use it later
- Visits to verify that the hearing aid conforms to the prescription: **no charge**
- Visits for fitting, counseling, adjustment, cleaning, and inspection after the warranty is exhausted: **no charge**

We select the provider or vendor that will furnish the covered hearing aid. Coverage is limited to the types and models of hearing aids furnished by the provider or vendor.

Services not covered under this "Hearing Services" section

Coverage for the following Services is described under these headings in this "Benefits, Copayments, and Coinsurance" section:

- Services related to the ear or hearing other than those described in this section (refer to the applicable heading in this "Benefits, Copayments, and Coinsurance" section)
- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")

Hearing Services exclusions

- Internally implanted hearing aids
- Replacement parts and batteries, repair of hearing aids, and replacement of lost or broken hearing aids (the manufacturer warranty may cover some of these)

Home Health Care

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

- You are substantially confined to your home
- Your condition requires the Services of a nurse, physical therapist, or speech therapist, or you have a continued need for an occupational therapist (home health aide Services are not covered unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide)
- A Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home and that the Services can be safely and effectively provided in your home
- The Services are provided inside your Home Region's Service Area. However, we will cover home health care if you were enrolled in Senior Advantage on December 31, 1998 and lived inside California, but outside your Home Region's Service Area, and you continue to live at the same address
- The Services are covered in accord with Medicare guidelines, such as part-time or intermittent skilled nursing care and part-time or intermittent Services of a home health aide

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

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

Home health care exclusion

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

Hospice Care

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

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

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

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

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

term inpatient care limited to no more than five consecutive days at a time

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

Special note if you have Medicare Part A

If you have Medicare Part A, you may receive care from any Medicare-certified hospice program. When you enroll in a Medicare-certified hospice program, your hospice services and your Original Medicare services related to your terminal condition are paid for by Original Medicare, not Health Plan and you will be responsible for payment of Original Medicare Copayment or Coinsurance amounts. If you elect hospice care, you are not entitled to any other benefits for the terminal illness under this "Benefits, Copayments, and Coinsurance" section or Medicare. However, we will continue to cover the Services described in this "Benefits, Copayments, and Coinsurance" section that are not related to the terminal illness. Original Medicare (rather than our Plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in a hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. You may change your decision to receive hospice care at any time.

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

- You can obtain your non-hospice care from plan providers. In this case, you only pay plan allowed Copayments and Coinsurance
- --or-- You can get your care covered by Original Medicare. In this case, you must pay the cost-sharing amounts under Original Medicare, except for emergency or urgently needed care

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

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

Infertility Services

We cover the following Services related to involuntary infertility:

- Services for diagnosis and treatment of involuntary infertility
- Artificial insemination
- You pay the following for these Services related to involuntary infertility:
- Consultations or exams: **a $10 Copayment per visit**
- Outpatient surgery and other outpatient procedures: **a $10 Copayment per procedure**
- Outpatient imaging, laboratory, and special procedures: **no charge**

- Hospital inpatient care (including room and board, imaging, laboratory, and special procedures, and Plan Physician Services): **no charge**

Services not covered under this "Infertility Services" section

Coverage for the following Services is described under these headings in this "Benefits, Copayments, and Coinsurance" section:

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

Infertility Services exclusions

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

Mental Health Services

We cover Services specified in this "Mental Health Services" section only when the Services are for the diagnosis or treatment of Mental Disorders. A Mental Disorder is a mental health condition as identified in the *Diagnostic and Statistical Manual of Mental* Disorders*, Fourth Edition, Text Revision (DSM)* that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning.

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

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

Outpatient mental health Services

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

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

You pay the following for these covered Services:

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

- Group mental health treatment: **a $5 Copayment per visit**

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

Inpatient psychiatric hospitalization and intensive psychiatric treatment programs

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

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

Services not covered under this "Mental Health Services" section

Coverage for the following Services is described under these headings in this “Benefits, Copayments, and Coinsurance” section:

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

Ostomy and Urological Supplies

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

Note: We will cover ostomy and urological supplies described in this section if you were enrolled in Senior Advantage on December 31, 1998 and lived inside California, but outside your Home Region’s Service Area, and you continue to live at the same address.

About our soft goods formulary

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

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

Ostomy and urological supplies exclusion

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Special Procedures

We cover the following Services at the Copayment or Coinsurance indicated only when prescribed as part of care covered under other headings in this "Benefits, Copayments, and Coinsurance" section:

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

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

Coverage for the following Services is described under these headings in this "Benefits, Copayments, and Coinsurance" section:

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

Outpatient Prescription Drugs, Supplies, and Supplements

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

- The item is prescribed either (a) by a Plan Physician, or (b) by a dentist or a Non–Plan Physician in the following circumstances unless a Plan Physician determines that the item is not Medically Necessary or is for a sexual dysfunction disorder:
  - a Non–Plan Physician prescribes the item after the Medical Group authorizes a written referral to a Non–Plan Physician (in accord with "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section) and the item is covered as part of that referral
  - a Non–Plan Physician prescribes the item in conjunction with covered Emergency

Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section

- a dentist prescribes the drug for dental care

- The item meets the requirements of our applicable drug formulary guidelines (our Medicare Part D formulary or our formulary applicable to non-Part D items)
- You obtain the item from a Plan Pharmacy or our mail-order service, except as otherwise described under "Certain items from Non–Plan Pharmacies" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section. Please refer to our *Kaiser Permanente Medicare Part D Pharmacy Directory* for the locations of Plan Pharmacies in your area. Plan Pharmacies can change without notice and if a pharmacy is no longer a Plan Pharmacy, you must obtain covered items from another Plan Pharmacy, except as otherwise described under "Certain items from Non–Plan Pharmacies" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section

Obtaining refills by mail

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

Certain items from Non–Plan Pharmacies

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

- The drug is related to covered Emergency Care, Post-Stabilization Care, or Out-of-Area Urgent Care, described in the "Emergency Services and Urgent Care" section. Note: Prescription drugs prescribed and provided outside of the United States and its territories as part of covered Emergency Care or Urgent Care are covered up to a 30-day supply in a 30-day period. These drugs are covered under Part C benefits, and are not covered under Medicare Part D. Therefore, payments for these drugs do not count toward reaching the Part D Catastrophic Coverage Stage
- For Medicare Part D covered drugs, the following are additional situations when a Part D drug may be covered:

- If you are traveling outside your Home Region's Service Area, but in the United States and its territories, and you become ill or run out of your covered Part D prescription drugs. We will cover prescriptions that are filled at a Non–Plan Pharmacy according to our Medicare Part D formulary guidelines
- If you are unable to obtain a covered drug in a timely manner inside your Home Region's Service Area because there is no Plan Pharmacy within a reasonable driving distance that provides 24 hour service. We may not cover your prescription if a reasonable person could have purchased the drug at a Plan Pharmacy during normal business hours

If you are trying to fill a prescription for a drug that is not regularly stocked at an accessible Plan Pharmacy or available through our mail order pharmacy (including high-cost drugs)

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

Medicare Part D drugs

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

Copayment and Coinsurance for Medicare Part D drugs. Unless you reach the Catastrophic Coverage Stage in a calendar year, you will pay the following Copayments and Coinsurance for covered Medicare Part D drugs:

- Generic (preferred and nonpreferred) drugs:
  - **a $5 Copayment** for up to a 30-day supply, **a $10 Copayment** for a 31- to 60-day supply, or **a $15 Copayment** for a 61- to 100-day supply at a Plan Pharmacy
  - **a $5 Copayment** for up to a 30-day supply, or **a $10 Copayment** for a 31- to 100-day supply through our mail-order service
- For brand-name (preferred and nonpreferred) drugs, Part D vaccines, and specialty drugs:
  - **a $20 Copayment** for up to a 30-day supply, **a $40 Copayment** for a 31- to 60-day supply, or **a $60 Copayment** for a 61- to 100-day supply at a Plan Pharmacy
  - **a $20 Copayment** for up to a 30-day supply or **a $40 Copayment** for a 31- to 100-day supply through our mail-order service
- Emergency contraceptive pills: **no charge**
- The following insulin-administration devices at **a $5 Copayment** for up to a 100-day supply: needles, syringes, alcohol swabs, and gauze

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

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

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

Catastrophic Coverage Stage. All Medicare Prescription Drug Plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend **$4,700** out-of-pocket during 2012. When the total amount you have paid for your

Copayments or Coinsurance reaches **$4,700**, you will pay the following for the remainder of 2012:

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

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

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

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

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

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

- Family members or other individuals
- Medicare programs that provide extra help with prescription drug coverage including the Medicare Coverage Gap Discount Program
- Most charities or charitable organizations that pay Copayment or Coinsurance on your behalf. Please note that if the charity is established, run, or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs
- AIDS drug assistance programs
- Indian Health Service

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

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

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

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

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

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

If you believe you have qualified for Extra Help and you believe that you are paying an incorrect Cost Sharing amount when you get your prescription at a Plan Pharmacy, we have established a process that allows you either to request assistance in obtaining evidence of your proper Cost Sharing level, or, if you already have the evidence, to provide this evidence to us. If you aren't sure what evidence to provide us, please contact a Plan Pharmacy or our Member Service Call Center. The evidence is often a letter from either your state Medicaid 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 Plan Pharmacy when obtaining covered Part D prescriptions so that we may charge you the appropriate Cost Sharing amount until the Centers for Medicare & Medicaid Services updates its records to reflect your current status. Once the Centers for Medicare & Medicaid Services updates its records, you will no longer need to present the evidence to the Plan Pharmacy. Please provide your evidence in one of the following ways so we can forward it to the Centers for Medicare & Medicaid Services for updating:

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

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

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

Medicare Part D List of Covered Drugs (Formulary)

Our Medicare Part D formulary is a list of covered drugs selected by our Plan in consultation with a team of health care providers, that represents the prescription therapies believed to be a necessary part of a

quality treatment program. Our formulary must meet requirements set by Medicare and is approved by Medicare. Our formulary includes all drugs that can be covered under Medicare Part D according to Medicare requirements. For a complete, current listing of the Medicare Part D prescription drugs we cover, please visit our website at **kp.org/seniormedrx** or call our Member Service Call Center.

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

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

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

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

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

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

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

- You may ask your Plan Physician if you can switch to another drug that is covered by us
- You or your Plan Physician may ask us to make an exception (a type of coverage

determination) to cover your Medicare Part D drug. See the "Coverage Decisions, Complaints, and Appeals" section for more information on how to request an exception

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

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

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

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

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

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

Other prescription drug coverage. If you have additional health care or drug coverage from

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

Outpatient drugs covered by Medicare Part B

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

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

Copayment for Medicare Part B drugs.

You pay the following for Medicare Part B drugs:

- Generic drugs:
  - **a $5 Copayment** for up to a 30-day supply, **a $10 Copayment** for a 31- to 60-day supply, or **a $15 Copayment** for a 61- to 100-day supply at a Plan Pharmacy
  - **a $5 Copayment** for up to a 30-day supply or **a $10 Copayment** for a 31- to 100-day supply through our mail-order service
- Brand-name drugs, specialty drugs and compounded products:
  - **a $20 Copayment** for up to a 30-day supply, **a $40 Copayment** for a 31- to 60-day supply, or **a $60 Copayment** for a 61- to 100-day supply at a Plan Pharmacy
  - **a $20 Copayment** for up to a 30-day supply or **a $40 Copayment** for a 31- to 100-day supply through our mail-order service

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

Other outpatient drugs, supplies, and supplements

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

- Drugs for which a prescription is required by law that are not covered by Medicare Part B or D. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary applicable to non-Part D items. Note: Certain tobacco-cessation drugs if not covered by Medicare Part D are covered only if you participate in a behavioral intervention program approved by the Medical Group

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

Copayments and Coinsurance for other outpatient drugs, supplies, and supplements. The Copayments and Coinsurance for these items are as follows:

- Generic items:
  - **a $5 Copayment** for up to a 30-day supply, **a $10 Copayment** for a 31- to 60-day supply, or **a $15 Copayment** for a 61- to 100-day supply at a Plan Pharmacy
  - **a $5 Copayment** for up to a 30-day supply or **a $10 Copayment** for a 31- to 100-day supply through our mail-order service
  - drugs prescribed for the treatment of sexual dysfunction disorders: **50 percent Coinsurance** for up to a 100-day supply at a Plan Pharmacy or through our mail-order service
  - drugs prescribed for the treatment of infertility: **50 percent Coinsurance** for up to a 100-day supply at a Plan Pharmacy or through our mail order service
- Brand-name items, specialty drugs, and compounded products:
  - **a $20 Copayment** for up to a 30-day supply, **a $40 Copayment** for a 31- to 60-day supply, or **a $60 Copayment** for a 61- to 100-day supply at a Plan Pharmacy
  - **a $20 Copayment** for up to a 30-day supply or **a $40 Copayment** for a 31- to 100-day supply through our mail-order service
  - drugs prescribed for the treatment of sexual dysfunction disorders: **50 percent Coinsurance** for up to a 100-day supply at a Plan Pharmacy or through our mail-order service
  - drugs prescribed for the treatment of infertility: **50 percent Coinsurance** for up to a 100-day supply at a Plan Pharmacy or through our mail order service
- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria) and elemental dietary enteral formula when used as a primary therapy for regional enteritis: **no charge** for up to a 30-day supply
- Continuity drugs: **50 percent Coinsurance** for up to a 30-day supply in a 30-day period
- Diaphragms and cervical caps: **a $15 Copayment per item**
- Diabetes urine-testing supplies: **no charge** for up to a 100-day supply

Non- Part D drug formulary. Our non- Part D drug formulary includes the list of drugs that have been approved by our Pharmacy and Therapeutics Committee for our Members. Our Pharmacy and Therapeutics Committee, which is primarily composed of Plan Physicians, selects drugs for the drug formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature. The Pharmacy and Therapeutics Committee meets quarterly to consider additions and

deletions based on new information or drugs that become available. If you would like to request a copy of our non- Part D drug formulary, please call our Member Service Call Center. Note: The presence of a drug on our drug formulary does not necessarily mean that your Plan Physician will prescribe it for a particular medical condition.

