GUIDE TO YOUR BENEFITS AND SERVICES

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Medical Benefits Chart: Senior Advantage without Part D

Medicare-Eligible Washington PEBB Employees

1983 - 301-307

For group benefits effective January 1, 2020, through December 31, 2020

You will see this apple next to the preventive services in this Medical Benefits Chart.

Services that are covered for you	What you must pay when you get these services
Maximum out-of-pocket amount	**$1,500** per person per year.
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Alternative care therapies (self-referred)	**$30** per chiropractic visit up to 12 visits per calendar year. Additional visits provided if treatment extension is approved by a network provider. See the "Chiropractic services" section in this Medical Benefits Chart for physician-referred chiropractic services. (See the Chiropractic Services Rider in the **EOC** for additional information about self-referred chiropractic services.)
Ambulance services • Covered ambulance services include fixed wing, rotary wing, and ground ambulance services to the nearest appropriate facility that can provide care if they are furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan.	**$50** per one-way trip.

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Services that are covered for you	What you must pay when you get these services
• We also cover the services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the **911** emergency response system where available) if 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. • You may need to file a claim for reimbursement unless the provider agrees to bill us (see Chapter 5). • †Nonemergency transportation by ambulance is appropriate if it is documented that the member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required.	
Annual routine physical exams Routine physical exams are covered if the exam is medically appropriate preventive care in accord with generally accepted professional standards of practice. This exam is covered once every 12 months.	There is no coinsurance, copayment, or deductible for this preventive care.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note:** Your first annual wellness visit can't take place within 12 months of your "Welcome to Medicare" preventive visit. However, you don't need to have had a "Welcome to Medicare" visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.

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Services that are covered for you	What you must pay when you get these services
Bone mass measurement For qualified individuals (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39. • One screening mammogram every 12 months for women age 40 and older. • Clinical breast exams once every 24 months.	There is no coinsurance, copayment, or deductible for covered screening mammograms.
Cardiac rehabilitation services† Comprehensive programs for cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**$30** per visit.
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease testing Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every five years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every five years.

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Services that are covered for you	What you must pay when you get these services
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months. • If you are at high risk of cervical or vaginal cancer or you are of childbearing age and have had an abnormal Pap test within the past three years: one Pap test every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.
Chiropractic services† Covered services include: • We cover only manual manipulation of the spine to correct subluxation. These Medicare-covered services are provided by a participating chiropractor of the CHP Group and listed in the **Provider Directory**.	**$20** per office visit.
Colorectal cancer screening • For people 50 and older, the following are covered: ♦ Flexible sigmoidoscopy (or screening barium enema as an alternative) every 48 months. • One of the following every 12 months: ♦ Guaiac-based fecal occult blood test (gFOBT). ♦ Fecal immunochemical test (FIT). • DNA-based colorectal screening every 3 years. • For people at high risk of colorectal cancer, we cover a screening colonoscopy (or screening barium enema as an alternative) every 24 months. • For people not at high risk of colorectal cancer, we cover a screening colonoscopy every 10 years (120 months), but not within 48 months of a screening sigmoidoscopy.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.

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Services that are covered for you	What you must pay when you get these services
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of the following risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. Based on the results of these tests, you may be eligible for up to two diabetes screenings every 12 months.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Diabetes self-management training and diabetic services and supplies For all people who have diabetes (insulin and noninsulin users), covered services include: • †Supplies to monitor your blood glucose: Blood glucose monitor, blood glucose test strips, lancet devices, lancets, and glucose-control solutions for checking the accuracy of test strips and monitors.	**No charge**.
• †For people with diabetes who have severe diabetic foot disease: One pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and two additional pairs of inserts, or one pair of depth shoes and three pairs of inserts (not including the noncustomized removable inserts provided with such shoes). Coverage includes fitting.	**No charge**.
• Diabetes self-management training is covered under certain conditions.	There is no coinsurance, copayment, or deductible for members eligible for the diabetes self-management training preventive benefit.

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Services that are covered for you	What you must pay when you get these services
Durable medical equipment (DME) and related supplies† (For a definition of "durable medical equipment," see Chapter 10 of this booklet.) Covered items include, but are not limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech-generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area does not carry a particular brand or manufacturer, you may ask them if they can special order it for you. The most recent list of suppliers is available on our website at **kp.org/directory**.	**No charge** for durable medical equipment. **No charge** for certain items such as CADD pumps, bone and spine stimulators, ventilators and enteral pumps and supplies.
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life, loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse. Cost-sharing for necessary emergency services furnished out-of-network is the same as for such services furnished in-network. **You have worldwide emergency care coverage.**	**$50** per Emergency Department visit. This copayment does not apply if you are immediately admitted directly to the hospital as an inpatient (it does apply if you are admitted to the hospital as an outpatient; for example, if you are admitted for observation). †If you receive emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must return to a network hospital in order for your care to continue to be covered or you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost-sharing you would pay at a network hospital.

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Services that are covered for you	What you must pay when you get these services
Fitness benefit (Silver&Fit® Exercise and Healthy Aging Program) With the Silver&Fit program, you can choose membership in a participating fitness center or the Silver&Fit Home Fitness Program. • You can join a participating Silver&Fit fitness center in our service area and take advantage of all of the services and amenities that are part of your basic fitness center membership. Amenities offered by fitness centers vary by center. Any nonstandard fitness center service that typically requires an additional fee is not included in your basic fitness membership (for example, court fees or personal trainer services). You can switch from one participating Silver&Fit fitness center once a month and your change will be effective the first of the following month. (You may need to complete a new membership agreement at the center.) • In lieu of a fitness facility membership, if you prefer to work out at home, you may want to sign up for the Silver&Fit Home Fitness Program and receive up to two fitness kits each calendar year for use at home. • Also, you have access to healthy aging educational materials by visiting **kp.org/SilverandFit**. Or you can request a selection of healthy educational materials be mailed to you every quarter once you have enrolled into a program. If you have questions or want to enroll or get a list of participating fitness center locations, visit **kp.org/SilverandFit** or call Silver&Fit Customer Service at **1-877-750-2746** (TTY/TDD users should call **711**), Monday–Friday, between 5 a.m. and 6 p.m. (PST). **Note**: The Silver&Fit Program is provided by American Specialty Health Fitness, Inc., a subsidiary of American Specialty Health Incorporated (ASH). All programs and services are not available in all areas. Silver&Fit® is a federally registered trademark of American Specialty Health, Inc.	**No charge**.

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Services that are covered for you	What you must pay when you get these services
Health and wellness education programs Health and wellness programs include weight management, quitting tobacco, diabetes management, life care planning, prediabetes, and more. Registered dietitians, health coaches, certified diabetes educators, and other health professionals facilitate our classes. We offer in-person, online, and phone options to fit your learning style. Please see our health and wellness classes and resources catalog at **kp.org/healthylivingcatalog/nw**. Contact Member Services for more details or to request a copy of our catalog.	**No charge**.
Hearing services • Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when furnished by a physician, audiologist, or other qualified provider. • Routine hearing exams.	**$30** per office visit.
• Evaluation and fitting for hearing aids.	**No charge**.
• *Hearing aids.	Balance after **$800** allowance is applied every three years. (See the Hearing Aid Rider in the **EOC** for additional information.)
HIV screening • For people who ask for an HIV screening test or who are at increased risk for HIV infection, we cover one screening exam every 12 months. • For women who are pregnant, we cover up to three screening exams during a pregnancy.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
• HIV screening test after each exposure.	**No charge**.

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Services that are covered for you	What you must pay when you get these services
Home-based palliative care† Services not covered by Medicare in the home are provided in the form of palliative care to diminish symptoms of terminally ill members with a life expectancy of 7–12 months. Services include non-Medicare covered palliative nursing and social work services in the home. Contact Member Services for more details.	**No charge**.
Home health agency care† Prior to receiving home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Covered services include, but are not limited to: • Part-time or intermittent skilled nursing and home health aide services. To be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week. • Physical therapy, occupational therapy, and speech therapy. • Medical and social services. • Medical equipment and supplies.	**No charge**. **Note:** There is no cost-sharing for home health care services and items provided in accord with Medicare guidelines. However, the applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply if the item is covered under a different benefit; for example, durable medical equipment not provided by a home health agency.
Home infusion therapy† We cover home infusion supplies and drugs if all of the following are true: • Your prescription drug is on our standard formulary (or you have a formulary exception). • We approved your prescription drug for home infusion therapy. • Your prescription is written by a network provider and filled at a network home-infusion pharmacy.	**No charge**.

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Services that are covered for you	What you must pay when you get these services
Hospice care You may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have six months or less to live if your illness runs its normal course. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief. • Short-term respite care. • Home care. ***For hospice services and services that are covered by Medicare Part A or B and are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay for your hospice services and any Part A and Part B services related to your terminal prognosis. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for. **For services that are covered by Medicare Part A or B and are not related to your terminal prognosis:** If you need nonemergency, non–urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network: • If you obtain the covered services from a network provider, you only pay the plan cost-sharing amount for in-network services. • *If you obtain the covered services from an out-of-network provider, you pay the cost-sharing under Fee-for-Service Medicare (Original Medicare). **For services that are covered by our plan but are not covered by Medicare Part A or B:** We will continue to cover plan-covered services that are not covered under Part A or B whether or not they are related to your terminal prognosis. You pay your plan cost-sharing amount for these services.	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, **not** our plan.

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Services that are covered for you	What you must pay when you get these services
Note: If you need nonhospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.	
We cover hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	**No charge**.
Immunizations Covered Medicare Part B services include: • Pneumonia vaccine. • Flu shots, once each flu season in the fall and winter, with additional flu shots if medically necessary. • Hepatitis B vaccine if you are at high or intermediate risk of getting Hepatitis B. • Other vaccines if you are at risk and they meet Medicare Part B coverage rules.	There is no coinsurance, copayment, or deductible for the pneumonia, influenza, and Hepatitis B vaccines.
Inpatient hospital care† Includes inpatient acute, inpatient rehabilitation, long-term care hospitals, and other types of inpatient hospital services. Inpatient hospital care starts the day you are formally admitted to the hospital with a doctor's order. The day before you are discharged is your last inpatient day. There is no limit to the number of medically necessary hospital days or services that are generally and customarily provided by acute care general hospitals. Covered services include, but are not limited to: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Regular nursing services. • Costs of special care units (such as intensive care or coronary care units). • Drugs and medications.	**$500** per admission. Cost-sharing is charged for each inpatient stay. If you get authorized inpatient care at an out-of-network hospital after your emergency condition is stabilized, your cost is the cost-sharing you would pay at a network hospital. **Note:** If you are admitted to the hospital in 2019 and are not discharged until sometime in 2020, the 2019 cost-sharing will apply to that admission until you are discharged from the hospital or transferred to a skilled nursing facility.

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Services that are covered for you	What you must pay when you get these services
• Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Physical, occupational, and speech language therapy. • Inpatient substance abuse services for medical management of withdrawal symptoms associated with substance abuse (detoxification). • Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/ multivisceral. If you need a transplant, we will arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you are a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If we provide transplant services at a location outside the pattern of care for transplants in your community and you choose to obtain transplants at this distant location, we will arrange or pay for appropriate lodging and transportation costs for you and a companion. • Blood—including storage and administration. • Physician services.	
Note: To be an "inpatient," your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an inpatient or an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf** or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.	

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Services that are covered for you	What you must pay when you get these services
Inpatient mental health care† Covered services include mental health care services that require a hospital stay. • We cover up to 190-days per lifetime for inpatient stays in a Medicare-certified psychiatric hospital. The number of covered lifetime hospitalization days is reduced by the number of inpatient days for mental health treatment previously covered by Medicare in a psychiatric hospital. • The 190-day limit does not apply to mental health stays in a psychiatric unit of a general hospital.	**$500** per admission. Cost-sharing is charged for each inpatient stay. **Note:** If you are admitted to the hospital in 2019 and are not discharged until sometime in 2020, the 2019 cost-sharing will apply to that admission until you are discharged from the hospital or transferred to a skilled nursing facility.
Inpatient stay: Covered services received in a hospital or SNF during a noncovered inpatient stay† If you have exhausted your inpatient mental health or skilled nursing facility (SNF) benefits or if the inpatient stay is not reasonable and necessary, we will not cover your inpatient or SNF stay. However, in some cases, we will cover certain services you receive while you are in the hospital or SNF. Covered services include, but are not limited to:	You pay the following for covered outpatient services and other items covered under Medicare Part B when provided by network providers:
• Physician services.	**$30** per primary care visit. **$30** per specialty care visit.
• Diagnostic tests (like lab tests).	**No charge** for lab tests.
• X-rays. • Radium and isotope therapy including technician materials and services.	**No charge** per visit, per department, for X-rays. **No charge** per visit for radium and isotope therapy. **No charge** per visit, per department, for specialty scans such as MRI, CT, PET scans.
• Surgical dressings.	**No charge** for surgical dressings. **No charge** for take-home dressings and supplies.

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Services that are covered for you	What you must pay when you get these services
• Splints, casts, and other devices used to reduce fractures and dislocations.	**No charge** for casts. **No charge** for splints and other devices to reduce fractures and dislocations.
• Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. • Leg, arm, back, and neck braces; trusses; and artificial legs, arms, and eyes (including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition).	**No charge**.
• Physical therapy, speech therapy, and occupational therapy.	**$30** per visit.
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover three hours of one-on-one counseling services during your first year that you receive medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and two hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to receive more hours of treatment with a physician's order. A physician must prescribe these services and renew his or her order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.
Medicare Diabetes Prevention Program (MDPP) MDPP services will be covered for eligible Medicare beneficiaries under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.

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Services that are covered for you	What you must pay when you get these services
Medicare Part B prescription drugs† These drugs are covered under Part B of Original Medicare. Members of our plan receive coverage for these drugs through our plan. Covered drugs include:	
• Antigens.	**No charge**.
• Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa).	**No charge**.
• 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.	**No charge**.
• Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug.	**No charge**.
• Clotting factors you give yourself by injection if you have hemophilia.	Your applicable prescription drug copayment or coinsurance.
• Immunosuppressive drugs, if you were enrolled in Medicare Part A at the time of the organ transplant.	Your applicable prescription drug copayment or coinsurance.
• Drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan.	Your applicable prescription drug copayment or coinsurance.
• Certain oral anti-cancer drugs and anti-nausea drugs.	Your applicable prescription drug copayment or coinsurance.
• Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases.	Your applicable prescription drug copayment or coinsurance.

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Services that are covered for you	What you must pay when you get these services
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.
Opioid treatment program services† Opioid use disorder treatment services are covered under Part B of Original Medicare. Members of our plan receive coverage for these services through our plan. Covered services include: • FDA-approved opioid agonist and antagonist treatment medications and the dispensing and administration of such medications, if applicable.	**No charge**.
• Substance use counseling. • Individual and group therapy. • Toxicology testing.	**$30** per visit.
Outpatient diagnostic tests and therapeutic services and supplies† Covered services include, but are not limited to: • X-rays. • Ultrasounds. • Special diagnostic tests, such as electrocardiograms (EKGs) and Holter monitoring.	**No charge** per visit, per department.
• Radiation (radium and isotope) therapy, including technician materials and supplies.	**No charge** per visit.
• Surgical supplies, such as dressings. • Splints, casts, and other devices used to reduce fractures and dislocations.	**No charge** for surgical supplies or casts. **No charge** for take-home dressings and supplies, splints, and other devices to reduce fractures and dislocations.

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Services that are covered for you	What you must pay when you get these services
• Laboratory tests.	**No charge**.
• Blood—including storage and administration.	**No charge**.
• Other outpatient diagnostic tests: ♦ Special imaging procedures, for example, MRI, CT, and PET scans.	**No charge** per visit, per department.
Outpatient hospital observation† Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet the Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another individual authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf** or by calling **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.	**$50** per stay when admitted directly to the hospital for observation as an outpatient. **Note**: There's no additional charge for outpatient observation stays when transferred from an Emergency Department or outpatient surgery.

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Services that are covered for you	What you must pay when you get these services
Outpatient hospital services† We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but are not limited to: • Services in an Emergency Department or outpatient clinic, such as observation services or outpatient surgery. **Note**: Refer to the "Outpatient hospital observation" section of this Medical Benefits Chart for the cost-sharing applicable to observation services.	**$50** per Emergency Department visit. **$50** per outpatient surgery visit or outpatient procedure.
• Laboratory and diagnostic tests billed by the hospital.	**No charge** for lab tests. **No charge** for diagnostic tests such as electrocardiograms.
• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it.	**$30** per day in partial hospitalization program.
• X-rays and other radiology services billed by the hospital.	**No charge** per visit, per department for X-rays and ultrasounds. **No charge** for radiation therapy. **No charge** per visit, per department for specialty scans, such as MRI, CT, PET scans.
• Medical supplies such as splints and casts.	**No charge** for splints and casts. **No charge** for take home dressings and supplies.
• Certain drugs and biologicals that you can't give yourself.	**No charge**.

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Services that are covered for you	What you must pay when you get these services
Note: Unless the provider has written an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an "outpatient." If you are not sure if you are an outpatient, you should ask the hospital staff. You can also find more information in a Medicare fact sheet called "Are You a Hospital Inpatient or Outpatient? If You Have Medicare – Ask!" This fact sheet is available on the Web at **https://www.medicare.gov/sites/default/files/2018-09/11435-Are-You-an-Inpatient-or-Outpatient.pdf** or by calling **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**. You can call these numbers for free, 24 hours a day, 7 days a week.	
Outpatient mental health care† Covered services include: • Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, nurse practitioner, physician assistant, or other Medicare-qualified mental health care professional as allowed under applicable state laws.	**$30** per individual therapy visit. **$15** per group therapy visit.
• Mental health day treatment.	**$30** per day.
Outpatient rehabilitation services† • Covered services include: physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	**$30** per visit (or per day at a comprehensive outpatient rehabilitation facility.
Outpatient substance abuse services† Covered services include: • Intensive outpatient treatment program.	**$30** per individual visit. **$15** per group visit.
• Substance abuse day treatment services.	**$30** per day.

† Your provider must obtain prior authorization from our plan.
* Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers† **Note:** If you are having surgery in a hospital facility, you should check with your provider about whether you will be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you are an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	**$50** per visit.
Outside service area benefit If you travel outside our service area, but inside the United States or its territories, we cover preventive, routine, follow-up, or continuing care office visits obtained from out-of-network Medicare providers not to exceed **$1,000** in covered plan charges per calendar year. We will pay up to **80%** of the Medicare allowable charge, if the provider accepts assignment. Otherwise, we will pay **80%** of the Medicare limiting charge, if the provider does not accept assignment.	**20%** of the Medicare allowable or the limiting charges. Up to **$1,000** maximum benefit per calendar year.
Partial hospitalization services† "Partial hospitalization" is a structured program of active psychiatric treatment, provided as a hospital outpatient service or by a community mental health center that is more intense than the care received in your doctor's or therapist's office and is an alternative to inpatient hospitalization. **Note:** Because there are no community mental health centers in our network, we cover partial hospitalization only as a hospital outpatient service.	**$30** per day.

† Your provider must obtain prior authorization from our plan.
* Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
Physician/practitioner services, including doctor's office visits Covered services include: • †Medically necessary medical care or surgery services furnished in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location. • †Consultation, diagnosis, and treatment by a specialist. • †Second opinion by another network provider prior to surgery. • Basic hearing and balance exams performed by a network provider, if your doctor orders it to see if you need medical treatment.	**$30** per primary care visit. **$30** per specialty care visit. **$50** per visit for an outpatient surgery or procedure at an ambulatory surgery center or hospital outpatient department.
• †Nonroutine dental care (covered services are limited to surgery of the jaw or related structures, setting fractures of the jaw or facial bones, extraction of teeth to prepare the jaw for radiation treatments of neoplastic cancer disease, or services that would be covered when provided by a physician).	**$30** per specialty care visit. **$50** per visit for an outpatient surgery or procedure at an ambulatory surgery center or hospital outpatient department.
• †Pain management office visits.	**$30** per individual visit. **$15** per group visit.
• Chemotherapy visits.	**No charge** per visit.
• †Ultraviolet light treatments.	**$5** per visit.
• †Visits for injections administered in outpatient settings.	**No charge** per injection.
• Certain telehealth services, including for: primary and specialty care, which includes cardiac and pulmonary rehabilitation, mental health care, substance abuse treatment, physical therapy, kidney disease, diabetes self-management, preparation for a hospital stay, and follow up visits after a hospital stay or Emergency Department visit. Services will only be provided via telehealth when deemed clinically	**No charge**.

† Your provider must obtain prior authorization from our plan.
* Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
appropriate by the network provider rendering the service. You have the option of receiving these services either through an in-person visit or via telehealth. If you choose to receive one of these services via telehealth, then you must use a network provider that currently offers the service via telehealth. We offer the following means of telehealth: ♦ Interactive video visits for professional services when care can be provided in this format as determined by a network provider. ♦ Scheduled telephone appointment visits for professional services when care can be provided in this format as determined by a network provider. • Telehealth services for monthly ESRD-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home. • Telehealth services for diagnosis, evaluation, or treatment of symptoms of an acute stroke. • Brief virtual (for example, via telephone or video chat) 5- to 10-minute check-ins with your doctor, if you are an established patient and the virtual check-in is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment. • Remote evaluation of prerecorded video and/or images you send to your doctor, including your doctor's interpretation and follow-up within 24 hours (except weekends and holidays)—if you are an established patient and the remote evaluation is not related to an office visit within the previous 7 days, nor leads to an office visit within the next 24 hours or soonest available appointment. • Consultation your doctor has with other physicians via telephone, internet, or electronic health record assessment—if you are an established patient.	
Note: Cost-sharing is charged based on the medical department where the service is provided, not the type of provider. In addition, multiple copayments may apply, depending on services provided and/or whether a consultation occurs.	