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

Certain intravenous drugs, supplies, and supplements

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

Drug utilization review

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

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

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

Medication therapy management programs

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

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

ID card at Plan Pharmacies

You must present your Kaiser Permanente ID card when obtaining covered items from Plan Pharmacies that are not owned and operated by Kaiser Permanente. If you do not have your ID card, the Plan Pharmacy may require you to pay

Charges for your covered items, and you will have to file a claim for reimbursement as described in the "Requests for Payment" section.

Notes:

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

Outpatient prescription drugs, supplies, and supplements limitations

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

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

- **Quantity limits:** The Plan Pharmacy may reduce the day supply dispensed at the Copayment or Coinsurance specified in this "Outpatient Drugs, Supplies, and Supplements" section to a 30-day supply in any 30-day period for specific drugs. Your Plan Pharmacy can tell you if a drug you take is one of these drugs. In addition, we cover episodic drugs prescribed for the treatment of sexual dysfunction up to a maximum of 8 doses in any 30-day period, up to 16 doses in any 60-day period, or up to 27 doses in any 100-day period. Also, when there is a shortage of a drug in the marketplace and the amount of available supplies, we may reduce the quantity of the drug dispensed accordingly and charge one Copayment
- **Generic substitution:** When there is a generic version of a brand-name drug available, Plan Pharmacies will automatically

give you the generic version, unless your Plan Physician has specifically requested a formulary exception because it is Medically Necessary for you to receive the brand-name drug instead of the formulary alternative

Outpatient prescription drugs, supplies, and supplements exclusions

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

Prosthetic and Orthotic Devices

Inside your Home Region's Service Area, we cover the prosthetic and orthotic devices specified in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes, and generally not useful to a person who is not ill or injured.
- The device is the standard device that adequately meets your medical needs.
- You receive the device from the provider or vendor that we select.

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

Note: If you were enrolled in Senior Advantage on December 31, 1998, and lived outside your Home Region's Service Area, but inside California, and you continue to live at the same address, we will cover prosthetic and orthotic devices described in this section.

Internally implanted devices

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

External devices

We cover the following external prosthetic and orthotic devices at **no charge**:

- Prosthetics and orthotics in accord with Medicare guidelines. These include braces, prosthetic shoes, artificial limbs, and therapeutic footwear for severe diabetes-related foot disease in accord with Medicare guidelines
- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- Prostheses needed after a Medically Necessary mastectomy, including custom-made prostheses when Medically Necessary
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist

- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect
- Other covered prosthetic and orthotic devices:
  - prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity
  - orthotic devices required to support or correct a defective body part in accord with Medicare guidelines
  - covered special footwear when custom made for foot disfigurement due to disease, injury, or developmental disability

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

Coverage for the following Services is described under these headings in this “Benefits, Copayments, and Coinsurance” section:

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

Prosthetic and orthotic devices exclusions

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

Reconstructive Surgery

We cover the following reconstructive surgery Services.

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

You pay the following for covered reconstructive surgery Services:

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

Services not covered under this "Reconstructive Surgery" section

Coverage for the following Services is described under these headings in this “Benefits, Copayments, and Coinsurance” section:

- Outpatient imaging and laboratory (refer to “Outpatient Imaging, Laboratory, and Special Procedures”)

- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")

Reconstructive surgery exclusions

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

Religious Nonmedical Health Care Institution Services

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

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

Routine Services Associated with Clinical Trials

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

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

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

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

you would if you received these Services from our Plan.

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

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

Routine Services associated with clinical trials exclusions

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

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

Skilled Nursing Facility Care

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

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

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

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

Coverage for the following Services is described under these headings in this “Benefits, Copayments, and Coinsurance” section:

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

Non–Plan Skilled Nursing Facility care

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

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

Transplant Services

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

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

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

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

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

Services not covered under this "Transplant Services" section

Coverage for the following Services is described under these headings in this “Benefits, Copayments, and Coinsurance” section:

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

Vision Services

We cover the following**:**

- Routine preventive vision screenings: no charge
- Glaucoma screenings in accord with Medicare guidelines and eye exams for refraction to determine the need for vision correction and to provide a prescription for eyeglass lenses: **a $10 Copayment per visit**.

We cover Services listed below at Plan Medical Offices or Plan Optical Sales Offices. The date we provide an Allowance toward (or otherwise cover) an item under this "Vision Services" section is the date on which you order the item. For example, if we last provided an Allowance toward an item you ordered on May 1, 2011, and if we provide an Allowance not more than once every 24 months for that type of item, then we would not provide another Allowance toward that type of item until on or after May 1, 2013. You can use the Allowances under this "Vision Services" section only when you first order an item. If you use part but not all of an Allowance when you first order an item, you cannot use the rest of that Allowance later.

Optical Services

Eyeglasses and contact lenses. We provide a single **$175 Allowance** toward the purchase price of any or all of the following every 24 months when a physician or optometrist prescribes an eyeglass lens (for eyeglass lenses and frames) or contact lens (for contact lenses):

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

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

Replacement lenses. If you have a change in prescription of at least .50 diopter in one or both eyes between 12 and 24 months of the date we covered eyeglasses lenses of the type described in this “Eyeglasses and contact lenses” section, we will cover a replacement Regular Eyeglass Lens for the eye that had the .50 diopter change at no charge.

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

- Up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period to treat aniridia (missing iris): **no charge.** We will not cover an aniridia contact lens if we provided an Allowance toward (or otherwise covered) more than one aniridia contact lens for that eye within the previous 12 months (including when we provided an allowance toward, or otherwise covered, one or more aniridia contact lenses under any other evidence of coverage offered by your Group)
- If contact lenses (other than contact lenses for aniridia) will provide a significant improvement in your vision that eyeglass lenses cannot provide, we cover either one pair of contact lenses (including fitting and dispensing) or an initial supply of disposable contact lenses (including fitting and dispensing) not more than once every 24 months at **no charge**. We will not cover any contact lenses under this “Special contact lenses” section if we provided an Allowance toward (or otherwise covered) a contact lens within the previous 24 months, but not including any of the following:
  - contact lenses for aniridia
  - contact lenses we provided an Allowance toward (or otherwise covered) under

"Eyeglasses and contact lenses following cataract surgery" in this "Vision Services" section as a result of cataract surgery

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

Aphakic Eyewear. In accord with Medicare guidelines, we cover at **no charge** corrective lenses (including contact lens fitting and dispensing) and frames (and replacements) for Members who are aphakic (for example, who have had a cataract removed but do not have an implanted intraocular lens (IOL) or who have congenital absence of the lens) when prescribed by a Plan Physician or Plan Optometrist.

Services not covered under this "Vision Services" section

Coverage for the following Services is described under other headings in this “Benefits, Copayments, and Coinsurance” section:

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

Vision Services exclusions

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

EXCLUSIONS, LIMITATIONS, COORDINATION OF BENEFITS, AND REDUCTIONS

Exclusions

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

Certain exams and Services

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

Conception by artificial means

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

Cosmetic Services

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

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

Custodial care

"Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine). This exclusion does not apply to assistance with activities of daily living that is provided as part covered hospice for Members who do not have Part A, Skilled Nursing Facility, or inpatient hospital care.

Dental care

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

Disposable supplies

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

This exclusion does not apply to disposable supplies covered in accord with Medicare guidelines or under "Durable Medical Equipment

for Home Use," "Home Health Care," "Hospice Care," "Ostomy and Urological Supplies," and "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits, Copayments, and Coinsurance" section.

Experimental or investigational Services

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

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

Hair loss or growth treatment

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

Intermediate care

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

Items and services that are not health care items and services

For example, we do not cover:

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

Massage therapy

Oral nutrition

Outpatient oral nutrition, such as dietary supplements, herbal supplements, weight loss aids, formulas, and food.
This exclusion does not apply to any of the following:

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

Residential care

Care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a

hospital, a Skilled Nursing Facility, inpatient respite care covered in the "Hospice Care" section for Members who do not have Part A, a licensed facility providing crisis residential Services covered under " Inpatient psychiatric hospitalization and intensive psychiatric treatment programs" in the "Mental Health Services" section, or a licensed facility providing transitional residential recovery Services covered under the "Chemical Dependency Services" section.

Routine foot care items and services

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

Services not approved by the U.S. Food and Drug Administration

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

Services not covered by Medicare

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

Services performed by unlicensed people

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

Services related to a noncovered Service

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

Surrogacy

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

Transgender surgery

Travel and lodging expenses

Travel and lodging expenses, except that in some situations if the Medical Group refers you to a Non–Plan Provider as described in “Medical Group authorization procedure for certain referrals” under “Getting a Referral” in the “How to Obtain Services” section, we may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines. Our travel and lodging guidelines are available from our Member Service Call Center.

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

Limitations

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

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

Coordination of Benefits

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

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

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

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

In general, the coverage that pays its share of your bills first is called the "primary payer." Then the other company or companies that are involved (called the "secondary payers") each pay their share of what is left of your bills. Often your other coverage will settle its share of payment directly with us and you will not have to be involved. However, if payment owed to us is sent directly to you, you are required under Medicare law to give this payment to us. When you have additional coverage, whether we pay first or

second, or at all, depends on what type or types of additional coverage you have and the rules that apply to your situation. Many of these rules are set by Medicare. Some of them take into account whether you have a disability or have end-stage renal disease, or how many employees are covered by an employer's group plan.

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

Reductions

Employer responsibility

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

Government agency responsibility

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

Injuries or illnesses alleged to be caused by third parties

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

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

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

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

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

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

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

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

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

Surrogacy arrangements

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

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

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

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

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

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

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

U.S. Department of Veterans Affairs

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

Workers' compensation or employer's liability benefits

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

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

REQUEST FOR PAYMENT

Request for Payment of Covered Services or Part D drugs

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

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

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

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

- **When you've received emergency, urgent, or dialysis care from a Non–Plan Provider.** You can receive emergency services from any provider, whether or not the provider is a Plan Provider. When you receive emergency, urgent, or dialysis care from a Non–Plan Provider, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill our Plan for our share of the cost
  - if you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made
  - at times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made. If the provider is owed anything, we will pay the provider directly. If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost
- **When a Plan Provider sends you a bill you think you should not pay.** Plan Providers should always bill us directly, and ask you only for your share of the cost
  - whenever you get a bill from a Plan Provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
  - if you have already paid a bill to a Plan Provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under our Plan.
- **If you are retroactively enrolled in our Plan.** Sometimes a person's enrollment in our Plan is retroactive. (Retroactive means that the first day of their enrollment has already past. The enrollment date may even have occurred last year.) If you were retroactively enrolled in our Plan and you paid out-of-pocket for any of your covered Services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need

to submit paperwork for us to handle the reimbursement. Please call our Member Service Call Center for additional information about how to ask us to pay you back and deadlines for making your request

- **When you use a Non–Plan Pharmacy to get a prescription filled.** If you go to a Non–Plan Pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. (We cover prescriptions filled at Non-Plan Pharmacies only in a few special situations. Please see "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits, Copayment and Coinsurance" section to learn more)
  - save your receipt and send a copy to us when you ask us to pay you back for our share of the cost
- **When you pay the full cost for a prescription because you don't have your Plan membership card with you.** If you do not have your Plan membership card with you, you can ask the pharmacy to call us or to look up your Plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself
  - save your receipt and send a copy to us when you ask us to pay you back for our share of the cost
- **When you pay the full cost for a prescription in other situations.** You may pay the full cost of the prescription because you find that the drug is not covered for some reason
  - for example, the drug may not be on our Plan's *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 patients 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 when you ask us to pay you back

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

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

How and where to send us your request for payment

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

- As soon as possible, request our claim form by calling our Member Service Call Center toll free at 1-800-443-0815 or 1-800-390-3510 (TTY users call 1-800-777-1370). One of our representatives will be happy to assist you if you need help completing our claim form
- If you have paid for Services, you must send us your request for reimbursement. Please attach any bills and receipts from the Non–Plan Provider

- You must complete and return to us any information that we request to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled. For example, we may require documents such as travel documents or original travel tickets to validate your claim
- The completed claim form must be mailed to the following address as soon as possible, but no later than 15 months after receiving the care (or up to 27 months according to Medicare rules, in some cases). Please do not send any bills or claims to Medicare. Any additional information we request should also be mailed to this address:

  For Northern California Members:
  Kaiser Foundation Health Plan, Inc.
  Claims Department
  P.O. Box 24010
  Oakland, CA 94623-1010

  For Southern California Members:
  Kaiser Foundation Health Plan, Inc.
  Claims Department
  P.O. Box 7004
  Downey, CA 90242-7004

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

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

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

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

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

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

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

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

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

For the details on how to make this appeal, go to the "Coverage Decisions, Appeals, and Complaints" section. The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new

to you, you will find it helpful to start by reading "A Guide to the Basics of Coverage Decisions and Appeals" in the "Coverage Decisions, Appeals, and Complaints" section, which is an introductory section that explains the process for coverage decisions and appeals and gives definitions of terms such as "appeal." Then after you have read "A Guide to the Basics of Coverage Decisions and Appeals," you can go to the section in "Coverage Decisions, Appeals, and Complaints" that tells what to do for your situation:

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

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

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

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

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

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

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

COVERAGE DECISIONS, APPEALS, AND COMPLAINTS

Introduction

What to do if you have a problem or concern

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

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

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

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

What about the legal terms?

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

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

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

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

Where to get more information and personalized assistance

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

Get help from an independent government organization

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

The services of State Health Insurance Assistance Program counselors are free. You will find phone numbers in the "Helpful Information" section.

You can also get help and information from Medicare

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

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

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

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

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

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

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

Other dispute resolution options

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

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

A Guide to the Basics of Coverage Decisions and Appeals

Asking for coverage decisions and making appeals: The big picture

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

Asking for coverage decisions

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

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

Making an appeal

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

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

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

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

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

- You can call our Member Service Call Center (phone numbers are on the cover)
- To get free help from an independent organization that is not connected with our Plan, contact your State Health Insurance Assistance Program (see the "Helpful Information" section)
- Your doctor or other provider can make a request for you. Your doctor or other provider can request a coverage decision or a Level 1 Appeal on your behalf. To request any appeal after Level 1, your doctor or other provider must be appointed as your representative
- You can ask someone to act on your behalf. If you want to, you can name another person to

act for you as your "representative" to ask for a coverage decision or make an appeal

- there may be someone who is already legally authorized to act as your representative under State law
- if you want a friend, relative, your doctor or other provider, or other person to be your representative, call our Member Service Call Center and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at www.cms.hhs.gov/cmsforms/downloads/cms1696.pdf.) The form gives that person permission to act on your behalf. It must be signed by you and by the person who you would like to act on your behalf. You must give us a copy of the signed form

- You also have the right to hire a lawyer to act for you. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision

Which section gives the details for your situation?