† Your provider must obtain prior authorization from our plan.
* Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
Podiatry services† Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	**$30** per visit. **$50** per outpatient surgery visit.
***Prescription drugs†** (Not covered by Medicare, but covered by your group plan.)	**$20** generic/**$40** brand, for up to a 30-day supply, per prescription. **$40** generic/**$80** brand for a 31- to 90-day supply from our Mail-Order Pharmacy. **No charge** for formulary contraceptives. (See the Outpatient Prescription Drug Rider in the **EOC** for additional information.)
Prostate cancer screening exams For men age 50 and older, covered services include the following once every 12 months: • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	There is no coinsurance, copayment, or deductible for an annual digital rectal exam or PSA test.
Prosthetic devices and related supplies† Devices (other than dental) that replace all or part of a body part or function. Covered items include, but are not limited to: • Colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). • Certain supplies related to prosthetic devices, and repair and/or replacement of prosthetic devices.	**No charge** for external prosthetic or orthotic devices and supplies, including wound care supplies. **No charge** for surgically implanted internal devices and enteral and parenteral nutrition therapy.

† Your provider must obtain prior authorization from our plan.
* Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
• Wigs following chemotherapy or radiation therapy (up to $100 benefit maximum per lifetime). • Some coverage following cataract removal or cataract surgery (see "Vision care" later in this section for more detail).	
Pulmonary rehabilitation services† Comprehensive programs for pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**$30** per day.
Residential treatment for mental health and substance abuse† There is no limit to the number of medically necessary days in our residential treatment program to treat mental health conditions and substance abuse when prescribed by a network provider. Covered services include the following: • Nursing care. • Room and meals. • Services by counselors and licensed therapists, such as assessments, care plans, and therapy. • Group, family, and individual counseling. • Occupational therapy. • Discharge planning.	**$250** per admission. Cost-sharing is charged per admission to a residential treatment program.
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults with Medicare (including pregnant women) who misuse alcohol, but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to four brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

† Your provider must obtain prior authorization from our plan.
* Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
Screening for lung cancer with low-dose computed tomography (LDCT)† For qualified individuals, a LDCT is covered every 12 months. • Eligible members are people aged 55–77 years who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 30 pack-years and who currently smoke or have quit smoking within the last 15 years, who receive a written order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. • For LDCT lung cancer screenings after the initial LDCT screening, the member must receive a written order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for subsequent lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to two individual 20- to 30-minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We will only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.

† Your provider must obtain prior authorization from our plan.
* Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care.	**No charge**.
• †Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3). • †Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments). • †Home dialysis equipment and supplies. • †Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and to check your dialysis equipment and water supply).	**No charge**.
• †Inpatient dialysis treatments (if you are admitted as an inpatient to a hospital for special care).	No additional charge for services received during a hospital stay. Refer to the "Inpatient hospital care" section of this Medical Benefits Chart for the cost-sharing applicable to inpatient stays.
Certain drugs for dialysis are covered under your Medicare Part B drug benefit. For information about coverage for Part B drugs, please go to the section called "Medicare Part B prescription drugs."	
Skilled nursing facility (SNF) care† (For a definition of "skilled nursing facility care," see Chapter 10 of this booklet. Skilled nursing facilities are sometimes called "SNFs.") We cover up to 150 days per benefit period of skilled inpatient services in a skilled nursing facility in accord with Medicare guidelines (a prior hospital stay is not required). Covered services include, but are not limited to: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets.	**No charge**.

† Your provider must obtain prior authorization from our plan.
* Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
• Skilled nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors). • Blood—including storage and administration. • Medical and surgical supplies ordinarily provided by SNFs. • Laboratory tests ordinarily provided by SNFs. • X-rays and other radiology services ordinarily provided by SNFs. • Use of appliances such as wheelchairs ordinarily provided by SNFs. • Physician/practitioner services. Generally, you will get your SNF care from network facilities. However, under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse is living at the time you leave the hospital.	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) **If you use tobacco, but do not have signs or symptoms of tobacco-related disease:** We cover two counseling quit attempts within a 12-month period as a preventive service with no cost to you. Each counseling attempt includes up to four face-to-face visits. **If you use tobacco and have been diagnosed with a tobacco-related disease or are taking medicine that may be affected by tobacco:** We cover cessation counseling services. We cover two counseling quit	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

† Your provider must obtain prior authorization from our plan.
* Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
attempts within a 12-month period; however, you will pay the applicable cost-sharing. Each counseling attempt includes up to four face-to-face visits.	
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30–60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication. • Be conducted in a hospital outpatient setting or a physician's office. • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD. • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques. **Note:** SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time, if deemed medically necessary by a health care provider.	**$30** per visit.
Urgently needed services Urgently needed services are provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. • **Inside our service area:** You must obtain urgent care from network providers, unless our provider network is temporarily unavailable or inaccessible due to an unusual	**$35** per provider office visit. **$50** per Emergency Department visit.

† Your provider must obtain prior authorization from our plan.
* Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
and extraordinary circumstance (for example, major disaster). • **Outside our service area:** You have worldwide urgent care coverage when you travel if you need medical attention right away for an unforeseen illness or injury and you reasonably believed that your health would seriously deteriorate if you delayed treatment until you returned to our service area. Cost-sharing for necessary urgently needed services furnished out-of-network is the same as for such services furnished in-network. See Chapter 3, Section 3, for more information.	
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration.	**$30** per visit.
• Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. However, our plan does cover the following exams: ♦ Routine eye exams (eye refraction exams) to determine the need for vision correction and to provide a prescription for eyeglass lenses. • Visual field tests.	**$30** per visit.
• For people who are at high risk of glaucoma, we will cover one glaucoma screening each year. People at high risk of glaucoma include: people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year.	**No charge**.

† Your provider must obtain prior authorization from our plan.
* Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

Services that are covered for you	What you must pay when you get these services
• One pair of eyeglasses or one conventional contact lens or up to a 6-month supply of disposable contact lenses after each cataract surgery that includes insertion of an intraocular lens. (If you have two separate cataract operations, you can reserve the benefit after the first surgery and purchase two eyeglasses after the second surgery.) • Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	**No charge** for eyewear in accord with Medicare guidelines. **Note:** If the eyewear you purchase costs more than what Medicare covers, you pay the difference.
• *Prescription eyewear (eyeglass lenses, eyeglass frames, and contact lenses).	Balance after $150 eyewear allowance to use toward the purchase price of eyewear once within a two-calendar-year period. (See the Prescription Eyewear Rider in the **EOC** for additional information.)
"Welcome to Medicare" preventive visit We cover the one-time "Welcome to Medicare" preventive visit. The visit includes a review of your health, as well as education and counseling about the preventive services you need (including certain screenings and shots), and referrals for other care if needed. **Important:** We cover the "Welcome to Medicare" preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you would like to schedule your "Welcome to Medicare" preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.
Note: Refer to Chapter 1 (Section 7) and Chapter 9 (Section 10) for information about coordination of benefits that applies to all covered services described in this Medical Benefits Chart.	

† Your provider must obtain prior authorization from our plan.
* Your cost-sharing for these services or items doesn't apply toward the maximum out-of-pocket amount.

January 1 – December 31, 2020

Evidence of Coverage

Your Medicare Health Benefits and Services as a Member of Kaiser Permanente Senior Advantage Group Plan (HMO) for Medicare Eligible Washington PEBB Employees

This booklet gives you the details about your Medicare health care coverage from January 1 to December 31, 2020. It explains how to get coverage for the health care services you need. This is an important legal document. Please keep it in a safe place.

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

This document is available in large print if you need it by calling Member Services (phone numbers are printed on the back cover of this booklet).

Benefits, premium, deductible, and/or copayments/coinsurance may change on January 1, 2021. The provider network may change at any time. You will receive notice when necessary.

KAISER PERMANENTE®

2020 Evidence of Coverage

Table of Contents

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

CHAPTER 1. Getting started as a member

SECTION 1. Introduction

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

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

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

Coverage under this plan qualifies as Qualifying Health Coverage (QHC) and satisfies the Patient Protection and Affordable Care Act's (ACA) individual shared responsibility requirement. Please visit the Internal Revenue Service (IRS) website at **https://www.irs.gov/Affordable-Care-Act/Individuals-and-Families** for more information.

Section 1.2 What is the Evidence of Coverage booklet about?

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

If you are not certain which plan you are enrolled in, please call Member Services or your group's benefits administrator.

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

It's important for you to learn what our plan's rules are and what services are available to you. We encourage you to set aside some time to look through this **Evidence of Coverage** booklet.

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

Section 1.3 Term of the Evidence of Coverage

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

If your group renews on January 1, the **Evidence of Coverage** is in effect for the months in which you are enrolled in Senior Advantage between January 1, 2020, and December 31, 2020, unless amended.

If your group's Agreement renews at a later date in 2020, the term of this **Evidence of Coverage** is during that contract period, unless amended.

Your group can tell you the term of this **Evidence of Coverage** and whether this **Evidence of Coverage** is still in effect, and give you a current one if this **Evidence of Coverage** has been amended.

Medicare must approve our plan each year

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

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

Section 2.1 Your Senior Advantage eligibility requirements

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

- You have both Medicare Part A and Medicare Part B (Section 2.2 below tells you about Medicare Part A and Medicare Part B).
- – *and* – you live in our geographic service area (Section 2.3 below describes our service area). If you have been a member of our plan continuously since before January 1999 and you were living outside of our service area before January 1999, you are still eligible as long as you have not moved since before January 1999.
- – *and* – you are a United States citizen or are lawfully present in the United States.
- – *and* – you do not have End-Stage Renal Disease (ESRD), with limited exceptions, such as if you develop ESRD when you are already a member of a plan that we offer, or you were a member of a different plan that was terminated.

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

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

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

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

Section 2.3 Here is our plan service area for Senior Advantage

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

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

If you plan to move out of the service area, please contact Member Services (phone numbers are printed on the back cover of this booklet). Active employees also need to contact their personnel, payroll, or benefits office. Retirees, COBRA, and LWOP members also need to contact the PEBB Program.

It is also important that you call Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

Section 2.4 Group eligibility requirements

Medical plan eligibility and enrollment for a retiree or survivor

In these sections, we use the term "subscriber" to refer to a retiree or survivor. The term "enrollee" refers to a subscriber and their dependents. The term "retiree" or "retiring employee" includes an elected or full-time appointed official of the legislative and executive branch of state government eligible to continue enrollment in Public Employees Benefits Board (PEBB) retiree insurance coverage. The term "retiree" or "retiring school employee" includes a retiring non-represented employee of an educational service district (ESD) or retiring school employee from a School Employees Benefits Board (SEBB) organization. Additionally, "health plan" is used to refer to a plan offering medical or dental, or both, developed by PEBB and provided by a contracted vendor or self-insured plans administered by the Health Care Authority (HCA).

Eligibility

The PEBB Program determines if a retiring employee or retiring school employee is eligible to enroll in PEBB retiree insurance coverage upon receipt of a completed **PEBB Retiree Coverage Election Form**. If the retiring employee or retiring school employee does not have substantive eligibility or does not meet the procedural requirements for enrollment in PEBB retiree insurance coverage, the PEBB Program will notify them of their right to an appeal. Information about appealing a PEBB Program decision can be found in Section 2.5 of this chapter under "Appeal rights." For information on how to enroll, see "Enrollment" in Section 2.5.

The PEBB Program determines if a dependent is eligible to enroll or continue enrollment in PEBB retiree insurance coverage as a survivor upon receipt of a completed **PEBB Retiree Coverage Election Form**. If the survivor does not meet the eligibility and procedural requirements for enrollment in PEBB retiree insurance coverage, the PEBB Program will notify them of their right to an appeal. Information about appealing a PEBB Program decision can be found in Section 2.5 of this chapter under "Appeal rights." For information on how to enroll, see "Enrollment" in Section 2.5.

A retiree, a survivor, and their enrolled dependents are required to enroll in Medicare Part A and Part B if they are entitled. Any enrollee who is entitled to Medicare must enroll and stay enrolled in Medicare Part A and Part B to enroll or continue enrollment in a PEBB retiree health plan. A subscriber must provide a copy of their or their dependent's Medicare card or entitlement letter from the Social Security Administration with Medicare Part A and Part B effective dates to the PEBB Program as proof of Medicare enrollment. If a subscriber or their dependent is not entitled to either Medicare Part A or Part B on their 65th birthday, a copy of the denial letter from the Social Security Administration must be provided to the PEBB Program. The only exception to this rule is for an employee or school employee who retired on or before July 1, 1991.

To enroll an eligible dependent the subscriber must follow the procedural requirements described in Section 2.5 of this chapter under "Enrollment." The PEBB Program verifies the eligibility of all dependents and requires the subscriber to provide documents that prove a dependent's eligibility.

The following are eligible as dependents:

1. Legal spouse.
2. State-registered domestic partner as defined in state statute and substantially equivalent legal unions from other jurisdictions as defined in Washington state statute.
3. Children. Children are eligible through the last day of the month in which their 26th birthday occurs except as described in subsection (g) of this section. Children are defined as the subscriber's:
    a. Children as defined in state statutes that establish a parent-child relationship, except when parental rights have been terminated;
    b. Children of the subscriber's spouse, based on the spouse's establishment of a parent-child relationship, except when parental rights have been terminated. The stepchild's relationship to the subscriber (and eligibility as a dependent) ends on the same date the marriage with the spouse ends through divorce, annulment, dissolution, termination, or death;
    c. Children for whom the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of the child;
    d. Children of the subscriber's state-registered domestic partner, based on the state-registered domestic partner's establishment of a parent-child relationship, except when parental rights have been terminated. The child's relationship to the subscriber (and eligibility as a dependent) ends on the same date the subscriber's legal relationship with

the state-registered domestic partner ends through divorce, annulment, dissolution, termination, or death;

e. Children specified in a court order or divorce decree for whom the subscriber has a legal obligation to provide support or health care coverage;

f. Extended dependent in the legal custody or legal guardianship of the subscriber, the subscriber's spouse, or subscriber's state-registered domestic partner. The legal responsibility is demonstrated by a valid court order and the child's official residence with the custodian or guardian. Extended dependent child does not include a foster child unless the subscriber, the subscriber's spouse, or the subscriber's state-registered domestic partner has assumed a legal obligation for total or partial support in anticipation of adoption; and

g. Children of any age with a developmental or physical disability that renders the child incapable of self-sustaining employment and chiefly dependent upon the subscriber for support and maintenance provided such condition occurs before the age of 26. The following requirements apply to a dependent child with a disability:

- The subscriber must provide proof of the disability and dependency within 60 days of the child's attainment of age 26;
- The subscriber must notify the PEBB Program, in writing, within 60 days of the last day of the month the child is no longer eligible under this subsection;
- A child with a developmental or physical disability who becomes self-supporting is not eligible as of the last day of the month in which they become capable of self-support;
- A child with a developmental or physical disability age 26 and older who becomes capable of self-support does not regain eligibility under this subsection if they later become incapable of self-support; and
- The PEBB Program with input from the medical plan will periodically verify the eligibility of a dependent child with a disability, but no more frequently than annually after the two-year period following the child's 26th birthday, which may require renewed proof from the subscriber.

4. Parents of the subscriber.

a. Parents covered under PEBB medical before July 1, 1990, may continue enrollment on a self-pay basis as long as:

- The parent maintains continuous enrollment in PEBB medical;
- The parent qualifies under the Internal Revenue Code as a dependent of the subscriber;
- The subscriber continues enrollment in PEBB insurance coverage; and
- The parent is not covered by any other group medical plan.

b. Parents eligible under this subsection may be enrolled with a different medical plan than that selected by the subscriber. Parents may not enroll additional dependents to their PEBB insurance coverage.

Section 2.5 When you can enroll and when coverage begins

Enrollment

Deferring enrollment in a PEBB retiree health plan

A retiring employee, a retiring school employee, and a dependent becoming eligible as a survivor who want to defer enrollment in a PEBB retiree health plan must submit a **PEBB Retiree Coverage Election Form** to the PEBB Program within the PEBB Program's enrollment timelines. Deferring enrollment will also defer enrollment for all eligible dependents, except as described below. A retiring employee, a retiring school employee, and a dependent becoming eligible as a survivor who do not enroll in a PEBB retiree health plan are only eligible to enroll later if they have deferred enrollment as identified below:

- Beginning January 1, 2001, enrollment in a PEBB health plan may be deferred when the subscriber is enrolled in employer-based group medical insurance as an employee or the dependent of an employee, or such medical insurance continued under Consolidated Omnibus Budget Reconciliation Act (COBRA) coverage or continuation coverage.
- Beginning January 1, 2001, enrollment in a PEBB health plan may be deferred when the subscriber is enrolled as a retiree or the dependent of a retiree in a federal retiree medical plan.
- Beginning January 1, 2006, enrollment in a PEBB health plan may be deferred when the subscriber is enrolled in Medicare Parts A and B and a Medicaid program that includes payment of medical and hospital benefits. Eligible dependents who are not enrolled in Medicaid coverage that includes payment of medical and hospital benefits may be enrolled.
- Beginning January 1, 2014, subscribers who are not eligible for Part A and Part B of Medicare may defer enrollment in a PEBB health plan when the subscriber is enrolled in coverage through a health care exchange developed under the Affordable Care Act.
- Beginning July 17, 2018, enrollment in a PEBB health plan may be deferred when the subscriber is enrolled in the Civilian Health and Medical Program of the Department of Veterans Affairs (CHAMPVA).

Exception: A retiree may defer enrollment in a PEBB retiree health plan during the period of time they are enrolled as a dependent in a medical plan sponsored by PEBB, a Washington State educational service district, or School Employees Benefits Board (SEBB), including such coverage under COBRA or continuation coverage. They do not need to submit a **PEBB Retiree Coverage Election Form**.

If a retiree or a survivor defers enrollment in PEBB medical, enrollment must also be deferred for PEBB dental.

Note: PEBB retiree health plan enrollment is deferred if a retiree or a survivor becomes newly eligible for PEBB benefits as an employee and enrolls in a PEBB health plan. If a retiree or a survivor becomes newly eligible for SEBB benefits as a school employee and enrolls in a SEBB health plan, they should consider deferring enrollment in a PEBB retiree health plan.

How to enroll

A subscriber or dependent can enroll in only one PEBB medical plan even if eligibility criteria is met under two or more subscribers.

To enroll in PEBB retiree insurance coverage, a retiring employee, a retiring school employee, and a dependent becoming eligible as a survivor must submit a **PEBB Retiree Coverage Election Form** along with any other required form(s) to the PEBB Program. The form(s) must be received within the required enrollment time limits described under "When medical coverage begins." The first premium payment and applicable premium surcharges are due to the HCA no later than 45 days after the election period ends, as described in "When medical coverage begins."

A retiree or a survivor who requests to enroll an eligible dependent must include the dependent's enrollment information on the form and provide any required document(s) as proof of the dependent's eligibility to the PEBB Program. The PEBB Program will not enroll dependents if their eligibility is not verified.

A retiree or survivor may also enroll eligible dependents during the PEBB Program's annual open enrollment (see "Annual open enrollment" later in this section) or during a special open enrollment (see "Special open enrollment" later in this section). The retiree or survivor must provide proof of the event that created the special open enrollment.

If a retiree or a survivor elects to enroll a dependent in medical coverage, the dependent must be enrolled in the same PEBB medical plan as the retiree or survivor.

Exception: If a retiree or a survivor selects the Kaiser Permanente NW Senior Advantage plan, non-Medicare enrollees will be enrolled in the Kaiser Permanente NW Classic plan.

A subscriber is required to notify the PEBB Program to remove dependents who are no longer eligible due to divorce, annulment, dissolution, or a qualifying event of a dependent ceasing to be eligible as a dependent child. The notice must be received within 60 days of the last day of the month the dependents no longer meet the eligibility criteria described under "Eligibility" in Section 2.4 of this chapter. Consequences for not submitting the notice within 60 days may include, but are not limited to:

- The dependent losing eligibility to continue health plan coverage under one of the continuation coverage options described under "Options for continuing PEBB medical coverage" later in this section;
- The subscriber being billed for claims paid by the health plan for services that were rendered after the dependent lost eligibility;
- The subscriber being unable to recover subscriber-paid insurance premiums for dependents that lost their eligibility; and
- The subscriber being responsible for premiums paid by the state for the dependent's health plan coverage after the dependent lost eligibility.

When medical coverage begins

For an eligible retiring employee or retiring school employee, and their dependents, the PEBB Program must receive the required form(s) **no later than 60 days after the employee's or the school employee's employer-paid coverage, COBRA coverage, or continuation coverage ends**, Medical coverage begins the first day of the month after the loss of employer-paid coverage, COBRA coverage, or continuation coverage.

For an eligible elected or full-time appointed official and their dependents, the PEBB Program must receive the required form(s) **no later than 60 days after the official leaves public office**. Medical coverage begins the first day of the month following the date the official leaves public office.

For an eligible survivor of a retiree and their dependents, the PEBB Program must receive the required form(s) **no later than 60 days after the death of the retiree**. Medical coverage will be continued without a gap subject to payment of premiums and applicable premium surcharges.