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

- "Your Medical Care: How to Ask For a Coverage Decision or Make an Appeal"
- "Your Part D prescription Drugs: How to Ask For a Coverage Decision or Make an Appeal"
- "How to Ask Us to Cover a Longer Inpatient Hospital Stay If You Think the Doctor is Discharging You Too Soon"
- "How to Ask Us to Keep Covering Certain Medical Services If You Think Your Coverage is Ending Too Soon" (Applies to these Services only: home health care, Skilled Nursing Facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) Services)

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

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

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

This section is about your benefits for Services. These benefits are described in the "Benefits, Copayments, and Coinsurance" section.

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

1) You are not getting certain Services you want, and you believe that this care is covered by our Plan.
2) Our Plan will not approve the Services your doctor or other medical provider wants to give you, and you believe that this care is covered by our Plan.
3) You have received Services that you believe should be covered by us, but we have said we will not pay for this care.
4) You have received and paid for Services that you believe should be covered by us, and you

want to ask our Plan to reimburse you for this care.

5) You are being told that coverage for certain Services you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health.

- Note: If the coverage that will be stopped is for hospital care, home health care, Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) Services, you need to read a separate section because special rules apply to these types of care. Here's what to read in those situations:
  - go to "How to Ask Us to Cover a Longer Inpatient Hospital Stay If You Think the Doctor Is Discharging You Too Soon"
  - go to "How to Ask Us to Keep Covering Certain Medical Services If You Think Your Coverage Is Ending Too Soon." This section is about three Services only: home health care, Skilled Nursing Facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) Services

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

Which of these situations are you in?

Do you want to find out whether we will cover the Services you want?

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

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

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

How to request coverage for the Services you want

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

Generally we use the standard deadlines for giving you our decision

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

- However, we can take up to 14 more calendar days if you ask for more time, or if we need information (such as medical records) that

may benefit you. If we decide to take extra days to make the decision, we will tell you in writing

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

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

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

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

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

- Generally, for a fast decision, we will give you our answer within 72 hours

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

- If our answer is yes to part or all of what you requested, we must authorize or provide the Services we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no

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

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

- If our answer is yes to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 14 calendar days after we received your request. If we extended the time needed to make our decision, we will provide the coverage by the end of that extended period
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no

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

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

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

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a "fast appeal"
An appeal to our Plan about a medical care coverage decision is called a Plan "reconsideration."

What to do

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

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

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

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

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

*Deadlines for a "**fast**" appeal*

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

*Deadlines for a "**standard**" appeal*

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

notice informing you that we have automatically sent your appeal to the Independent Review Organization for a Level 2 Appeal

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

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

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

If we say no to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the Independent Review Organization reviews the decision we made when we said no to your first appeal. This organization decides whether the decision we made should be changed.

Step 1: The Independent Review Organization reviews your appeal

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

*If you had a **“fast”** appeal at Level 1, you will also have a **“fast”** appeal at Level 2*

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

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

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

Step 2: The Independent Review Organization gives you their answer

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

- If the review organization says yes to part or all of what you requested, we must authorize

the Services within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization

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

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

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

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

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

Asking for reimbursement is asking for a coverage decision from us

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

We will say yes or no to your request

- If the Service you paid for is covered and you followed all of the rules, we will send you the payment for our share of the cost of your Services within 60 calendar days after we receive your request. Or if you haven't paid for the Services, we will send the payment directly to the provider. (When we send the payment, it's the same as saying yes to your request for a coverage decision)
- If the Service is not covered, or you did not follow all of the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the Services and the reasons why. (When we turn down your

request for payment, it's the same as saying no to your request for a coverage decision)

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

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

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

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

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

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

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

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

Part D coverage decisions and appeals

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

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

- You ask us to make an exception, including:
  - asking us to cover a Part D drug that is not on our Plan's *List of Covered Drugs (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)
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. (For example, when your drug is on our Plan's *List of Covered Drugs (Formulary)* but we require you to get approval from us before we will cover it for you)

- if your pharmacy tells you that your prescription cannot be filled as written, you will get a written notice explaining how to contact us to ask for a coverage decision
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment

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

Which of these situations are you in?

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

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

What is a Part D exception?

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

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

1. **Covering a Part D drug for you that is not on our *List of Covered Drugs (Formulary).*** (We call it the "Drug List" for short.)
   - If we agree to make an exception and cover a drug that is not on the Drug List, you will need to pay the Copayments or Coinsurance amount that applies to drugs in the generic or brand-name drug tier. You cannot ask for an exception to the Copayment or Coinsurance amount we require you to pay for the drug
   - You cannot ask for coverage of any "excluded drugs" or other non–Part D drugs which Medicare does not cover. (For more information about excluded drugs, see "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits, Copayments, and Coinsurance" section)
2. **Removing a restriction on our coverage for a covered Part D drug**. There are extra rules or restrictions that apply to certain drugs on our *List of Covered Drugs (Formulary)* (for more information, go to "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits, Copayments, and Coinsurance" section).

- The extra rules and restrictions on coverage for certain drugs include:
  - being **required to use the generic version** of a drug instead of the brand-name drug
  - getting **Plan approval in advance** before we will agree to cover the drug for you. (This is sometimes called "prior authorization")
  - **Quantity limits.** For some drugs, there are restrictions on the amount of the drug you can have
- If we agree to make an exception and waive a restriction for you, you can ask for an exception to the Copayment or Coinsurance amount we require you to pay for the Part D drug

Important things to know about asking for a Part D exception

Your doctor must tell us the medical reasons

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

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

We can say yes or no to your request

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

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

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

Step 1: You ask us to make a coverage decision about the drug(s) or payment you need. If your health requires a quick response, you must ask us to make a "fast decision." You cannot ask for a fast decision if you are asking us to pay you back for a drug you already bought.

What to do

- Request the type of coverage decision you want. Start by calling, writing, or faxing us to make your request. You, your representative, or your doctor (or other prescriber) can do this. For the details, go to "How to contact us when you are asking for a coverage decision or making an appeal or a complaint about your Part D prescription drugs" in the "Helpful Information" section. Or if you are asking us to pay you back for a drug, go to "Where to send a request asking us to pay for our share of the cost for a Service or a Part D drug you have received" in the "Helpful Information" section
- You or your doctor or someone else who is acting on your behalf can ask for a coverage decision. The "A Guide to the Basics of Coverage Decisions and Appeals" section tells how you can give written permission to

someone else to act as your representative. You can also have a lawyer act on your behalf

- If you want to ask us to pay you back for a drug, start by reading the "Requests for Payment" section, which describes the situations in which you may need to ask for reimbursement. It also tells how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for
- If you are requesting a Part D exception, provide the "doctor's statement." Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "doctor's statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See "What is a Part D exception?" and "Important things to know about asking for a Part D exception" for more information about exception requests

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

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast decision means we will answer within 24 hours
- **To get a fast decision, you must meet two requirements:**
  - you can get a fast decision only if you are asking for a drug you have not yet received. (You cannot get a fast decision if you are asking us to pay you back for a drug you already bought)
  - you can get a fast decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function
- If your doctor or other prescriber tells us that your health requires a "fast decision," we will automatically agree to give you a fast decision
- If you ask for a fast decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast decision
  - if we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter that says so (and we will use the standard deadlines instead)
  - this letter will tell you that if your doctor or other prescriber asks for the fast decision, we will automatically give a fast decision
  - the letter will also tell how you can file a complaint about our decision to give you a standard decision instead of the fast decision you requested. It tells how to file a "fast" complaint, which means you would get our answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section

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

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

- If we are using the fast deadlines, we must give you our answer within 24 hours
  - generally, this means within 24 hours after we receive your request. If you are requesting a Part D exception, we will give you our answer within 24 hours after we

receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to

- if we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent outside organization. Later in this section, we tell about this review organization and explain what happens at Appeal Level 2

- If our answer is yes to part or all of what you requested, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request
- If our answer is no to part or all of what you requested, we will send you a written statement that explains why we said no

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

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

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

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

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

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

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

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

What to do

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

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

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

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

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

*Deadlines for a "**fast**" appeal*

- If we are using the fast deadlines, we must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires it
  - if we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process
- If our answer is yes to part or all of what you requested, we must provide the coverage we

have agreed to provide within 72 hours after we receive your appeal

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

*Deadlines for a "**standard**" appeal*

If we are using the standard deadlines, we must give you our answer within 7 calendar days after we receive your appeal. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for a "fast" appeal

- if we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell about this review organization and explain what happens at Level 2 of the appeals process

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

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

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

- If we say no to your appeal, you then choose whether to accept this decision or continue by making another appeal

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

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

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

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

- If we say no to your Level 1 Appeal, the written notice we send you will include instructions on how to make a Level 2 Appeal with the Independent Review Organization. These instructions will tell who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization

- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." You have the right to ask us for a copy of your case file. We are allowed to charge you a fee for copying and sending this information to you

- You have a right to give the Independent Review Organization additional information to support your appeal

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

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

*Deadlines for "**fast**" appeal at Level 2*

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

*Deadlines for "**standard**" appeal at Level 2*

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

What if the review organization says no to your appeal?

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

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

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

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

you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details on how to do this are in the written notice you got after your second appeal

- The Level 3 Appeal is handled by an administrative law judge. "Taking your Appeal to Level 3 and Beyond" tells more about Levels 3, 4, and 5 of the appeals process

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

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

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

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

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

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

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

notice does not mean you are agreeing on a discharge date

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

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

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

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

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

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

What is the Quality Improvement Organization?

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

How can you contact this organization?

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

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization before you leave the hospital and no later than your planned discharge date. (Your "planned discharge date" is the date that has been set for you to leave the hospital)
  - if you meet this deadline, you are allowed to stay in the hospital after your discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization

- if you do not meet this deadline, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you receive after your planned discharge date
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our Plan instead. For details about this other way to make your appeal, see "What if you miss the deadline for making your Level 1 Appeal"

Ask for a "fast review":

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

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the Services should continue. You don't have to prepare anything in writing, but you may do so if you wish
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them

By noon of the day after the reviewers informed our Plan of your appeal, you will also get a written notice that gives your planned discharge date and explains the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date. This written explanation is called the *Detailed Notice of Discharge*

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

- If the Quality Improvement Organization has turned down your appeal, and you stay in the

hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process

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

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

Here are the steps for Level 2 of the 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 hospital care for as long as it is medically necessary
- You must continue to pay your share of the costs and coverage limitations may apply

If the review organization says no:

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

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

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

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

You can appeal to us instead

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

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

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

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

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

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

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

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

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

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

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

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

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

If we say no to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the Independent Review Organization reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

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

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

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

- The Independent Review Organization is an 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. (For more information about this organization, refer to the “Helpful Information” section)
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge
- If this organization says yes to your appeal, then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue our Plan's coverage of your hospital Services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your Services
- If this organization says no to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.
  - the notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by a judge

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

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

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

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

This section is only about the following types of care:

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

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

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, we will stop paying our share of the cost for your care.

If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

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

- **You receive a notice in writing.** At least two days before our Plan is going to stop covering your care, the agency or facility that is providing your care will give you a notice
  - the written notice tells you the date when we will stop covering the care for you
  - the written notice also tells what you can do if you want to ask our Plan to change this decision about when to end your care, and keep covering it for a longer period of time

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

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

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

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and

follow the deadlines that apply to things you must do. There are also deadlines our Plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section tells you how to file a complaint)

- **Ask for help if you need it**. If you have questions or need help at any time, please call our Member Service Call Center (phone numbers are on the front cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see the "Helpful Information" section)

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

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

What is the Quality Improvement Organization?

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

How can you contact this organization?

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

What should you ask for?

- Ask this organization to do an independent review of whether it is medically appropriate for us to end coverage for your medical Services

Your deadline for contacting this organization

- You must contact the Quality Improvement Organization to start your appeal no later than noon of the day after you receive the written notice telling you when we will stop covering your care
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see "Step-by-step: How to make a Level 2 Appeal to have our Plan cover your care for a longer time"

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

What happens during this review?

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

for ending our coverage for your Services. This notice explanation is called the *Detailed Explanation of Non-Coverage*

Step 3: Within one full day after they have all of the information they need, the reviewers will tell you their decision

What happens if the reviewers say yes to your appeal?

- If the reviewers say yes to your appeal, then we must keep providing your covered Services for as long as it is medically necessary
- You will have to keep paying your share of the costs (such as Copayments or Coinsurance, if applicable). In addition, there may be limitations on your covered Services (see the "Benefits, Copayments, and Coinsurance" section)

What happens if the reviewers say no to your appeal?

- If the reviewers say no to your appeal, then your coverage will end on the date we have told you. We will stop paying our share of the costs of this care
- If you decide to keep getting the home health care, or Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) Services after this date when your coverage ends, then you will have to pay the full cost of this care yourself

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

- This first appeal you make is "Level 1" of the appeals process. If reviewers say no to your Level 1 Appeal – and you choose to continue getting care after your coverage for the care has ended – then you can make another appeal
- Making another appeal means you are going on to "Level 2" of the appeals process

Step-by-step: How to make a Level 2 Appeal to have our Plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If we turn down your Level 2 Appeal, you may have to pay the full cost for your home health care, or Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Here are the steps for Level 2 of the 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 continued getting care after the date that your coverage for the care ended

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

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

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

What happens if the review organization says yes to your appeal?

- We must reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary
- You must continue to pay your share of the costs and there may be coverage limitations that apply

What happens if the review organization says no?

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

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further

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

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

You can appeal to us instead

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

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

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

Here are the steps for a Level 1 Alternate Appeal:

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

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

Step 2: We do a "fast" review of the decision we made about when to end coverage for your Services

- During this review, we take another look at all of the information about your case. We check to see if we were following all of the rules when we set the date for ending our Plan's coverage for Services you were receiving

- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review. (Usually, if you make an appeal to our Plan and ask for a "fast review," we are allowed to decide whether to agree to your request and give you a "fast review." But in this situation, the rules require us to give you a fast response if you ask for it)

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

- If we say yes to your fast appeal, it means we have agreed with you that you need Services longer, and will keep providing your covered Services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply)
- If we say no to your fast appeal, then your coverage will end on the date we have told you and we will not pay after this date. We will stop paying our share of the costs of this care
- If you continued to get home health care, or Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) Services after the date when we said your coverage would end, then you will have to pay the full cost of this care yourself

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

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

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

If we say no to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the Independent Review Organization reviews the decision we made when we said no to your "fast appeal." This organization decides whether the decision we made should be changed.

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

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

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

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work. (For more information about this organization, refer to the “Helpful Information” section)

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal
- If this organization says yes to your appeal, then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your Services
- If this organization says no to your appeal, it means they agree with the decision 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
- "Taking Your Appeal to Level 3 and Beyond" in this "Coverage Decisions, Appeals, and Complaints" section tells more about Levels 3, 4, and 5 of the appeals process

Taking Your Appeal to Level 3 and Beyond

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

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

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: A judge who works for the federal government will review your appeal and give you an answer. This judge is called an "administrative law judge"

- If the administrative law judge says yes to your appeal, the appeals process may or may not be over. We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you
  - if we decide not to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the judge's decision
  - if we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal

decision before authorizing or providing the service in dispute

- If the administrative law judge says no to your appeal, the appeals process may or may not be over
  - if you decide to accept this decision that turns down your appeal, the appeals process is over
  - if you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal

Level 4 Appeal: The Medicare Appeals Council will review your appeal and give you an answer. The Medicare Appeals Council works for the federal government

- If the answer is yes, or if the Medicare Appeals Council denies our request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over. We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you
  - if we decide not to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Medicare Appeals Council's decision
  - if we decide to appeal the decision, we will let you know in writing
- If the answer is no or if the Medicare Appeals Council denies the review request, the appeals process may or may not be over
  - if you decide to accept this decision that turns down your appeal, the appeals process is over
  - if you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what to do next if you choose to continue with your appeal

Level 5 Appeal: A judge at the Federal District Court will review your appeal.

- This is the last step of the administrative appeals process

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

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

If the dollar value of the Part D drug you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: A judge who works for the federal government will review your appeal and give you an answer. This judge is called an "administrative law judge"

- If the answer is yes, the appeals process is over. What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the administrative law judge within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision
- If the answer is no, the appeals process may or may not be over
  - if you decide to accept this decision that turns down your appeal, the appeals process is over
  - if you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge says no to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal

Level 4 Appeal: The Medicare Appeals Council will review your appeal and give you an answer. The Medicare Appeals Council works for the federal government

- If the answer is yes, the appeals process is over. What you asked for in the appeal has been approved We must authorize or provide the drug coverage that was approved by the Medicare Appeals Council within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision
- If the answer is no, the appeals process may or may not be over
  - if you decide to accept this decision that turns down your appeal, the appeals process is over
  - if you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Medicare Appeals Council says no to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what to do next if you choose to continue with your appeal

Level 5 Appeal: A judge at the Federal District Court will review your appeal.

- This is the last step of the appeals process

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

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

What kinds of problems are handled by the complaint process?

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

Here are examples of the kinds of problems handled by the complaint process.

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

- **Quality of your Services**

- are you unhappy with the quality of care you have received (including care in the hospital)?

- **Respecting your privacy**
  - do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
- **Disrespect, poor customer service, or other negative behaviors**
  - has someone been rude or disrespectful to you?
  - are you unhappy with how our Member Service Call Center has treated you?
  - do you feel you are being encouraged to leave our Plan?
- **Waiting times**
  - are you having trouble getting an appointment, or waiting too long to get it?
  - have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Service Call Center or other staff at our Plan?

    Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room
- **Cleanliness**
  - are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
- **Information you get from our Plan**
  - do you believe we have not given you a notice that we are required to give?
  - do you think written information we have given you is hard to understand?

These are more examples of possible reasons for making a complaint

These types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals.

The process of asking for a coverage decision and making appeals is explained in this "Coverage Decisions, Appeals, and Complaints" section. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast response" for a coverage decision or appeal, and we have said we will not, you can make a complaint
- If you believe we are not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint
- When a coverage decision we made is reviewed and we are told that we must cover or reimburse you for certain medical Services or Part D drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint

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

Step-by-step: Making a complaint

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

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

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

If you request an expedited grievance, we will respond to your request within 24 hours.

- Whether you call or write, you should contact our Member Service Call Center right away. The complaint must be made within 60 calendar days after you had the problem you want to complain about
- If you are making a complaint because we denied your request for a "fast response" to a coverage decision or appeal, we will automatically give you a "fast" complaint. If you have a "fast" complaint, it means we will give you an answer within 24 hours

Step 2: We look into your complaint and give you our answer

- If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that

- Most complaints are answered in 30 calendar days. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint
- If we do not agree with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not

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

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about quality of care, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (without making the complaint to us)
  - the Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the Federal government to check and improve the care given to Medicare patients
  - to find the name, address, and phone number of the Quality Improvement Organization for your state, look in the "Helpful Information" section. If you make a complaint to this organization, we will work with them to resolve your complaint;
- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

CalPERS Final Administrative Determination

If you do not achieve resolution of your complaint through the dispute resolution processes described in this “Coverage Decisions, Appeals, and Complaints” section you have additional dispute resolution options, depending on the nature of the complaint.

Eligibility issues

Issues of eligibility must be referred directly to CalPERS. Contact the CalPERS Health Account Services Section at Attn: Enrollment Administration, P.O. Box 942714, Sacramento, CA 94229-2714, fax number 916-795-1277, or telephone the CalPERS Customer Service and Outreach Division at **888-CalPERS** (**888-225-7377**).

Coverage issues

If you have a coverage issue and are dissatisfied with the outcome of our grievance process or the Medicare appeal process described in this “Coverage Decisions, Appeals, and Complaints” section, you may submit the matter to binding arbitration (or Small Claims Court if applicable), or you may request an administrative review through the CalPERS Board of Administration. A coverage issue concerns the denial of Services substantially based on a finding that a Service is excluded as a covered benefit under this *Evidence of Coverage*. Coverage issues do not include a Plan Provider’s decision about a disputed Service. However, you must choose between the CalPERS final administrative determination process and the other dispute resolution procedures. You may not take the same issue to both the CalPERS Board and use one of the other dispute resolution procedures.

CalPERS final administrative determination process

CalPERS staff may conduct an administrative review of your dispute if we deny your grievance or your Medicare Appeal described in this "Coverage Decisions, Appeals, and Complaints" section. However, your written request must be submitted to CalPERS within 30 days of the date of our denial letter.

If the dispute remains unresolved during the administrative review process, the matter may proceed to an Administrative Hearing. During the hearing, evidence and testimony will be presented to an Administrative Law Judge. As an alternative to this hearing, you may have recourse through binding arbitration (or Small Claims Court if applicable). However, you must choose between the Administrative Hearing and binding arbitration (or Small Claims Court if applicable). You may not take the same issue through both procedures. You may withdraw your request from CalPERS at any time, and proceed to binding arbitration (or Small Claims Court if applicable).

To request an administrative review, please contact CalPERS Health Plan Administration Division, Attn: Health Appeals Coordinator at P.O. Box 1953, Sacramento, CA 95812-1953, fax number 916-795-1513, or telephone the CalPERS Customer Service and Outreach Division toll free at **888-CalPERS** (**888-225-7377**).

Binding Arbitration

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

Scope of arbitration

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

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

- The claim is *not* subject to a Medicare appeal procedure

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

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

"Kaiser Permanente Parties" include:

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

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

Initiating arbitration

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

Serving Demand for Arbitration

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

For Northern California Members:
Kaiser Foundation Health Plan, Inc.
Legal Department
1950 Franklin St, 17th Floor
Oakland, CA 94612

For Southern California Members:
Kaiser Foundation Health Plan, Inc.
Legal Department
393 E. Walnut St
Pasadena, CA 91188

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

Filing fee

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

or the number of Claimants or Respondents named in the Demand for Arbitration.

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

Number of arbitrators

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

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

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

Payment of arbitrators' fees and expenses

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

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

Costs

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

Rules of Procedure

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

General provisions

A claim shall be waived and forever barred if (1) on the date the Demand for Arbitration of the claim is served, the claim, if asserted in a civil action, would be barred as to the Respondents served by the applicable statute of limitations, (2) Claimants fail to pursue the arbitration claim in accord with the Rules of Procedure with reasonable diligence, or (3) the arbitration hearing is not commenced within five years after

the earlier of (a) the date the Demand for Arbitration was served in accord with the procedures prescribed herein, or (b) the date of filing of a civil action based upon the same incident, transaction, or related circumstances involved in the claim. A claim may be dismissed on other grounds by the neutral arbitrator based on a showing of a good cause. If a party fails to attend the arbitration hearing after being given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

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

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

TERMINATION OF MEMBERSHIP

Your Group is required to inform the Subscriber of the date your membership terminates. The guidelines that determine the termination of coverage from the CalPERS Health Program are governed in accord with the Public Employees' Medical & Hospital Care Act (PEMHCA). For an explanation of specific eligibility criteria and termination requirements, please consult your Health Benefits Officer (or, if you are retired, the CalPERS Health Account Services Section). Your *CalPERS Health Program Guide* also includes eligibility and termination information and can be ordered through the CalPERS Web site or by calling CalPERS.

Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2012, your last minute of coverage was at 11:59 p.m. on December 31, 2011). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Services you receive after your membership terminates.

Health Plan and Plan Providers have no further liability or responsibility under this *Evidence of Coverage* after your membership terminates, except:

As provided under "Payments after Termination" in this "Termination of Membership" section

If you are receiving covered Services as an acute care hospital inpatient on the termination date, we will continue to cover those hospital Services (but not physician Services or any other Services) until you are discharged

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

Note: If you enroll in another Medicare Health Plan or a prescription drug plan, your Senior Advantage membership will terminate as described under "Disenrolling from Senior Advantage" in this "Termination of Membership" section.

Termination Due to Loss of Eligibility

If you meet the eligibility requirements described under "Eligibility" in the "Premiums, Eligibility, and Enrollment" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership will end at 11:59 p.m. on the last day of that month. For example, if you become ineligible on December 5, 2011, your termination date is January 1, 2012, and your last minute of coverage is at 11:59 p.m. on December 31, 2011.

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

- Are temporarily absent from your Home Region's Service Area for more than six months in a row
- Permanently move from your Home Region's Service Area
- No longer are entitled to Medicare Part B.
- Enroll in another Medicare-Health Plan (for example, a Medicare Advantage Plan or a Medicare prescription drug plan). The Centers for Medicare & Medicaid Services will automatically terminate your Senior Advantage membership when your enrollment in the other plan becomes effective

Note: If you lose eligibility for Senior Advantage due to any of these circumstances, you may be eligible to transfer your membership to another Kaiser Permanente plan offered by your Group. Please contact your Group's Health Benefits Officer (or, if you are retired, the CalPERS Health Account Services Section) for information.

Termination of *Agreement*

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

Disenrolling from Senior Advantage

Please check with the CalPERS Health Account Services Section). at the CalPERS Customer Service and Outreach Division at **888-CalPERS** (**888-225-7377**) before you disenroll from Senior Advantage. Disenrolling from Senior Advantage so you can return to Original Medicare or at any time other than CalPERS open enrollment period may result in loss of CalPERS-sponsored health coverage.

If you request disenrollment during your Group's open enrollment, your disenrollment effective date is determined by the date your written request is received by us and the date your Group coverage ends. The effective date will not be earlier than the first day of the following month after we receive your written request, and no later than three months after we receive your request.

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

You may request disenrollment by calling toll free 800-MEDICARE/800-633-4227 (TTY users call 877-486-2048), 24 hours a day, seven days a week, or sending written notice to the following address:

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

For Southern California Members:
Kaiser Foundation Health Plan, Inc
California Service Center
P.O. Box 232407
San Diego, CA 92193-2407

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

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

Original Medicare. If you request disenrollment from Senior Advantage and you do not enroll in another Medicare Health Plan, you will automatically be enrolled in Original Medicare when your Senior Advantage membership terminates (your disenrollment date). On your disenrollment date, you can start using your red, white, and blue Medicare card to get services under Original Medicare. You will not get anything in writing that tells you that you have Original Medicare after you disenroll. If you choose Original Medicare and you want to

continue to get Medicare Part D prescription drug coverage, you will need to enroll in a prescription drug plan.

If you receive Extra Help from Medicare to pay for your prescription drugs, and you switch to Original Medicare and do not enroll in a separate Medicare Part D prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage, you may need to pay a late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) See "Premiums" in the "Premiums, Eligibility, and Enrollment" section for more information about the late enrollment penalty.

Termination of Contract with the Centers for Medicare & Medicaid Services

If our contract with the Centers for Medicare & Medicaid Services to offer Senior Advantage terminates, your Senior Advantage membership will terminate on the same date. We will send you advance written notice and advise you of your health care options. Also, you may be eligible to transfer your membership to another Kaiser Permanente plan offered by your Group. Please contact the CalPERS Health Account Services Section). for information.

Termination for Cause

If you commit one of the following acts, we will ask CalPERS to approve termination of your membership in accord with Section 22841 of the California Government Code. If CalPERS approves termination of your membership, CalPERS will send written notice to the Subscriber:

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

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

Termination of a Product or all Products

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

Group's *Agreement* by sending you written notice at least 180 days before the *Agreement* terminates.

Payments after Termination

If we terminate your membership for cause, we will:

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

Review of Membership Termination

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

CONTINUATION OF MEMBERSHIP

If your membership under this *Evidence of Coverage* ends, you may be eligible to maintain Health Plan membership without a break in coverage under this *Evidence of Coverage* (group coverage) or you may be eligible to convert to an individual (nongroup) plan.