For an eligible survivor of an employee or school employee and their dependents, the PEBB Program must receive the required form(s) **no later than 60 days after the later of the date of the employee's or the school employee's death, or the date the survivor's PEBB, educational service district, or SEBB insurance coverage ends.** Medical coverage begins the first day of the month following the later of the date of the employee's or the school employee's death, or the date the survivor's PEBB, educational service district, or SEBB insurance coverage ends. This does not include emergency service personnel killed in the line of duty.

For an eligible employee or school employee determined to be retroactively eligible for disability retirement, and their dependents, the PEBB Program must receive the required form(s) and formal determination letter **no later than 60 days after the date on the determination letter.** Medical coverage begins on the date chosen by the employee or school employee as allowed under PEBB Program rules.

For an eligible survivor of an emergency service personnel killed in the line of duty, the PEBB Program must receive the required form(s) **no later than 180 days after the later of**:

- The date on the letter from the Department of Retirement Systems or the Board for Volunteer Firefighters and Reserve Officers that informs the survivor that they are determined to be an eligible survivor;
- The date of the emergency service worker's death; or
- The last day the survivor was covered under a health plan through the emergency service worker's employer or COBRA coverage from the emergency service worker's employer.

Medical coverage begins on the date chosen as allowed under PEBB Program rules.

For a retiree or a survivor who deferred enrollment and is enrolling in a PEBB retiree health plan, the PEBB Program must receive the required forms **no later than 60 days after a loss of other qualifying coverage**. Medical coverage begins the first day of the month after the loss of the other qualifying coverage. See the "Enrollment following deferral" later in this section for additional enrollment time lines.

For a retiree, a survivor, or their dependent enrolling **during the PEBB Program's annual open enrollment**, medical coverage begins on January 1 of the following year.

For a retiree, a survivor, or their dependent enrolling **during a special open enrollment**, medical coverage begins the first of the month following the later of the event date or the date the required form is received. If that day is the first of the month, the coverage is effective on that day.

Exceptions:

1. If the special open enrollment is due to the birth or adoption of a child, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption of a child, medical coverage begins as follows:
   a. For the newly born child, medical coverage begins the date of birth;
   b. For a newly adopted child, medical coverage begins on the date of placement or the date a legal obligation is assumed in anticipation of adoption, whichever is earlier; or
   c. For a spouse or state registered domestic partner of a subscriber, medical coverage begins the first day of the month in which the event occurs.
2. If adding a child who becomes eligible as an extended dependent through legal custody or legal guardianship, or a dependent child with a disability, medical coverage begins on the first day of the month following eligibility certification.

Enrollment following deferral

A retiree or survivor who defers enrollment in a PEBB retiree health plan:

- **While enrolled in employer-based group medical or such coverage under COBRA coverage or continuation coverage** may enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period or no later than 60 days after the date their enrollment in employer-based group medical coverage or such coverage under COBRA coverage or continuation coverage ends.
- **While enrolled in a federal retiree medical plan as a retiree or dependent** will have a one-time opportunity to enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period, or no later than 60 days after their enrollment in a federal retiree medical plan ends.
- **While enrolled in Medicare Parts A and B and a Medicaid program that provides creditable coverage** may enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period, or no later than 60 days after their Medicaid coverage ends, or no later than the end of the calendar year when their Medicaid coverage ends if they were also enrolled in a subsidized Medicare Part D plan.
- **While enrolled in coverage through a health care exchange** developed under the Affordable Care Act will have a one-time opportunity to enroll or reenroll in a PEBB medical plan during the PEBB Program's annual open enrollment period or no later than 60 days after exchange coverage ends.
- **While enrolled in CHAMPVA** will have a one-time opportunity to enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period, or no later than 60 days after their enrollment in a CHAMPVA medical plan ends.
- **While enrolled as a dependent in a medical plan sponsored by PEBB, a Washington State educational service district, or SEBB, including coverage under COBRA or continuation coverage**, may enroll in a PEBB medical plan during the PEBB Program's annual open enrollment period or no later than 60 days after the enrollment in a medical plan sponsored by PEBB, a Washington State educational service district, or SEBB ends, or such coverage under COBRA or continuation coverage ends.

- May enroll in a PEBB medical plan if they receive formal notice that the HCA has determined it is more cost-effective to enroll in PEBB medical than a medical assistance program.

To enroll in a PEBB medical plan, the PEBB Program must receive a **PEBB Retiree Coverage Election Form** along with any other required form(s) and proof of continuous enrollment in one or more qualifying coverages during the timelines described in this section.

A retiree or survivor should contact the PEBB Program or visit **hca.wa.gov/pebb-retirees** to get the required form(s), information on premiums, and available medical plans.

Annual open enrollment

A subscriber may make the following changes to their enrollment during the PEBB Program's annual open enrollment:

- Enroll in a medical plan following a deferral
- Defer or terminate their enrollment in a medical plan;
- Enroll or remove eligible dependents; or
- Change their medical plan.

The subscriber must submit the change online in PEBB My Account or return the required form(s) and any other required documents to the PEBB Program. The form(s) must be received no later than the last day of the annual open enrollment. The enrollment change will become effective January 1 of the following year.

Exceptions:

- An enrolled retiree or survivor may defer enrollment in a PEBB retiree health plan at any time by submitting the required form(s) to the PEBB Program. Enrollment in a PEBB retiree health plan will be deferred effective the first of the month following the date the required form(s) are received. If the forms are received on the first day of the month, enrollment will be deferred effective that day.
- A retiree or survivor who deferred their enrollment in a PEBB retiree health plan may enroll as described under "Enrollment following deferral" earlier in this section.
- An enrolled retiree or survivor may voluntarily terminate enrollment in a PEBB retiree health plan at any time by submitting a request in writing to the PEBB Program. Enrollment in a PEBB retiree health plan will be terminated the last day of the month in which the PEBB Program receives the request. If the request is received on the first day of the month, enrollment will be terminated on the last day of the previous month. Once coverage is terminated, a retiree or a survivor may not enroll again in the future unless they reestablish eligibility for PEBB insurance coverage by becoming newly eligible.

Special open enrollment

A subscriber may change their enrollment outside of the annual open enrollment if a special open enrollment event occurs. However, the change in enrollment must be allowable under Internal Revenue Code (IRC) and Treasury Regulations, and correspond to and be consistent with the event that creates the special open enrollment for the subscriber, their dependent, or both.

Exceptions:

- An enrolled retiree or survivor may defer enrollment in a PEBB retiree health plan at any time by submitting the required form(s) to the PEBB Program. Enrollment in a PEBB retiree health plan will be deferred effective the first of the month following the date the required form(s) are received. If the forms are received on the first day of the month, enrollment will be deferred effective that day.
- A retiree or survivor who deferred their enrollment in a PEBB retiree health plan may enroll as described under "Enrollment following deferral" earlier in this section.
- An enrolled retiree or survivor may voluntarily terminate enrollment in a PEBB retiree health plan at any time by submitting a request in writing to the PEBB Program. Enrollment in a PEBB retiree health plan will be terminated the last day of the month in which the PEBB Program receives the request. If the request is received on the first day of the month, enrollment will be terminated on the last day of the previous month. Once coverage is terminated, a retiree or a survivor may not enroll again in the future unless they reestablish eligibility for PEBB insurance coverage by becoming newly eligible.

To make an enrollment change, the subscriber must submit the required form(s) to the PEBB Program. The form(s) must be received no later than 60 days after the event that created the special open enrollment. In addition to the required form(s), the PEBB Program will require the subscriber to provide proof of the dependent's eligibility, proof of the event that created the special open enrollment, or both.

Exceptions:

- A subscriber has six months from the date of their or their dependents enrollment in Medicare Part B to change their enrollment to a PEBB Medicare Supplement Plan. The PEBB Program must receive the required form(s) no later than six months after the enrollment in Medicare Part B for either the subscriber or their dependent.
- If a subscriber wants to enroll a newborn or child whom the subscriber has adopted or has assumed a legal obligation for total or partial support in anticipation of adoption, the subscriber should notify the PEBB Program by submitting the required form(s) as soon as possible to ensure timely payment of claims. If adding the child increases the premium, the required form(s) must be received no later than 60 days after the date of the birth, adoption, or the date the legal obligation is assumed for total or partial support in anticipation of adoption.

When may a subscriber change their health plan?

Any one of the following events may create a special open enrollment:

1. Subscriber gains a new dependent due to:
    a. Marriage or registering a state-registered domestic partnership;
    b. Birth, adoption, or when the subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or
    c. A child becoming eligible as an extended dependent through legal custody or legal guardianship.

2. Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Subscriber has a change in employment status that affects the subscriber's eligibility for the employer contribution toward their employer-based group health plan;
4. Subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;

   Note: "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R 54.9801-6.
5. Subscriber or their dependent has a change in residence that affects health plan availability. If the subscriber moves and their current health plan is not available in the new location, the subscriber must select a new health plan, otherwise there will be limited accessibility to network providers and covered services;
6. A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (a former spouse or former state-registered domestic partner is not an eligible dependent);
7. Subscriber or their dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP;
8. Subscriber or their dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP;
9. Subscriber or their dependent becomes entitled to coverage under Medicare, or the subscriber or their dependent loses eligibility for coverage under Medicare, or enrolls in or terminates enrollment in a Medicare Part D plan. If the subscriber's current health plan becomes unavailable due to the subscriber's or their dependent's entitlement to Medicare the subscriber must select a new health plan;
10. Subscriber or their dependent's current health plan becomes unavailable because the subscriber or enrolled dependent is no longer eligible for a health savings account (HSA);
11. Subscriber or their dependent experiences a disruption of care for active and ongoing treatment that could function as a reduction in benefits for the subscriber or their dependent. The subscriber may not change their health plan election if the subscriber's or dependent's physician stops participation with the subscriber's health plan unless the PEBB Program determines that a continuity of care issue exists. The PEBB Program will consider but is not limited to considering the following:
    a. Active cancer treatment such as chemotherapy or radiation therapy;
    b. Treatment following a recent organ transplant;
    c. A scheduled surgery;
    d. Recent major surgery still within the postoperative period; or
    e. Treatment for a high-risk pregnancy.

Note: If an enrollee's provider or health care facility discontinues participation with this plan, the enrollee may not change medical plans until the PEBB Program's next annual open enrollment or when another qualifying event occurs that creates a special open enrollment, unless the PEBB Program determines that a continuity of care issue exists. The plan cannot guarantee that any one physician, hospital, or other provider will be available or remain under contract with us.

When can a subscriber enroll or remove eligible dependents?