Continuation of Group Coverage

COBRA

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

If your Group is subject to COBRA and you are eligible for COBRA coverage, in order to enroll, you must submit a COBRA election form to your Group within the COBRA election period. Please ask your Health Benefits Officer (or, if you are retired, the CalPERS Health Account Services Section) for details about COBRA coverage, such as how to elect coverage, how much you must pay for coverage, when coverage and Premiums may change, and where to send your Premium payments.

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

Coverage for a disabling condition

If you became Totally Disabled, while you were a Member under your Group's *Agreement* with us and while the Subscriber was employed by your Group, and your Group's *Agreement* with us terminates, and is not renewed, we will cover Services for your totally disabling condition until the earliest of the following events occurs:

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

Your coverage will be subject to the terms of this *Evidence of Coverage* including Copayments and Coinsurance, but we will not cover Services for any condition other than your totally disabling condition.

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

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

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

Conversion from Group Membership to an Individual Plan

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

How to convert

If you are no longer eligible for Group membership, we will automatically convert your Group membership to our Senior Advantage Individual Plan if you still meet the eligibility requirements for Senior Advantage and have not disenrolled from Senior Advantage. The premiums and coverage under our individual plan will differ from those under this *Evidence of Coverage* and will include Medicare Part D prescription drug coverage.

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

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

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

ASH PLANS CHIROPRACTIC SERVICES

ASH Plans Member Services Department: 800-678-9133, 5 a.m. to 6 p.m., Monday-Friday, www.ashplans.com.

Please refer to the "Benefits, Copayments, and Coinsurance" section for information about the chiropractic services that we cover in accord with Medicare guidelines, which are separate from the services covered under this "ASH Plans Chiropractic Services" section. Medicare rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." Medicare is the primary coverage except when federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary.

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

Definitions

In addition to the terms defined in the "Definitions" section, the following terms, when capitalized and used in any part of this "ASH Plans Chiropractic Services" section have the following meaning:

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

Chiropractic Services: Chiropractic Services provided or prescribed by a chiropractor (including laboratory tests, X-rays, and chiropractic appliances) for the treatment of your Neuromusculoskeletal Disorder.

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

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

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

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

Participating Provider: A Participating Chiropractor, or any licensed provider with which

ASH Plans contracts to provide covered care, including laboratory tests or X-rays that are covered chiropractic care.

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

Participating Providers

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

ASH Plans contracts with Participating Chiropractors and other Participating Providers to provide covered Chiropractic Services (including laboratory tests, X-rays, and chiropractic appliances). You must receive Services covered under this "ASH Plans Chiropractic Services" section from a Participating Provider, except for Emergency Chiropractic Services and Services that are not available from Participating Providers that are authorized in advance by ASH Plans.

How to obtain Services

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

Covered Services

We cover the Services listed in this "Covered Services" section, subject to exclusions described in the "Exclusions" section, only all of the following conditions are satisfied:

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- ASH Plans has authorized the services as part of your Treatment Plan except for :
  - the initial examination described under "Office Visits" in this "Covered Services" section
  - Emergency Chiropractic Services described under "Emergency Services" in this "Covered Services" section
- You receive the Services from Participating Providers, except for:
  - Emergency Chiropractic Services described under "Emergency Services" in this "Covered Services" section
  - Services that are not available from Participating Providers that are authorized in advance by ASH Plans

Covered services are provided at the Copayment or Coinsurance listed in this "Covered Services" section. However, you may be liable for the cost of noncovered Services you obtain from Participating Providers or Non–Participating Providers.

Coverage of chiropractic Services under this "ASH Plans Chiropractic Services" is different from the coverage of chiropractic Services under "Outpatient Care" in the "Benefits, Copayments, and Coinsurance" section of the *Evidence of Coverage*. You do not need a referral to get covered Services under this "ASH Plans Chiropractic Services," but covered Services and Copayments and Coinsurance may differ from those under "Outpatient Care" in the "Benefits, Copayments, and Coinsurance" section of the *Evidence of Coverage*. If you receive chiropractic

Services for which you have a referral, as described under "Getting a Referral" in the "How to Obtain Services" section of the *Evidence of Coverage*, then unless you tell us otherwise, we will assume that you are using your coverage under "Outpatient Care" in the "Benefits, Copayments, and Coinsurance" section of the *Evidence of Coverage*.

Office visits

We cover up to a combined total of 20 of the following types of office visits per calendar year at **a $10 Copayment per visit.**

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

Laboratory tests and X-rays

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

Chiropractic appliances

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

Second opinions

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

Emergency Chiropractic Services

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

How to file a claim. As soon as possible after receiving Emergency Chiropractic Services, you must file an ASH Plans claim form. To request a claim form or for more information, please call ASH Plans toll free at 1-800-678-9133 (TTY users call 711). You must send the completed claim form to:

ASH Plans
P.O. Box 509002
San Diego, CA 92150-9002

Exclusions and Limitations

The Services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this "ASH Plans Chiropractic Services" section:

- Any Services not provided by a Participating Chiropractor or Participating Provider, except for Emergency Chiropractic Services and Services that are not available from Participating Providers but that are authorized in advance by ASH Plans
- Hypnotherapy, behavior training, sleep therapy, and weight programs
- Thermography
- Experimental or investigational Services. Please refer to the "Coverage Decisions, Appeals, and Complaints" section for information about Independent Medical Review related to denied requests for Medically Necessary and experimental or investigational Services
- MRI,CT,PET, bone scans, nuclear radiology, and any types of diagnostic radiology other than X-rays covered under the "Covered Services" section of this "ASH Plans Chiropractic Services" section
- Ambulance and other transportation
- Education programs, nonmedical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing
- Services for pre-employment physicals or vocational rehabilitation
- Air conditioners, air purifiers, therapeutic mattresses, chiropractic appliances, durable medical equipment, supplies, devices, appliances, and any other item except those listed as covered under "Chiropractic appliances" in the "Covered Services" section of this "ASH Plans Chiropractic Services" section
- Drugs and medicines, including non-legend or proprietary drugs and medicines
- Services you receive outside the state of California, except for Emergency Chiropractic Services
- Hospital Services, anesthesia, manipulation under anesthesia, and related services
- For chiropractic Services, adjunctive therapy not associated with spinal, muscle, or joint manipulations
- Dietary and nutritional supplements, including vitamins, minerals, herbs, herbal products, injectable supplements, and similar products
- Massage therapy
- Services for asthma or addiction, such as nicotine addiction
- Services provided by a chiropractor that are not within the scope of licensure for a chiropractor licensed in California
- Maintenance care (services provided to Members whose treatment records indicate he

or she has reached maximum therapeutic benefit)

Member Services

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

ASH Plans
Member Services
P.O. Box 509002
San Diego, CA 92150-9002

Grievances

You can file a grievance with Kaiser Permanente regarding any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied about Services you received. You may submit your grievance orally or in writing to Kaiser Permanente as described in the "Coverage Decisions, Appeals, and Complaints" section of this Senior Advantage *Evidence of Coverage*.

HELPFUL INFORMATION

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

How to contact Member Services

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

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

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

- A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services
- An appeal is a formal way of asking us to review and change a coverage decision we have made
- You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes

For more information on asking for coverage decisions, or making an appeal or complaint about your medical care, see the "Coverage Decisions, Appeals, and Complaints" section.

Coverage decisions, appeals, or complaints for Services	
Call	**1-800-443-0815** Calls to this number are free. 8 a.m. to 8 p.m., seven days a week. If your coverage decision, appeal, or complaint qualifies for a fast decision, call the Expedited Review Unit, 8:30 a.m. to 5 p.m., Monday through Saturday, at 1-888-987-7247. After hours, you may leave a message and we will return your call the next business day.
TTY	**1-800-777-1370** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
Fax	If your coverage decision, appeal, or complaint **qualifies for a fast decision**, fax your request to our Expedited Review Unit at **1-888-987-2252**.
Write	Member Services office located at a Plan Facility, unless you are requesting an appeal, a fast complaint, or a fast coverage decision, in which case, you would write to one of the following locations: For a **standard appeal**, write to the

	address shown on the denial notice we send you (a standard appeal is one that does not involve a request for a fast decision). If your coverage decision, appeal, or complaint **qualifies for a fast decision**, write to: Kaiser Foundation Health Plan, Inc. Expedited Review Unit P.O. Box 23170 Oakland, CA 94623-0170

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

- A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your Part D prescription drugs
- An appeal is a formal way of asking us to review and change a coverage decision we have made

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

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

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

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about the plan's coverage or payment, you should look at the section above about making an appeal.) For more information on making a complaint about your Part D prescription drugs, see the "Coverage Decisions, Appeals, and Complaints" section.

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

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

Where to send a request asking us to pay for our share of the cost for Services or a Part D drug you have received

For more information on situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see the "Requests for Payment" section.

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

Payment Requests	
Call	**1-800-443-0815** Calls to this number are free. 8 a.m. to 8 p.m., seven days a week. Note: If you are requesting payment of a Part D drug that was prescribed by a Plan Provider and obtained from a Plan Pharmacy, call our Part D unit at 1-866-206-2973. Calls to this number are free. 8:30 a.m. to 5 p.m., seven days a week.
TTY	**1-800-777-1370** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
Write	*For Northern California Members:* Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 24010 Oakland, CA 94623-1010 *For Southern California Members:* Kaiser Foundation Health Plan, Inc. Claims Department P.O. Box 7004 Downey, CA 90242-7004 Note: If you are requesting payment of a Part D drug that was prescribed by a Plan Provider and obtained from a Plan Pharmacy, write to: Kaiser Foundation Health Plan, Inc. Part D Unit P.O. Box 23170 Oakland, CA 94623-0170

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

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

Medicare	
Call	**1-800-MEDICARE** or **1-800-633-4227** Calls to this number are free. 24 hours a day, seven days a week.
TTY	**1-877-486-2048** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
Website	**www.medicare.gov** This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about

hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state by selecting “Help and Support” and then clicking on “Useful Phone Numbers and Websites.”

The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:

Medicare Eligibility Tool: Provides Medicare eligibility status information. Select "Find Out if You’re Eligible."

Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare Health Plans, and Medigap (Medicare Supplement Insurance) policies in your area. Select "Health & Drug Plans" and then "Compare Drug and Health Plans” or "Compare Medigap Policies." These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans.

If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare at the number above and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you.

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

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

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

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

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

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

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

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

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

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

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

Social Security

The Social Security Administration is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens who are 65 or older, or who have a disability or end stage renal disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

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

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

Medicaid is a joint federal and state government program that helps with medical costs for certain

people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These programs help people with limited income and resources save money each year

- Qualified **Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other Cost Sharing.
- **Specified Low-Income Medicare Beneficiary (SLMB) and Qualifying Individual (QI):** Helps pay Part B premiums
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums

To find out more about Medicaid and its programs, contact Medi-Cal.

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

Railroad Retirement Board

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board	
Call	**1-877-772-5772** Calls to this number are free. Available 9:00 a.m. to 3:30 p.m., Monday through Friday. If you have a touch-tone telephone, recorded information and automated services are available 24 hours a day, including weekends and holidays.
TTY	**1-312-751-4701** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.
Website	**www.rrb.gov**

Group Insurance or Other Health Insurance From an Employer

If you have any questions about your employer-sponsored Group plan, please contact your Group's benefits administrator. You can ask about your (or your Spouse's) employer or retiree health benefits, premiums, or the enrollment period.

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact **that group's benefits administrator.** The benefits administrator can help you determine how your current prescription drug coverage will work with our Plan.

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern and Southern California Regions

PART THREE – EVIDENCE OF COVERAGE FOR KAISER PERMANENTE BASIC PLAN AND KAISER PERMANENTE SENIOR ADVANTAGE

General Information for All Members —*The information in this Part Three is applicable to both Basic Plan (Part One) and Kaiser Permanente Senior Advantage (Part Two).*

January 1, 2012, through December 31, 2012

Member Service Call Center
800-464-4000 toll free for Basic Plan
Weekdays 7 a.m.−7 p.m. and
weekends 7 a.m.−3 p.m. (except holidays)
800-443-0815 toll free for Senior Advantage
Every day 8 a.m.–8 p.m.
800-777-1370 (toll free TTY for the
hearing/speech impaired)
kp.org

MISCELLANEOUS PROVISIONS

Administration of *Agreement*

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of your Group's *Agreement*, including this *Evidence of Coverage.*

Advance directives

The California Health Care Decision Law offers several ways for you to control the kind of health care you will receive if you become very ill or unconscious, including the following:

- *A Power of Attorney for Health Care* lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your own views on life support and other treatments
- *Individual health care instructions* let you express your wishes about receiving life support and other treatment. You can express these wishes to your doctor and have them documented in your medical chart, or you can put them in writing and have that included in your medical chart

To learn more about advance directives, including how to obtain forms and instructions, contact your local Member Services Department at a Plan Facility. You can also refer to *Your Guidebook* for more information about advance directives.

***Agreement* binding on Members**

By electing coverage or accepting benefits under this *Evidence of Coverage,* all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *Evidence of Coverage*.

Amendment of *Agreement*

Your Group's *Agreement* with us will change periodically. If these changes affect this *Evidence of Coverage,* your Group is required to inform you in accord with applicable law and your Group's *Agreement*.

Applications and statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this *Evidence of Coverage*.

Assignment

You may not assign this *Evidence of Coverage* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

Attorney and advocate fees and expenses

In any dispute between a Member and Health Plan, the Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses.

Claims review authority

We are responsible for determining whether you are entitled to benefits under this *Evidence of Coverage* and we have the discretionary authority to review and evaluate claims that arise under this *Evidence of Coverage*. We conduct this evaluation independently by interpreting the provisions of this *Evidence of Coverage*. If coverage under this *Evidence of Coverage* is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), then we are a "named claims fiduciary" to review claims under this *Evidence of Coverage*.

Governing law

Except as preempted by federal law, this *Evidence of Coverage* will be governed in accord with California law and any provision that is required to be in this *Evidence of Coverage* by state or federal law shall bind Members and

Health Plan whether or not set forth in this *Evidence of Coverage*.

Group and Members not our agents

Neither your Group nor any Member is the agent or representative of Health Plan.

Health Insurance Counseling and Advocacy Program (HICAP)

For additional information concerning benefits, you can contact the Health Insurance Counseling and Advocacy Program (HICAP). Please refer to the "Helpful Information" section of Part Two of this *Evidence of Coverage* for more about HICAP and contact information.