To enroll a dependent, the subscriber must include the dependent's enrollment information on the form and provide any required document(s) as proof of the dependent's eligibility. The dependent will not be enrolled if their eligibility is not verified. Any one of the following events may create a special open enrollment:

1. Subscriber gains a new dependent due to:
    a. Marriage or registering for a state-registered domestic partnership;
    b. Birth, adoption, or when a subscriber has assumed a legal obligation for total or partial support in anticipation of adoption; or
    c. A child becoming eligible as an extended dependent through legal custody or legal guardianship.
2. Subscriber or their dependent loses other coverage under a group health plan or through health insurance coverage, as defined by the Health Insurance Portability and Accountability Act (HIPAA);
3. Subscriber has a change in employment status that affects the subscriber's eligibility for their employer contribution toward their employer-based group health plan;
4. Subscriber's dependent has a change in their own employment status that affects their eligibility for the employer contribution under their employer-based group health plan;

    Note: "Employer contribution" means contributions made by the dependent's current or former employer toward health coverage as described in Treasury Regulation 26 C.F.R 54.9801-6.
5. Subscriber or their dependent has a change in enrollment under an employer-based group health plan during its annual open enrollment that does not align with the PEBB Program's annual open enrollment;
6. Subscriber's dependent has a change in residence from outside of the United States to within the United States, or from within the United States to outside of the United States and the change in residence resulted in the dependent losing their health insurance;
7. A court order requires the subscriber or any other individual to provide insurance coverage for an eligible dependent of the subscriber (A former spouse or former state-registered domestic partner is not an eligible dependent.);
8. Subscriber or their dependent becomes entitled to coverage under Medicaid or a state Children's Health Insurance Program (CHIP), or the subscriber or their dependent loses eligibility for coverage under Medicaid or CHIP;

9. Subscriber or their dependent becomes eligible for state premium assistance subsidy for PEBB health plan coverage from Medicaid or CHIP.

Medicare entitlement

Medicare Part A and Medicare Part B

If a subscriber or their enrolled dependent becomes entitled to Medicare, they should contact the Social Security Administration to ask about Medicare enrollment. The Medicare entitled subscriber or their dependent must enroll and stay enrolled in Medicare Part A and Part B to keep PEBB retiree health plan coverage. The only exception is if retirement occurred before July 1, 1991, or the enrollee is a dependent of an employee or school employee who retired before July 1, 1991 and is enrolled in PEBB retiree insurance coverage. In most cases, Medicare will become the primary insurance coverage, and the PEBB retiree medical plan will become the secondary insurance coverage.

Medicare Part D

The PEBB Program has determined that this medical plan has prescription drug coverage that is, on average, as good as or better than the standard Medicare Part D prescription drug coverage (it is "creditable coverage"). Therefore, a subscriber or their enrolled dependent cannot enroll in a Medicare Part D plan and remain in this medical plan. If the subscriber terminates this medical plan, they may contact the PEBB Program to request a certificate of creditable coverage. If creditable prescription drug coverage is not maintained, Medicare Part D premiums may be higher in the future.

If a subscriber or their enrolled dependent chooses to enroll in a Medicare Part D plan, PEBB retiree insurance coverage may only be continued by enrolling in the PEBB-sponsored Medicare supplement plan.

When medical coverage ends

Medical coverage ends on the following dates:

1. On the last day of the month when any enrollee ceases to be eligible;
2. On the date a medical plan terminates. If that should occur, the subscriber will be given the opportunity to enroll in another PEBB medical plan; or
3. On the last day of the month in which the monthly premium and applicable premium surcharges were paid. The subscriber is responsible for timely payment of premiums and applicable premium surcharges. If the monthly premium or applicable premium surcharges remain unpaid for 30 days it will be considered delinquent. A subscriber is allowed a grace period of 30 days from the date the monthly premium or applicable premium surcharges become delinquent to pay the unpaid premium balance or applicable premium surcharges. If the subscriber’s premium balance or applicable premium surcharges remain unpaid for 60 days from the original due date, coverage will be terminated retroactive to the last day of the month for which the monthly premium and any applicable premium surcharges were paid. A full month’s premium is charged for each calendar month of coverage. Payments are not prorated during any month, even if an enrollee dies or if the subscriber requests to terminate their medical plan before the end of a month.

If an enrollee or newborn eligible for benefits under obstetric and newborn care is confined in a hospital or skilled nursing facility for which benefits are provided when PEBB medical coverage ends and the enrollee is not immediately covered by other health plan coverage, benefits will be extended until whichever of the following occurs first:

- The enrollee is discharged from the hospital or from a hospital to which the enrollee is directly transferred;
- The enrollee is discharged from a skilled nursing facility when directly transferred from a hospital when the nursing facility confinement is in lieu of hospitalization;
- The enrollee is discharged from a skilled nursing facility or from a skilled nursing facility to which the enrollee is directly transferred;
- The enrollee is covered by another health plan that will provide benefits for the services; or
- Benefits are exhausted.

When medical coverage ends, an enrollee may be eligible for continuation coverage or conversion to other health plan coverage if they apply within the timelines explained in the "Options for continuing PEBB medical coverage" subsection below or under "Conversion of coverage" later in this section.

Options for continuing PEBB medical coverage

A subscriber and their dependents covered by this medical plan may be eligible to continue enrollment under PEBB Continuation Coverage (COBRA) if they lose eligibility. PEBB Continuation Coverage (COBRA) temporarily extends group insurance coverage if certain circumstances occur that would otherwise end the subscriber or their dependent's PEBB medical coverage. PEBB Continuation Coverage (COBRA) includes eligibility and administrative requirements under federal law and regulation and also includes coverage for some enrollees who are not qualified beneficiaries under federal COBRA continuation coverage.

The PEBB Program administers this coverage. Contact the PEBB Program at 1-800-200-1004 or refer to the **PEBB Continuation Coverage Election Notice** booklet for details.

Options for continuing coverage under PEBB retiree insurance

A dependent becoming eligible as a survivor of a retiree is eligible to continue enrollment or defer enrollment in PEBB retiree insurance coverage if they meet procedural and substantive eligibility requirements. See the PEBB Retiree Enrollment Guide for details.

General provisions

Conversion of coverage

An enrollee (including a spouse and dependent of a subscriber terminated for cause) have the right to switch from PEBB group medical coverage to an individual conversion plan offered by this plan when they are no longer eligible to continue the PEBB group medical plan, and are not eligible for Medicare or covered under another group insurance coverage that provides benefits for hospital or medical care. An enrollee must apply for conversion coverage no later than 31 days after their group medical plan ends or within 31 days from the date the notice of the termination of coverage is received, whichever is later.

Evidence of insurability (proof of good health) is not required to obtain the conversion coverage. Rates, coverage, and eligibility requirements of our conversion plan differ from those of the enrollee's current group medical plan. To obtain detailed information on conversion options under this medical plan, call Member Services at **1-877-221-8221**.

Termination for just cause

The purpose of this provision is to allow for a fair and consistent method to process the plan-designated provider's request to terminate coverage from this plan for Just Cause.

A retiree or an eligible dependent may have coverage terminated by HCA for the following reasons:

1. Failure to comply with the PEBB program's procedural requirements, including failure to provide information or documentation requested by the due date in written requests from the PEBB program;
2. Knowingly providing false information;
3. Failure to pay the monthly premium and applicable premium surcharges when due;
4. Misconduct. If a retiree's PEBB insurance coverage is terminated for misconduct, PEBB insurance coverage will not be reinstated at a later date. Examples of such termination include, but are not limited to the following:
    a. Fraud, intentional misrepresentation or withholding of information the subscriber knew or should have known was material or necessary to accurately determine eligibility or the correct premium;
    b. Abusive or threatening conduct repeatedly directed to an HCA employee, a health plan, or other HCA contracted vendor providing PEBB insurance coverage on behalf of the HCA, its employees, or other persons.

If a retiree's PEBB insurance coverage is terminated by HCA for the above reasons, PEBB insurance coverage for all of the retiree's eligible dependents is also terminated.

Appeal rights

Any enrollee may appeal a decision made by the PEBB Program regarding PEBB eligibility, enrollment, premium payments, or premium surcharges (if applicable) to the PEBB Appeals Unit. Learn more at **hca.wa.gov/pebb-appeals**.

Fax: 360-586-9080

Mail: Health Care Authority
Attn: PEBB Appeals Unit
PO Box 45504
Olympia, WA 98504-5504

Hand deliver: Health Care Authority
626 8th Avenue SE
Olympia, WA 98501

Any enrollee may appeal a decision regarding the administration of a health plan by following the appeal provisions of the plan, except when regarding eligibility, enrollment, and premium payment decisions.

Relationship to law and regulations

Any provision of this **Evidence of Coverage** that is in conflict with any governing law or regulation of the state of Washington is hereby amended to comply with the minimum requirements of such law or regulation.

Customer service

For questions about PEBB retiree eligibility and enrollment, please contact the PEBB Program at **1-800-200-1004** or visit **hca.wa.gov/pebb-retirees**. For questions about Medicare, please contact the Centers for Medicare and Medicaid Services (CMS) at **1-800-MEDICARE** or visit **https://www.medicare.gov**.

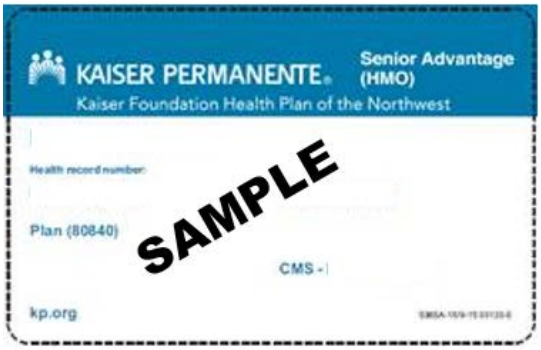
Section 2.6 U.S. citizen or lawful presence

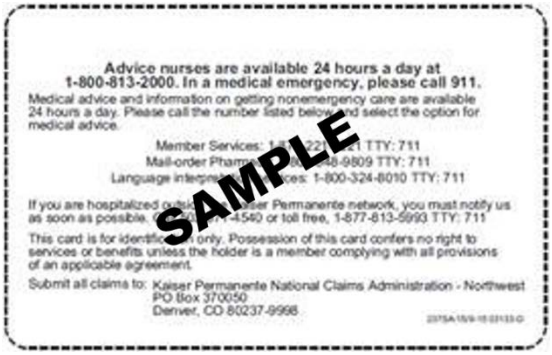
A member of a Medicare health plan must be a U.S. citizen or lawfully present in the United States. Medicare (the Centers for Medicare & Medicaid Services) will notify us if you are not eligible to remain a member on this basis. We must disenroll you if you do not meet this requirement.

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

Section 3.1 Your plan membership card—use it to get all covered care

While you are a member of our plan, you must use your membership card for our plan whenever you get any services covered by our plan. You should also show the provider your Medicaid card, if applicable. Here's a sample membership card to show you what yours will look like:





As long as you are a member of our plan, in most cases, **you must <u>not</u> use your red, white, and blue Medicare card** to get covered medical services (with the exception of routine clinical research studies and hospice services). You may be asked to show your Medicare card if you

need hospital services. Keep your red, white, and blue Medicare card in a safe place in case you need it later.

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

If your plan membership card is damaged, lost, or stolen, call Member Services right away and we will send you a new card. Phone numbers for Member Services are printed on the back cover of this booklet.