No waiver

Our failure to enforce any provision of this *Evidence of Coverage* will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

Nondiscrimination

We do not discriminate in our employment practices or in the delivery of Services on the basis of age, race, color, national origin, cultural background, religion, sex, sexual orientation, physical or mental disability, or genetic information.

Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call our Member Service Call Center as soon as possible to report the address change. If you are a Kaiser Permanente Senior Advantage Member, you should also call the Social Security Administration toll free at 800-772-1213 (TTY users call 800-325-0778). If a Member does not reside with the Subscriber, he or she should contact our Member Service Call Center to discuss alternate delivery options.

Other *Evidence of Coverage* formats for Members with disabilities

You can request a copy of this *Evidence of Coverage* in an alternate format (Braille, audio, electronic text file, or large print) by calling our Member Service Call Center.

Overpayment recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment or from any person or organization obligated to pay for the Services.

Privacy practices

Kaiser Permanente will protect the privacy of your protected health information. We also require contracting providers to protect your protected health information. Your protected health information is individually-identifiable information (oral, written, or electronic) about your health, health care services you receive, or payment for your health care. You may generally see and receive copies of your protected health information, correct or update your protected health information, and ask us for an accounting of certain disclosures of your protected health information.

We may use or disclose your protected health information for treatment, health research, payment, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give protected health information to others, such as government agencies or in judicial actions. In addition, protected health information is shared with your Group only with your authorization or as otherwise permitted by law. We will not use or disclose your protected health information for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. Our *Notice of Privacy*

***Practices,* which provides additional information about our privacy practices and your rights regarding your protected health information is available and will be furnished to you upon request. To request a copy, please call our Member Service Call Center. You can also find the notice at your local Plan Facility or on our website at kp.org.**

Public policy participation

The Kaiser Foundation Health Plan, Inc., Board of Directors establishes public policy for Health Plan. A list of the Board of Directors is available on our website at **kp.org** or from our Member Service Call Center. If you would like to provide input about Health Plan public policy for consideration by the Board, please send written comments to:

Kaiser Foundation Health Plan, Inc.
Office of Board and Corporate Governance Services
One Kaiser Plaza, 19th Floor
Oakland, CA 94612

Telephone access (TTY)

If you are hearing or speech impaired and use a text telephone device (TTY, also known as TDD) to communicate by phone, you can use the California Relay Service by calling 711 if a dedicated TTY number is not available for the telephone number that you want to call.

PLAN FACILITIES

At most of our Plan Facilities, you can usually receive all of the covered Services you need, including specialty care, pharmacy, and lab work. You are not restricted to a particular Plan Facility, and we encourage you to use the facility that will be most convenient for you:

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Services are available from Plan Hospital Emergency Departments as described in *Your Guidebook* (please refer to *Your Guidebook* for Emergency Department locations in your area)
- Same-day Urgent Care appointments are available at many locations (please refer to *Your Guidebook* for Urgent Care locations in your area)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services Department (refer to *Your Guidebook* for locations in your area)
- Most Plan Medical Offices include pharmacy Services

Plan Hospitals and Plan Medical Offices

The following is a list of Plan Hospitals and most Plan Medical Offices in the Service Area of our Northern and Southern California Regions. As a Member, you are enrolled in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), called your Home Region. The coverage information in this *Evidence of Coverage* applies when you obtain care in your Home Region. When you visit the other California Region, you may receive care from Plan Facilities in that Region as described in "Visiting Other Regions" in the "How to Obtain Services" section.

Please refer to *Your Guidebook* for the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services. Additional Plan Medical Offices are listed in *Your Guidebook* and on our website at **kp.org**.

This list is subject to change at any time without notice. If you have any questions about the current locations of Plan Facilities, please call our Member Service Call Center.

Northern California Region Plan Facilities

Alameda

- Medical Offices: 2417 Central Ave.

Antioch

- Hospital and Medical Offices: 4501 Sand Creek Rd.
- Medical Offices: 3400 Delta Fair Blvd.

Campbell

- Medical Offices: 220 E. Hacienda Ave.

Clovis

- Medical Offices: 2071 Herndon Ave.

Daly City

- Medical Offices: 395 Hickey Blvd.

Davis

- Medical Offices: 1955 Cowell Blvd.

Elk Grove

- Medical Offices: 9201 Big Horn Blvd.

Fairfield

- Medical Offices: 1550 Gateway Blvd.

Folsom

- Medical Offices: 2155 Iron Point Rd.

Fremont

- Hospital and Medical Offices: 39400 Paseo Padre Pkwy.

Fresno

- Hospital and Medical Offices: 7300 N. Fresno St.

Gilroy

- Medical Offices: 7520 Arroyo Circle

Hayward

- Hospital and Medical Offices: 27400 Hesperian Blvd.

Lincoln

- Medical Offices: 1900 Dresden Dr.

Livermore

- Medical Offices: 3000 Las Positas Rd.

Manteca

- Hospital and Medical Offices: 1777 W. Yosemite Ave.
- Medical Offices: 1721 W. Yosemite Ave.

Martinez

- Medical Offices: 200 Muir Rd.

Milpitas

- Medical Offices: 770 E. Calaveras Blvd.

Modesto

- Hospital and Medical Offices: 4601 Dale Rd.
- Medical Offices: 3800 Dale Rd.
- Please refer to *Your Guidebook* for other Plan Providers in Stanislaus County

Mountain View

- Medical Offices: 555 Castro St.

Napa

- Medical Offices: 3285 Claremont Way

Novato

- Medical Offices: 97 San Marin Dr.

Oakhurst

- Medical Offices: 40595 Westlake Dr.

Oakland

- Hospital and Medical Offices: 280 W. MacArthur Blvd.

Petaluma

- Medical Offices: 3900 Lakeville Hwy.

Pinole

- Medical Offices: 1301 Pinole Valley Rd.

Pleasanton

- Medical Offices: 7601 Stoneridge Dr.

Rancho Cordova

- Medical Offices: 10725 International Dr.

Redwood City

- Hospital and Medical Offices: 1150 Veterans Blvd.

Richmond

- Hospital and Medical Offices: 901 Nevin Ave.

Rohnert Park

- Medical Offices: 5900 State Farm Dr.

Roseville

- Hospital and Medical Offices: 1600 Eureka Rd.
- Medical Offices: 1001 Riverside Ave.

Sacramento

- Hospitals and Medical Offices: 2025 Morse Ave. and 6600 Bruceville Rd.
- Medical Offices: 1650 Response Rd. and 2345 Fair Oaks Blvd.

San Bruno

- Medical Offices: 901 El Camino Real

San Francisco

- Hospital and Medical Offices: 2425 Geary Blvd.

San Jose

- Hospital and Medical Offices: 250 Hospital Pkwy.

San Rafael

- Hospital and Medical Offices: 99 Montecillo Rd.
- Medical Offices: 1033 3rd St.

Santa Clara

- Hospital and Medical Offices: 700 Lawrence Expwy.

Santa Rosa

- Hospital and Medical Offices: 401 Bicentennial Way

Selma

- Medical Offices: 2651 Highland Ave.

South San Francisco

- Hospital and Medical Offices: 1200 El Camino Real

Stockton

- Hospital: 525 W. Acacia St. (Dameron Hospital)
- Medical Offices: 7373 West Ln.

Tracy

- Medical Offices: 2185 W. Grant Line Rd.

Turlock

- Hospital: 825 Delbon Ave. (Emanuel Medical Center)

Union City

- Medical Offices: 3553 Whipple Rd.

Vacaville

- Hospital and Medical Offices: 1 Quality Dr.

Vallejo

- Hospital and Medical Offices: 975 Sereno Dr.

Walnut Creek

- Hospital and Medical Offices: 1425 S. Main St.
- Medical Offices: 320 Lennon Ln.

Southern California Region Plan Facilities

Aliso Viejo

- Medical Offices: 24502 Pacific Park Dr.

Anaheim

- Hospital and Medical Offices: 441 N. Lakeview Ave.
- Medical Offices: 411 N. Lakeview Ave., 5475 E. La Palma Ave., and 1188 N. Euclid St.

Bakersfield

- Hospital: 2615 Chester Ave. (San Joaquin Community Hospital)
- Medical Offices: 1200 Discovery Dr., 3501 Stockdale Hwy., 3700 Mall View Rd., 4801 Coffee Rd., and 8800 Ming Ave.

Baldwin Park

- Hospital and Medical Offices: 1011 Baldwin Park Blvd.

Bellflower

- Medical Offices: 9400 E. Rosecrans Ave.

Bonita

- Medical Offices: 3955 Bonita Rd.

Brea

- Medical Offices: 1900 E. Lambert Rd.

Camarillo

- Medical Offices: 2620 E. Las Posas Rd.

Carlsbad

- Medical Offices: 6860 Avenida Encinas

Chino

- Medical Offices: 11911 Central Ave.

Claremont

- Medical Offices: 250 W. San Jose St.

Colton

- Medical Offices: 789 S. Cooley Dr.

Corona

- Medical Offices: 2055 Kellogg Ave.

Cudahy

- Medical Offices: 7825 Atlantic Ave.

Culver City

- Medical Offices: 5620 Mesmer Ave.

Diamond Bar

- Medical Offices: 1336 Bridge Gate Dr.

Downey

- Hospital: 9333 E. Imperial Hwy.
- Medical Offices: 9449 E. Imperial Hwy.

El Cajon

- Medical Offices: 1630 E. Main St.

Escondido

- Hospital: 555 E. Valley Pkwy. (Palomar Medical Center)
- Medical Offices: 732 N. Broadway St.

Fontana

- Hospital and Medical Offices: 9961 Sierra Ave.

Garden Grove

- Medical Offices: 12100 Euclid St.

Gardena

- Medical Offices: 15446 S. Western Ave.

Glendale

- Medical Offices: 444 W. Glenoaks Blvd.

Harbor City

- Hospital and Medical Offices: 25825 S. Vermont Ave.

Huntington Beach

- Medical Offices: 18081 Beach Blvd.

Indio

- Hospital: 47111 Monroe St. (John F. Kennedy Memorial Hospital)
- Medical Offices: 81-719 Doctor Carreon Blvd.

Inglewood

- Medical Offices: 110 N. La Brea Ave.

Irvine

- Hospital and Medical Offices: 6640 Alton Pkwy.
- Medical Offices: 6 Willard St.

Joshua Tree (Emergency Care and Out-of-Area Urgent Care only)

- Hospital: 6601 White Feather Rd. (Hi-Desert Medical Center)
- Please refer to *Your Guidebook* for other Plan Providers in the Yucca Valley–Twentynine Palms area

La Mesa

- Medical Offices: 8080 Parkway Dr. and 3875 Avocado Blvd.

La Palma

- Medical Offices: 5 Centerpointe Dr.

Lancaster

- Hospital: 1600 W. Avenue J (Antelope Valley Hospital)
- Medical Offices: 43112 N. 15th St. W.

Long Beach

- Medical Offices: 3900 E. Pacific Coast Hwy.

Los Angeles

- Hospitals and Medical Offices: 1526 N. Edgemont St. and 6041 Cadillac Ave.
- Medical Offices: 5119 E. Pomona Blvd. and 12001 W. Washington Blvd.

Lynwood

- Medical Offices: 3840 Martin Luther King Jr. Blvd.

Mission Hills

- Medical Offices: 11001 Sepulveda Blvd.

Mission Viejo

- Medical Offices: 23781 Maquina Ave.

Montebello

- Medical Offices: 1550 Town Center Dr.

Moreno Valley

- Hospital: 27300 Iris Ave. (Moreno Valley Community Hospital)
- Medical Offices: 12815 Heacock St.

Murrieta

- Hospital: 25500 Medical Center Dr. (Rancho Springs Medical Center)

Oceanside

- Medical Offices: 3609 Ocean Ranch Blvd.

Ontario

- Medical Offices: 2295 S. Vineyard Ave.

Oxnard

- Medical Offices: 2200 E. Gonzales Rd.

Palm Desert

- Medical Offices: 75-036 Gerald Ford Dr.

Palm Springs

- Hospital: 1150 N. Indian Canyon Dr. (Desert Regional Medical Center)
- Medical Offices: 1100 N. Palm Canyon Dr.

Palmdale

- Medical Offices: 4502 E. Avenue S

Panorama City

- Hospital and Medical Offices: 13652 Cantara St.

Pasadena

- Medical Offices: 3280 E. Foothill Blvd.

Rancho Cucamonga

- Medical Offices: 10850 Arrow Rte.

Redlands

- Medical Offices: 1301 California St.

Riverside

- Hospital and Medical Offices: 10800 Magnolia Ave.

San Bernardino

- Medical Offices: 1717 Date Pl.

San Diego

- Hospital and Medical Offices: 4647 Zion Ave.
- Medical Offices: 3250 Wing St., 4405 Vandever Ave., 4650 Palm Ave., 7060 Clairemont Mesa Blvd., and 11939 Rancho Bernardo Rd.

San Dimas

- Medical Offices: 1255 W. Arrow Hwy.

San Juan Capistrano

- Medical Offices: 30400 Camino Capistrano

San Marcos

- Medical Offices: 400 Craven Rd.

Santa Ana

- Medical Offices: 3401 S. Harbor Blvd. and 1900 E. 4th St.

Santa Clarita

- Medical Offices: 27107 Tourney Rd.

Simi Valley

- Medical Offices: 3900 Alamo St.

Temecula

- Medical Offices: 27309 Madison Ave.

Thousand Oaks

- Medical Offices: 365 E. Hillcrest Dr. and 145 Hodencamp Rd.

Torrance

- Medical Offices: 20790 Madrona Ave.

Upland

- Medical Offices: 1183 E. Foothill Blvd.

Ventura

- Hospital: 147 N. Brent St. (Community Memorial Hospital of San Buenaventura)
- Medical Offices: 888 S. Hill Rd.

Victorville

- Medical Offices: 14011 Park Ave.

West Covina

- Medical Offices: 1249 Sunset Ave.

Whittier

- Medical Offices: 12470 Whittier Blvd.

Wildomar

- Hospital: 36485 Inland Valley Dr. (Inland Valley Medical Center)
- Medical Offices: 36450 Inland Valley Dr.