Section 3.2 The Provider Directory: Your guide to all providers in our network

The **Provider Directory** lists our network providers and durable medical equipment suppliers.

What are "network providers"?

Network providers are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health care facilities that have an agreement with us to accept our payment and any plan cost-sharing as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The most recent list of providers and suppliers is available on our website at **kp.org/directory**.

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

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

If you don't have your copy of the **Provider Directory**, you can request a copy from Member Services (phone numbers are printed on the back cover of this booklet). You may ask Member Services for more information about our network providers, including their qualifications. You can view or download the **Provider Directory** at **kp.org/directory**. Both Member Services and our website can give you the most up-to-date information about our network providers.

SECTION 4. Premiums

Section 4.1 Plan and Medicare premiums

Plan premiums

Your group will notify you if you are required to contribute to your group's premium and if you pay your portion of the premium directly to us. Please contact the PEBB Program at **1-800-200-1004** or online at **www.pebb.hea.wa.gov** for information about your plan premium.

Medicare late enrollment penalties

If you become eligible for Medicare Part B and do not enroll, Medicare may require you to pay a late enrollment penalty to get Medicare Part B coverage if you later enroll in Medicare Part B. However, if you delay enrollment in Part B because you or your husband or wife are still working and have coverage through an employer group health plan, you may not have to pay the penalty.

Also, if you are (or become) eligible for Medicare and go without creditable prescription drug coverage (drug coverage that is at least as good as the standard Medicare Part D prescription drug coverage) for a continuous period of 63 days or more, you may have to pay a late enrollment penalty if you later sign up for Medicare prescription drug coverage. If you are (or become) eligible for Medicare, your Group is responsible for informing you about whether your drug coverage under this **Evidence of Coverage** is creditable prescription drug coverage at the time required by the Centers for Medicare & Medicaid Services and upon your request. If you are required to pay a late enrollment, your group will inform you the amount that you will be required to pay your group.

Many members are required to pay other Medicare premiums

Many members are required to pay other Medicare premiums. As explained in Section 2 of this chapter, in order to be eligible for our plan, you must be entitled to Medicare Part A and enrolled in Medicare Part B. For that reason, some plan members (those who aren't eligible for premium-free Part A) pay a premium for Medicare Part A and most plan members pay a premium for Medicare Part B. **You must continue paying your Medicare premiums to remain a member of our plan.**

Your copy of **Medicare & You** 2020 gives you information about Medicare premiums in the section called "2020 Medicare Costs." This explains how the Medicare Part B and Part D premiums differ for people with different incomes. Everyone with Medicare receives a copy of **Medicare & You** each year in the fall. Those new to Medicare receive it within a month after first signing up. You can also download a copy of **Medicare & You** 2020 from the Medicare website (**https://www.medicare.gov**) or you can order a printed copy by phone at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users call **1-877-486-2048**.

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

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

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

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

Let us know about these changes:

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

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

It is also important to contact Social Security if you move or change your mailing address. You can find phone numbers and contact information for Social Security in Chapter 2, Section 5.

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

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

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

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

Section 6.1 We make sure that your health information is protected

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

For more information about how we protect your personal health information, please go to Chapter 6, Section 1.3, of this booklet.

SECTION 7. How other insurance works with our plan

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

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

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

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

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

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

- Workers' compensation.

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

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

CHAPTER 2. Important phone numbers and resources

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

How to contact our plan's Member Services

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

Method	Member Services – contact information
CALL	**1-877-221-8221** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
FAX	**1-855-347-7239**
WRITE	Member Services Kaiser Foundation Health Plan of the Northwest 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099
WEBSITE	**kp.org**

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

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 about asking for a coverage decision or making an appeal or complaint about your medical care, see Chapter 7, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)." You may call us if you have questions about our coverage decision, appeal, or complaint processes.

Method	Coverage decisions, appeals, or complaints about medical care – contact information
CALL	**1-877-221-8221** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. If your coverage decision, appeal, or complaint **qualifies for a fast decision** as described in Chapter 7, you may also call Member Relations directly at **503-813-4480**, Monday – Friday, 8 a.m. to 5 p.m.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
FAX	**1-855-347-7239**
WRITE	Member Relations Kaiser Foundation Health Plan of the Northwest 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099
WEBSITE	**kp.org**
MEDICARE WEBSITE	You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to **https://www.medicare.gov/MedicareComplaintForm/home.aspx**.

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

For more information about situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see Chapter 5, "Asking us to pay our share of a bill you have received for covered medical services."

Please note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See Chapter 7, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," for more information.

Method	Payment requests – contact information
CALL	**1-877-221-8221** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.

Method	Payment requests – contact information
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	Kaiser Permanente Claims Administration – Northwest P.O. Box 370050 Denver, CO 80237-9998
WEBSITE	**kp.org**

SECTION 2. **Medicare** (how to get help and information directly from the federal Medicare program)

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with End-Stage Renal Disease (permanent kidney failure requiring dialysis or a kidney transplant).

The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage organizations, including our plan.

Method	Medicare – contact information
CALL	**1-800-MEDICARE or 1-800-633-4227** Calls to this number are free. 24 hours a day, 7 days a week.
TTY	**1-877-486-2048** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free.
WEBSITE	**https://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.

Method	Medicare – contact information
	The Medicare website also has detailed information about your Medicare eligibility and enrollment options, with the following tools: • **Medicare Eligibility Tool:** Provides Medicare eligibility status information. • **Medicare Plan Finder:** Provides personalized information about available Medicare prescription drug plans, Medicare health plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an estimate of what your out-of-pocket costs might be in different Medicare plans. You can also use the website to tell Medicare about any complaints you have about our plan: • **Tell Medicare about your complaint:** You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to **https://www.medicare.gov/MedicareComplaintForm/home.aspx**. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program. If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. (You can call Medicare at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.)

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

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

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

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

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

Method	Senior Health Insurance Benefits Assistance (Oregon's SHIP) – contact information	Statewide Health Insurance Benefits Advisors (Washington's SHIP) – contact information
CALL	**1-800-722-4134**	**1-800-562-6900**
TTY	**711** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.	**1-360-586-0241**
WRITE	Oregon SHIBA P.O. Box 14480 Salem, OR 97309	Washington SHIBA P.O. Box 40255 Olympia, WA 98504-0255
WEBSITE	**healthcare.oregon.gov/shiba**	**insurance.wa.gov/shiba**

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

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For Oregon and Washington, the Quality Improvement Organization is called KEPRO.

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

You should contact KEPRO in any of these situations:

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

Method	KEPRO (Oregon's and Washington's Quality Improvement Organization) – contact information
CALL	**1-888-305-6759** Monday – Friday, 9 a.m. – 5 p.m. Weekends and holidays, 11 a.m. – 3 p.m.
TTY	**1-855-843-4776** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
WRITE	KEPRO 5700 Lombardo Center Dr., Suite 100 Seven Hills, OH 44131
WEBSITE	**https://www.keproqio.com**

SECTION 5. Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or End-Stage Renal Disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. Social Security handles the enrollment process for Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

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

SECTION 6. **Medicaid** (a joint federal and state program that helps with medical costs for some people with limited income and resources)

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other cost-sharing (like deductibles, coinsurance, and copayments). Some people with QMB are also eligible for full Medicaid benefits (QMB+).
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. Some people with SLMB are also eligible for full Medicaid benefits (SLMB+).
- **Qualified Individual (QI):** Helps pay Part B premiums.
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums.

To find out more about Medicaid and its programs, contact Oregon's or Washington's Medicaid program.

Method	Oregon Health Plan – contact information	Washington State Department of Social and Health Services – contact information
CALL	**1-800-273-0557**, 8 a.m.–5 p.m., Monday–Friday	**1-877-501-2233**, 8 a.m.–5 p.m., Monday–Friday

Method	Oregon Health Plan – contact information	Washington State Department of Social and Health Services – contact information
TTY	**711**	**711**
WRITE	Division of Medical Assistance Programs 500 Summer St. NE Salem, OR 97301	Department of Social and Health Services 1115 Washington St. SE Olympia, WA 98504
WEBSITE	**healthcare.oregon.gov**	**washingtonconnection.org**

SECTION 7. Programs that help pay for prescription drugs

You may qualify for help paying for prescription drugs. Below we list different kinds of help:

- **"Extra Help" from Medicare.** People with limited incomes may qualify for "Extra Help" to pay for their prescription drug costs. If you qualify, Medicare could pay up to 75% or more of your drug costs, including monthly prescription drug premiums, annual deductibles, and coinsurance. Additionally, those who qualify will not have a coverage gap or late enrollment penalty. Many people are eligible and don't even know it. To see if you qualify, call:
  - **1-800-MEDICARE (1-800-633-4227)**. TTY users should call **1-877-486-2048**, 24 hours a day/7 days a week;
  - The Social Security Office at **1-800-772-1213**, between 7 a.m. and 7 p.m., Monday through Friday. TTY users should call **1-800-325-0778** (applications); or
  - Your state Medicaid office (applications).
- **Prescription Cost-sharing Assistance for Persons with HIV/AIDS.** The AIDS Drug Assistance Program (ADAP) helps ensure that ADAP-eligible individuals living with HIV/AIDS have access to life-saving HIV medications. Individuals must meet certain criteria, including proof of state residence and HIV status, low income as defined by the state, and uninsured/underinsured status. Medicare Part D prescription drugs that are also covered by ADAP qualify for prescription cost-sharing assistance through CAREAssist for Oregon residents and the Early Intervention Program for Washington residents. For information on eligibility criteria, covered drugs, or how to enroll in the program, please contact CAREAssist at **1-800-805-2313** for Oregon residents and the Early Intervention Program at **1-877-376-9316** for Washington residents.

SECTION 8. How to contact the Railroad Retirement Board

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

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Method	Railroad Retirement Board – contact information
CALL	**1-877-772-5772** Calls to this number are free. If you press "0," you may speak with an RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9 a.m. to 12 p.m. on Wednesday. If you press "1," you may access the automated RRB HelpLine and recorded information 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	**https://secure.rrb.gov/**

SECTION 9. Do you have "group insurance" or other health insurance from an employer?

If you (or your spouse) get benefits from your (or your spouse's) employer or retiree group as part of this plan, you may call the employer/union benefits administrator or Member Services if you have any questions. You can ask about your (or your spouse's) employer or retiree health benefits, premiums, or the enrollment period. Phone numbers for Member Services are printed on the back cover of this booklet. You may also call **1-800-MEDICARE** (**1-800-633-4227**; TTY: **1-877-486-2048**) with questions related to your Medicare coverage under this plan.