Woodland Hills

- Hospital and Medical Offices: 5601 De Soto Ave.
- Medical Offices: 21263 Erwin St.

Yorba Linda

- Medical Offices: 22550 E. Savi Ranch Pkwy.

Note: State law requires evidence of coverage documents to include the following notice: "Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the Kaiser Permanente Member Service Call Center, to ensure that you can obtain the health care services that you need."

Please be aware that if a Service is covered but not available at a particular Plan Facility, we will make it available to you at another facility.

Your Guidebook to Kaiser Permanente Services (Your Guidebook)

Plan Medical Offices and Plan Hospitals for your area are listed in greater detail in *Your Guidebook to Kaiser Permanente Services (Your Guidebook). Your Guidebook* describes the types of covered Services that are available from each Plan Facility in your area, because some facilities provide only specific types of covered Services. It includes additional facilities that are not listed in this "Plan Facilities" section. Also, it explains how to use our Services and make appointments, lists hours of operation, and includes a detailed telephone directory for appointments and advice. *Your Guidebook* provides other important information, such as preventive care guidelines and your Member rights and responsibilities.

Your Guidebook is subject to change and is periodically updated. We mail it annually and you can get a copy by visiting our website at **kp.org** or by calling our Member Service Call Center.

DEFINITIONS

Some terms have special meaning in this *Evidence of Coverage*. When we use a term with special meaning in only one section of this *Evidence of Coverage*, we define it in that section. The terms in this "Definitions" section have special meaning when capitalized and used in any section of this *Evidence of Coverage*.

Allowance: A specified credit amount that you can use toward the purchase price of an item. If the price of the item(s) you select exceeds the Allowance, you will pay the amount in excess of the Allowance (and that payment does not apply toward your annual out-of-pocket maximum).

ASH Plans: American Specialty Health Plans of California, Inc., a specialized health care service plan that contracts with licensed chiropractors in California.

Catastrophic Coverage Stage: The stage in the Part D Drug Benefit where you pay a low Copayment or Coinsurance for your Part D drugs after you or other qualified parties on your behalf have spent $4,700 in covered Part D drugs during the covered year.

Centers for Medicare & Medicaid Services (CMS): The federal agency that administers the Medicare program.

Charges: "Charges" means the following:

- For Services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members
- For Services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan)
- For all other Services, the payments that Kaiser Permanente makes for the Services (or, if Kaiser Permanente subtracts a Copayment or Coinsurance from its payment, the amount Kaiser Permanente would have paid if it did not subtract a Copayment or Coinsurance)

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service as described in the "Benefits, Copayments, and Coinsurance" section.

Comprehensive Outpatient Rehabilitation Facility (CORF): A facility that mainly provides rehabilitation Services after an illness or injury, and provides a variety of Services, including physician's Services, physical therapy, social or psychological Services, and outpatient rehabilitation.

Copayment: A specific dollar amount that you must pay when you receive a covered Service as described in the "Benefits, Copayments, and Coinsurance" section. Note: The dollar amount of the Copayment can be $0 (no charge).

Coverage Determination: An initial determination we make about whether a Part D drug prescribed for you is covered under Part D and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription for a Part D drug to a Plan Pharmacy and the pharmacy tells you the prescription isn't

covered by us, that isn't a coverage determination. You need to call or write us to ask for a formal decision about the coverage. Coverage determinations are called "coverage decisions" in this *Evidence of Coverage*.

Dependent: A Member who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see “Eligibility” in the “Premiums, Eligibility, and Enrollment” section).

Disclosure Form and Evidence of Coverage (Evidence of Coverage): This Evidence of Coverage document, which describes the health care coverage of “the Basic Plan and the Kaiser Permanente Senior Advantage Plan” under Health Plan’s Agreement with your Group.

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

A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to himself or herself or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

Emergency Services: All of the following with respect to an Emergency Medical Condition:

- A medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services (such as imaging and laboratory Services) routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the hospital, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services you receive are Post Stabilization Care and not Emergency Services)

Extra Help: A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Family: A Subscriber and all of his or her Dependents.

Group: California Public Employees Retirement System (CalPERS).

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. This *Evidence of Coverage* sometimes refers to Health Plan as “we” or “us.”

Initial Enrollment Period: When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, if you're eligible for Part B when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Home Region: The Region where you enrolled (either the Northern California Region or the Southern California Region).

Kaiser Permanente: Kaiser Foundation Hospitals (a California nonprofit corporation), Health Plan, and the Medical Group.

Medical Group: For Northern California Region Members, The Permanente Medical Group, Inc., a for-profit professional corporation, and for Southern California Region Members, the Southern California Permanente Medical Group, a for-profit professional partnership.

Medically Necessary: A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). In this *Evidence of Coverage*, Members who are "eligible for" Medicare Part A or B are those who would qualify for Medicare Part A or B coverage if they applied for it. Members who "have" Medicare Part A or B are those who have been granted Medicare Part A or B coverage. Also, a person enrolled in a Medicare Part D plan has Medicare Part D by virtue of his or her enrollment in the Part D plan (this *Evidence of Coverage* is for a Part D plan).

Medicare Advantage Organization: A public or private entity organized and licensed by a state as a risk-bearing entity that has a contract with the Centers for Medicare & Medicaid Services to provide Services covered by Medicare, except for hospice care covered by Original Medicare. Kaiser Foundation Health Plan, Inc., is a Medicare Advantage Organization.

Medicare Advantage Plan: Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. Medicare Advantage Plans may also offer Medicare Part D (prescription drug coverage). This *Evidence of Coverage* is for a Medicare Part D plan.

Medicare Health Plan: A Medicare Health Plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage plans, Medicare Cost plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medigap (Medicare Supplement Insurance) Policy: Medicare supplement insurance sold by private insurance companies to fill "gaps" in the Original Medicare plan coverage. Medigap policies only work with the Original Medicare plan. (A Medicare Advantage Plan is not a Medigap policy.)

Member: A person who is eligible and enrolled under this *Evidence of Coverage,* and for whom we have received applicable Premiums. This *Evidence of Coverage* sometimes refers to a Member as "you."

Non–Plan Hospital: A hospital other than a Plan Hospital.

Non–Plan Pharmacy: A pharmacy other than a Plan Pharmacy. These pharmacies are also called "out-of-network pharmacies."

Non–Plan Physician: A physician other than a Plan Physician.

Non–Plan Provider: A provider other than a Plan Provider.

Non–Plan Skilled Nursing Facility: A Skilled Nursing Facility other than a Plan Skilled Nursing Facility.

Organization Determination: An initial determination we make about whether we will cover or pay for Services that you believe you should receive. Organization determinations are called "coverage decisions" in this *Evidence of Coverage*.

Original Medicare ("Traditional Medicare" or "Fee-for-Service Medicare"): The Original Medicare plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay a deductible. Medicare pays its share of the Medicare approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance), and is available everywhere in the United States and its territories.

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health resulting from an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy) if all of the following are true:

- You are temporarily outside your Home Region's Service Area
- You reasonably believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to your Home Region's Service Area

Plan Facility: Any facility listed in the "Plan Facilities" section or in a Kaiser Permanente guidebook *(Your Guidebook)* for your Home Region's Service Area, except that Plan Facilities are subject to change at any time without notice. For the current locations of Plan Facilities, please call our Member Service Call Center.

Plan Hospital: Any hospital listed in the "Plan Facilities" section or in a Kaiser Permanente guidebook *(Your Guidebook)* for your Home Region's Service Area, except that Plan Hospitals are subject to change at any time without notice. For the current locations of Plan Hospitals, please call our Member Service Call Center.

Plan Medical Office: Any medical office listed in the "Plan Facilities" section or in a Kaiser Permanente guidebook *(Your Guidebook)* for your Home Region's Service Area, except that Plan Medical Offices are subject to change at any time without notice. For the current locations of Plan Medical Offices, please call our Member Service Call Center.

Plan Optical Sales Office: An optical sales office owned and operated by Kaiser Permanente or another optical sales office that we designate. Please refer to *Your Guidebook* for a list of Plan Optical Sales Offices in your area, except that Plan Optical Sales Offices are subject to change at any time without notice. For the current locations of Plan Optical Sales Offices, please call our Member Service Call Center.

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Please refer to *Your Guidebook* for a list of Plan Pharmacies in your area, except that Plan Pharmacies are subject to change at any time without notice. For the current locations of Plan Pharmacies, please call our Member Service Call Center.

Plan Physician: Any licensed physician who is a partner or employee of the Medical Group, or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other health care provider that we designate as a Plan Provider.

Plan Skilled Nursing Facility: A Skilled Nursing Facility approved by Health Plan.

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive after your treating physician determines that this condition is Stabilized.

Premiums: The periodic amounts that your Group is responsible for paying for your membership under this *Evidence of Coverage*, except that you are responsible for paying Premiums if you have Cal-COBRA coverage.

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Please refer to our website at **kp.org** for a directory of Primary Care Physicians, except that the directory is subject to change without notice. For the current list of physicians that are available as Primary Care Physicians, please call the personal physician selection department at the phone number listed in *Your Guidebook.*

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. For information about Region locations in the District of Columbia and parts of Southern and Northern California, Colorado, Georgia, Hawaii, Idaho, Maryland, Ohio, Oregon, Virginia, and Washington, please call our Member Service Call Center.

Service Area: Health Plan has two Regions in California: the Northern California Region and the Southern California Region. As a Member enrolled under the CalPERS *Agreement,* you are enrolled in one of the two California Regions. This *Evidence of Coverage* describes the coverage of both California Regions.

Please refer to the "Service Area" section for the description your Home Region's Service Area.

Services: Health care services or items ("health care" includes both physical health care and mental health care).

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

Spouse: The Subscriber's legal husband or wife. For the purposes of this *Evidence of Coverage,* the term "Spouse" includes the Subscriber's same-sex spouse if the Subscriber and spouse are a couple who meet all of the requirements of Section 308(c) of the California Family Code or the Subscriber's registered domestic partner who meets all of the requirements of Section 297 or 299.2 of the California Family Code. If your Group allows enrollment of domestic partners who do not meet all of the requirements of Section 297 or 299.2 of the California Family Code, the term "Spouse" also includes the Subscriber's domestic partner who meets your Group's eligibility requirements for domestic partners.

Stabilize: To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability, that no material deterioration of the

condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

Subscriber: A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see “Eligibility” in the “Premiums, Eligibility, and Enrollment” section).

Urgent Care: Medically Necessary Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition.

SERVICE AREA

Northern California Region Service Area

The ZIP codes below for each county are in our Service Area:

- All ZIP codes in Alameda County are inside our Service Area: 94501–02, 94514, 94536–46, 94550–52, 94555, 94557, 94560, 94566, 94568, 94577–80, 94586–88, 94601–15, 94617–21, 94622–24, 94649, 94659–62, 94666, 94701–10, 94712, 94720, 95377, 95391
- The following ZIP codes in **Amador** County are inside our Service Area**:** 95640, 95669
- All ZIP codes in Contra Costa county are inside our Service Area: 94505–07, 94509, 94511, 94513–14, 94516–31, 94547–49, 94551, 94553, 94556, 94561, 94563–65, 94569–70, 94572, 94575, 94582–83, 94595–98, 94706–08, 94801–08, 94820, 94850
- The following ZIP codes in **El Dorado** County are inside our Service Area**:** 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762
- The following ZIP codes in **Fresno** County are inside our Service Area**:** 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618–19, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701–12, 93714–18, 93720–30, 93737, 93741, 93744–45, 93747, 93750, 93755, 93760–61, 93764–65, 93771–79, 93786, 93790–94, 93844, 93888
- The following ZIP codes in **Kings** County are inside our Service Area**:** 93230, 93232, 93242, 93631, 93656
- The following ZIP codes in **Madera** County are inside our Service Area**:** 93601–02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, 93720
- All ZIP codes in **Marin** County are inside our Service Area: 94901, 94903–04, 94912–15, 94920, 94924–25, 94929–30, 94933, 94937–42, 94945–50, 94956–57, 94960, 94963–66, 94970–71, 94973–74, 94976–79
- The following ZIP codes in **Mariposa** County are inside our Service Area**:** 93601, 93623, 93653
- The following ZIP codes in **Napa** County are inside our Service Area**:** 94503, 94508, 94515, 94558–59, 94562, 94567 (for Basic Plan Members Knoxville is not in your Home Region's Service Area), 94573–74, 94576, 94581, 94589–90, 94599, 95476
- The following ZIP codes in **Placer** County are inside our Service Area**:** 95602–04, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95692, 95703, 95722, 95736, 95746–47, 95765
- All ZIP codes in **Sacramento** County are inside our Service Area: 94203–09, 94211, 94229–30, 94232, 94234–37, 94239–40, 94244, 94246–50, 94252, 94254, 94256–59, 94261–63, 94267–69, 94271, 94273–74, 94277, 94279–80, 94282–91, 94293–98, 94571, 95608–11, 95615, 95621, 95624, 95626, 95628, 95630, 95632, 95638–41, 95652, 95655, 95660, 95662, 95670–71, 95673, 95680, 95683, 95690, 95693, 95741–42, 95757–59, 95763, 95811–38, 95840–43, 95851–53, 95860, 95864–67, 95894, 95899
- All ZIP codes in **San Francisco** county are inside our Service Area: 94102–05, 94107–12, 94114–27, 94129–34, 94137, 94139–47, 94151, 94156, 94158–64, 94172, 94177, 94188, 94199
- All ZIP codes in **San Joaquin** county are inside our Service Area: 94514, 95201–13, 95215, 95219–20, 95227, 95230–31, 95234, 95236–37, 95240–42, 95253, 95258, 95267, 95269, 95296–97, 95304, 95320, 95330, 95336–37, 95361, 95366, 95376–78, 95385, 95391, 95632, 95686
- All ZIP codes in **San Mateo** county are inside our Service Area: 94002, 94005, 94010–11,

94014–21, 94025–28, 94030, 94037–38, 94044, 94060–66, 94070, 94074, 94080, 94083, 94128, 94303, 94401–04, 94497

- The following ZIP codes in **Santa Clara** County are inside our Service Area**:** 94022–24, 94035, 94039–43, 94085–89, 94301–06, 94309, 94550, 95002, 95008–09, 95011, 95013–15, 95020–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95076, 95101, 95103, 95106, 95108–13, 95115–36, 95138–41, 95148, 95150–61, 95164, 95170, 95172–73, 95190–94, 95196
- All ZIP codes in **Solano** county are inside our Service Area: 94510, 94512, 94533–35, 94571, 94585, 94589–92, 95616, 95620, 95625, 95687–88, 95690, 95694, 95696
- The following ZIP codes in **Sonoma** County are inside our Service Area**:** 94515, 94922–23, 94926–28, 94931, 94951–55, 94972, 94975, 94999, 95401–07, 95409, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471–73, 95476, 95486–87, 95492
- All ZIP codes in **Stanislaus** county are inside our Service Area: 95230, 95304, 95307, 95313, 95316, 95319, 95322–23, 95326, 95328–29, 95350–58, 95360–61, 95363, 95367–68, 95380–82, 95385–87, 95397
- The following ZIP codes in **Sutter** County are inside our Service Area**:** 95626, 95645, 95648, 95659, 95668, 95674, 95676, 95692, 95836-37.
- The following ZIP codes in **Tulare** County are inside our Service Area**:** 93238, 93261, 93618, 93631, 93646, 93654, 93666, 93673
- The following ZIP codes in **Yolo** County are inside our Service Area**:** 95605, 95607, 95612, 95616–18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99
- The following ZIP codes in **Yuba** County are inside our Service Area**:** 95692, 95903, 95961

Southern California Region Service Area

The ZIP codes below for each county are inside our Service Area:

- The following ZIP codes in **Kern** County are inside our Service Area**:** 93203, 93205–06, 93215–16, 93220, 93222, 93224–26, 93238, 93240–41, 93243, 93250–52, 93263, 93268, 93276, 93280, 93285, 93287, 93301–09, 93311–14, 93380, 93383–90, 93501–02, 93504–05, 93518–19, 93531, 93536, 93560–61, 93581
- The following ZIP codes in **Los Angeles** County are inside our Service Area**:** 90001–84, 90086–91, 90093–96, 90101, 90103, 90189, 90201–02, 90209–13, 90220–24, 90230–33, 90239–42, 90245, 90247–51, 90254–55, 90260–67, 90270, 90272, 90274–75, 90277–78, 90280, 90290–96, 90301–12, 90401–11, 90501–10, 90601–10, 90623, 90630–31, 90637–40, 90650–52, 90660–62, 90670–71, 90701–03, 90706–07, 90710–17, 90723, 90731–34, 90744–49, 90755, 90801–10, 90813–15, 90822, 90831–35, 90840, 90842, 90844, 90846–48, 90853, 90895, 91001, 91003, 91006–12, 91016–17, 91020–21, 91023–25, 91030–31, 91040–43, 91046, 91066, 91077, 91101–10, 91114–18, 91121, 91123–26, 91129, 91182, 91184–85, 91188–89, 91199, 91201–10, 91214, 91221–22, 91224–26, 91301–11, 91313, 91316, 91321–22, 91324–31, 91333–35, 91337, 91340–46, 91350–57, 91361-62, 91364–65, 91367, 91371–72, 91376, 91380–81, 91383–87, 91390, 91392–96, 91401–13, 91416, 91423, 91426, 91436, 91470, 91482, 91495–96, 91499, 91501–08, 91510, 91521–23, 91601–12, 91614–18, 91702, 91706, 91709, 91711, 91714–16, 91722–24, 91731–35, 91740–41, 91744–50, 91754–56, 91765–73, 91775–76, 91778, 91780, 91788–93, 91795, 91801–04, 91896, 93243, 93510, 93532, 93534–36, 93539, 93543–44, 93550–53, 93560, 93563, 93584, 93586, 93590–91, 93599

- All ZIP codes in **Orange** County are inside our Service Area: 90620–24, 90630–33, 90638, 90680, 90720–21, 90740, 90742–43, 92602–07, 92609–10, 92612, 92614–20, 92623–30, 92637, 92646–63, 92672–79, 92683–85, 92688, 92690–94, 92697–98, 92701–08, 92711–12, 92728, 92735, 92780–82, 92799, 92801–09, 92811–12, 92814–17, 92821–23, 92825, 92831–38, 92840–46, 92850, 92856–57, 92859, 92861–63, 92865–71, 92885–87, 92899
- The following ZIP codes in **Riverside** County are inside our Service Area**:** 91752, 92201–03, 92210–11, 92220, 92223, 92230, 92234–36, 92240–41, 92247–48, 92253, 92255, 92258, 92260–64, 92270, 92276, 92282, 92320, 92324, 92373, 92399, 92501–09, 92513–19, 92521–22, 92530–32, 92543–46, 92548, 92551–57, 92562–64, 92567, 92570–72, 92581–87, 92589–93, 92595–96, 92599, 92860, 92877–83
- The following ZIP codes in **San Bernardino** County are inside our Service Area**:** 91701, 91708–10, 91729–30, 91737, 91739, 91743, 91758-59, 91761–64, 91766, 91784–86, 91792, 92305, 92307–08, 92313–18, 92321–22, 92324–26, 92329, 92331, 92333–37, 92339–41, 92344–46, 92350, 92352, 92354, 92357–59, 92369, 92371–78, 92382, 92385–86, 92391–95, 92397, 92399, 92401–08, 92410–15, 92418, 92423–24, 92427, 92880
- The following ZIP codes in **San Diego** County are inside our Service Area**:** 91901–03, 91908–17, 91921, 91931–33, 91935, 91941–47, 91950–51, 91962–63, 91976–80, 91987, 92007–11, 92013–14, 92018–27, 92029–30, 92033, 92037–40, 92046, 92049, 92051–52, 92054–58, 92064–65, 92067–69, 92071–72, 92074–75, 92078–79, 92081–85, 92091–93, 92096, 92101–24, 92126–32, 92134-40, 92142–43, 92145, 92147, 92149–50, 92152–55, 92158–79, 92182, 92184, 92186–87, 92190–91, 92193, 92195–99
- The following ZIP codes in **Ventura** County are inside our Service Area**:** 90265, 91304, 91307, 91311, 91319–20, 91358–62, 91377, 93001–07, 93009–12, 93015–16, 93020–22, 93030–36, 93040–44, 93060–66, 93094, 93099, 93252

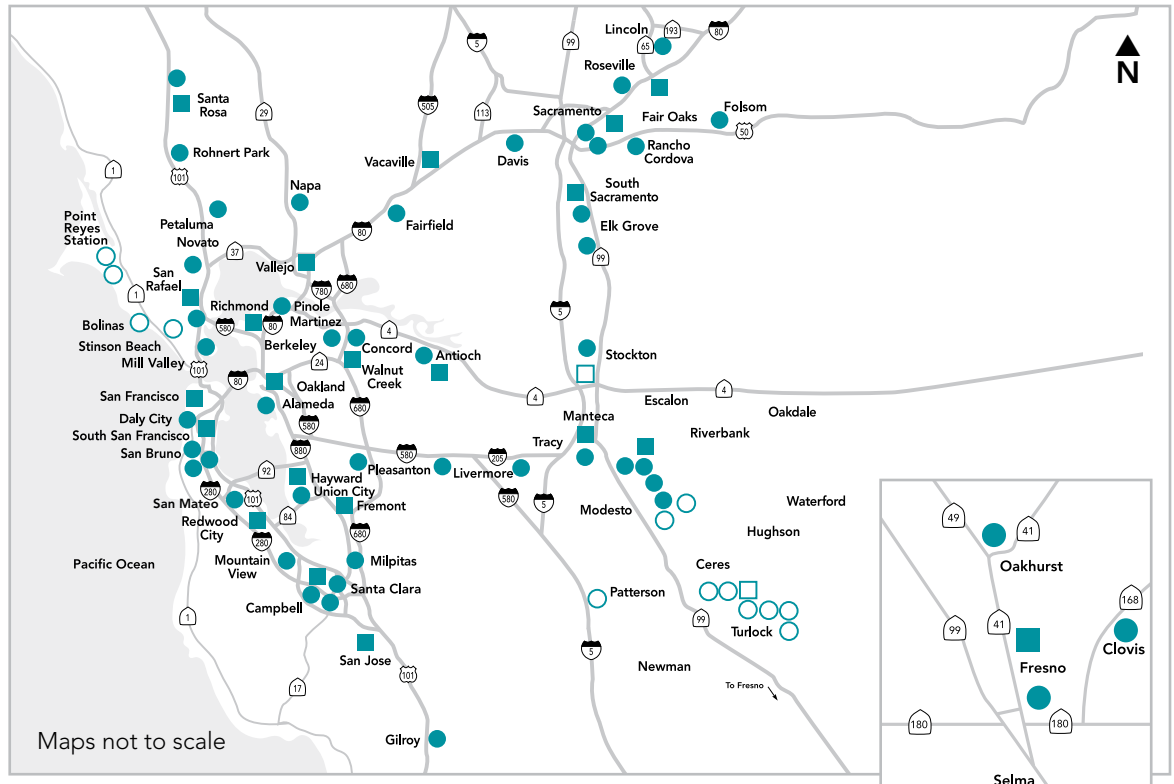
For each ZIP code listed for a county, your Home Region's Service Area includes only the part of that ZIP code that is in that county. When a ZIP code spans more than one county, the part of that ZIP code that is in another county is not inside your Home Region's Service Area unless that other county is also listed above and that ZIP code is also listed for that other county.

Note: Your Home Region's Service Areas are the geographic area approved by the Centers for Medicare & Medicaid Services within which an eligible person may enroll in Senior Advantage. Subject to approval by the Centers for Medicare & Medicaid Services, we may reduce or expand our Southern California Region's or Northern California Region's Service Area effective any January 1 by giving prior written notice to your Group. We may expand our Southern California Region's or Northern California Region's Service Area at any time by giving written notice to your Group. ZIP codes are subject to change by the U.S. Postal Service. If you have a question about whether a ZIP code is currently in your Home Region's Service Area, please call our Member Service Call Center.

Northern California

Legend:

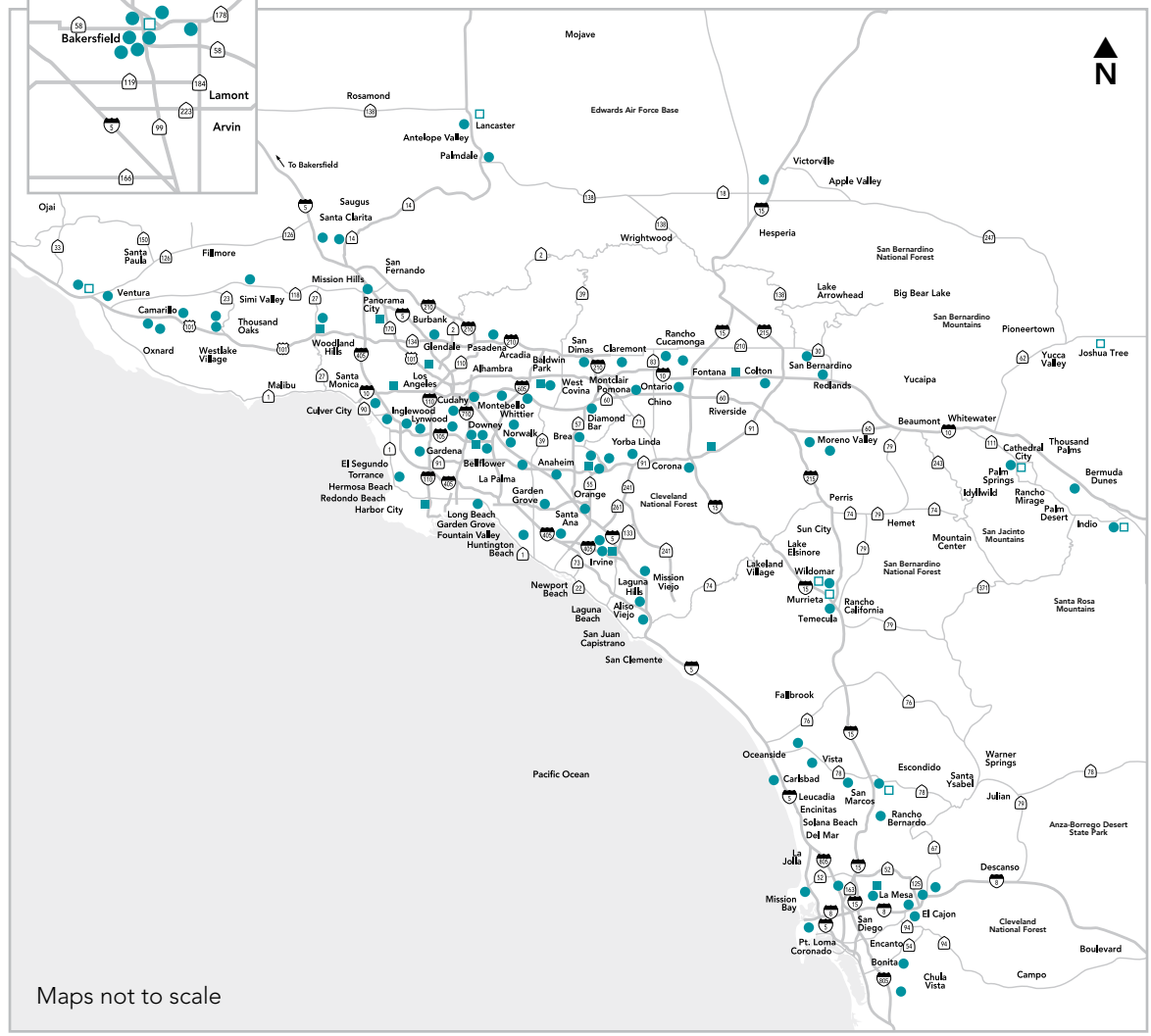
- ■ Kaiser Permanente medical centers (hospital and medical offices)
- ● Kaiser Permanente medical offices
- □ Affiliated plan hospitals
- ○ Affiliated medical offices



Fresno County area

Southern California

Legend:

- ■ Kaiser Permanente medical centers (hospital and medical offices)
- ● Kaiser Permanente medical offices
- □ Affiliated plan hospitals

Kern County area