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

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

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

For the details on what medical care is covered by our plan and how much you pay when you get this care, use the benefits chart found at the front of this **EOC.**

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

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

- "**Providers**" are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- "**Network providers**" are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We have arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- "**Covered services**" include all the medical care, health care services, supplies, and equipment that are covered by our plan. Your covered services for medical care are listed in the benefits chart found at the front of this **EOC.**

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

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

We will generally cover your medical care as long as:

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

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

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

- **You must receive your care from a network provider** (for more information about this, see Section 2 in this chapter). In most cases, care you receive from an out-of-network provider (a provider who is not part of our plan's network) will not be covered. Here are four exceptions:
  - We cover emergency care or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services means, see Section 3 in this chapter.
  - If you need medical care that Medicare requires our plan to cover and the providers in our network cannot provide this care, you can get this care from an out-of-network provider if we or Medical Group authorize the services before you get the care. In this situation, you will pay the same as you would pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, see Section 2.3 in this chapter.
  - We cover kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area.
  - If you travel outside our service area, but inside the United States or its territories, we will provide limited coverage for preventive, routine, follow-up, and continuing care obtained from out-of-network providers (see the Medical Benefits Chart found at the front of this **EOC** for more information).

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

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

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

As a member, you may choose one of our available network providers to be your primary care provider. Your primary care provider is a physician who meets state requirements and is trained to give you primary medical care.

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

- X-rays.
- Laboratory tests.
- Therapies.
- Care from doctors who are specialists.

- Hospital admissions.
- Follow-up care.

"Coordinating" your services includes checking or consulting with other network providers about your care and how it is going.

You should talk with your PCP about your medical needs or requests for services. Your PCP provides, prescribes, or authorizes covered services that are medically necessary in his/her medical judgment. If your PCP determines that services are not medically necessary and you disagree with his/her determination, you may get a second opinion from another network provider and you may request that we make a coverage determination (see Chapter 7 for details).

If you need certain types of covered services or supplies, you must get approval in advance from your PCP (for example, if you need to see a specialist). In some cases, your PCP will need to get prior authorization (prior approval) from us (see Section 2.3 in this chapter for more information).

How do you choose your PCP?

Your relationship with your PCP is an important one. That's why we strongly recommend you choose a PCP close to your home or place of employment as soon as you enroll but you aren't required to choose a PCP. You choose who you want as your PCP. You can pick any available provider in family practice or internal medicine. Also, women can select any available primary care provider from obstetrics/gynecology. You are not restricted to a particular PCP or network facility and you may use any network medical office when you need care. We encourage you to use the one facility that will be most convenient for you. The **Provider Directory** lists network providers by medical office.

To choose a PCP, call Member Services and request information to help you select a PCP or you can register and choose your PCP online at **kp.org**. Member Services can give you the names of providers who are accepting new patients and his/her professional and educational background. Once you have selected a PCP, be sure to let Member Services know so they can update your membership file.

Changing your PCP

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

To change your PCP, call Member Services. When you call, be sure to tell Member Services if you are seeing specialists or getting other covered services that need your PCP's approval (such as home health services and durable medical equipment). Member Services will help make sure that you can continue with the specialty care and other services you have been getting when you change your PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Member Services will change your membership record to show the name of your new PCP, which will take effect immediately upon receipt of your request. If you prefer, you can register online and change your PCP at **kp.org**.

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

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

- Routine women's health care, which includes breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider.
- Flu shots, Hepatitis B vaccinations, and pneumonia vaccinations, as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed services from network providers or from out-of-network providers when network providers are temporarily unavailable or inaccessible (for example, when you are temporarily outside of our service area).
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area. (If possible, please call Member Services before you leave the service area so we can help arrange for you to have maintenance dialysis while you are away.) Phone numbers for Member Services are printed on the back cover of this booklet.
- Most preventive care.
- Outpatient care for mental health at network Mental Health departments.
- Routine vision exams.
- Routine hearing exams.
- Cancer counseling.
- Second opinions from another network provider except for certain specialty care.

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

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

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

Referrals from your PCP

You will usually see your PCP first for most of your routine health care needs. There are only a few types of covered services you may get on your own, without getting approval from your PCP first, which are described in Section 2.2 of this chapter. Your PCP will refer you to a network specialist when appropriate. In most cases, you will need a PCP referral to see a network specialist the first time. In some cases, a standing referral may be allowed to a network specialist for a time period that is in accord with your individual medical needs as determined by your PCP and our plan.

Prior authorization

For the services and items listed below and in the Medical Benefits Chart found at the front of this **EOC**, your network provider will need to get approval in advance from our plan or Medical Group (this is called getting "prior authorization"). Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

- If your network provider decides that you require **covered services not available from network providers**, he or she will recommend to our plan and Medical Group that you be referred to an out-of-network provider inside or outside our service area. If it is determined that the services are medically necessary and are not available from a network provider and we determine that the services are covered services, our plan will authorize your referral to an out-of-network provider for the covered services. The cost-sharing for these approved referral services are the same as those required for services provided by a network provider. You will need written authorization in advance in order for the services to be covered. If our plan authorizes the services, we will give you a written "Authorization for Outside Medical Care" referral to the out-of-network provider or out-of-network facility. Only the services and number of visits listed on the written referral will be covered, subject to any benefit limitations and exclusions applicable to the services. If the out-of-network specialist wants you to come back for more care, be sure to check if the "Authorization for Outside Medical Care" covers more visits to the specialist. If it doesn't, please contact your network provider.
- If your network physician makes a written referral for **bariatric surgery**, Medical Group's regional bariatric medical director or his or her designee will authorize the service if he or she determines that it is medically necessary.
- Medically necessary **transgender surgery** and associated procedures.
- Care from a **religious nonmedical health care institution** described in Section 6 of this chapter.
- If your network provider makes a written referral for a **transplant**, 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, Medical Group will refer you to physician(s) at a transplant center, and 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 network physician may provide or authorize a corneal transplant without using this Medical Group transplant authorization procedure.

Some services are subject to utilization review, based upon utilization review criteria developed by Medicare, our Medical Group, or another organization utilized by Medical Group and approved by our plan. This means we evaluate whether a specific health care service, procedure, item or setting is necessary, appropriate, effective and efficient for the condition in question and we monitor the use of a specific health care service, procedure, item, or setting. If you think you need a specific type of care, talk to your health care provider. He or she will discuss it with you and recommend the appropriate care.

Please contact Member Services for more information about utilization review, a copy of the complete utilization review criteria developed by Medicare or Medical Group and approved by our plan for a specific condition, or to talk to a utilization review staff person.

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

We may make changes to the hospitals, doctors, and specialists (providers) that are part of your plan during the year. There are a number of reasons why your provider might leave your plan, but if your doctor or specialist does leave your plan, you have certain rights and protections that are summarized below:

- Even though our network of providers may change during the year, Medicare requires that we furnish you with uninterrupted access to qualified doctors and specialists.
- We will make a good faith effort to provide you with at least 30 days' notice that your provider is leaving our plan so that you have time to select a new provider.
- We will assist you in selecting a new qualified provider to continue managing your health care needs.
- If you are undergoing medical treatment, you have the right to request, and we will work with you to ensure that the medically necessary treatment you are receiving is not interrupted.
- If you believe we have not furnished you with a qualified provider to replace your previous provider or that your care is not being appropriately managed, you have the right to file an appeal of our decision.
- If you find out your doctor or specialist is leaving your plan, please contact us at **1-877-221-8221** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m., so we can assist you in finding a new provider and managing your care.

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

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

- Emergency or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services mean, see Section 3 in this chapter.
- Our plan or Medical Group authorizes a referral to an out-of-network provider described in Section 2.3 of this chapter.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you are temporarily outside our service area.
- If you visit the service area of another Kaiser Permanente region, you can receive certain care covered under this **Evidence of Coverage** from designated providers in that service area. Please call Member Services or our away from home travel line at **1-951-268-3900** (24 hours a day, 7 days a week except holidays), TTY **711,** for more information about getting care when visiting another Kaiser Permanente region's service area, including coverage information and facility locations in the District of Columbia and parts of California,

Colorado, Georgia, Hawaii, Maryland, Virginia, and Washington in areas outside of the Longview and Vancouver areas.

- If you travel outside our service area, but inside the United States or its territories, we will provide coverage for preventive, routine, follow-up, and continuing care obtained from out-of-network providers not to exceed the annual benefit maximum (see the Medical Benefits Chart found at the front of this **EOC** for more information).

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

Section 3.1 Getting care if you have a medical emergency

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

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

If you have a medical emergency:

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

What is covered if you have a medical emergency?

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

You may get covered emergency medical care (including ambulance) when you need it anywhere in the world. However, you may have to pay for the services and file a claim for reimbursement (see Chapter 5 for more information).

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

After the emergency is over, you are entitled to follow-up care to be sure your condition continues to be stable. We will cover your follow-up post-stabilization care in accord with

Medicare guidelines. If your emergency care is provided by out-of-network providers, we will try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow. It is very important that your provider call us to get authorization for post-stabilization care before you receive the care from the out-of-network provider. In most cases, you will only be held financially liable if you are notified by the out-of-network provider or us about your potential liability.

What if it wasn't a medical emergency?

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

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

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

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

What are "urgently needed services"?

"Urgently needed services" are a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible. The unforeseen condition could, for example, be an unforeseen flare-up of a known condition that you have.

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

You should always try to obtain urgently needed services from network providers. However, if providers are temporarily unavailable or inaccessible, and it is not reasonable to wait to obtain care from your network provider when the network becomes available, we will cover urgently needed services that you get from an out-of-network provider.

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

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

When you are outside the service area and cannot get care from a network provider, we will cover urgently needed services that you get from any provider. Our plan covers worldwide urgent care services outside the United States under the following circumstances:

- You are temporarily outside of our service area.
- The services were necessary to treat an unforeseen illness or injury to prevent serious deterioration of your health.
- It was not reasonable to delay treatment until you returned to our service area.
- The services would have been covered had you received them from a network provider.

Section 3.3 Getting care during a disaster

If the governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you are still entitled to care from us.

Please visit the following website—**kp.org**—for information on how to obtain needed care during a disaster.

Generally, if you cannot use a network provider during a disaster, we will allow you to obtain care from out-of-network providers at in-network cost-sharing.

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

Section 4.1 You can ask us to pay our share of the cost for covered services

If you have paid more than your share for covered services, or if you have received a bill for the full cost of covered medical services, go to Chapter 5, "Asking us to pay our share of a bill you have received for covered medical services," for information about what to do.

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

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

If you have any questions about whether we will pay for any medical service or care that you are considering, you have the right to ask us whether we will cover it before you get it. You also have the right to ask for this in writing. If we say we will not cover your services, you have the right to appeal our decision not to cover your care.

Chapter 7, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made. You may also call Member Services to get more information (phone numbers are printed on the back cover of this booklet).

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

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

Section 5.1 What is a "clinical research study"?

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

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

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

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

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

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

If you plan on participating in a clinical research study, contact Member Services (phone numbers are printed on the back cover of this booklet) to let them know that you will be participating in a clinical trial and to find out more specific details about what we will pay.

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

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

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

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

- We will pay the difference between the cost-sharing in Original Medicare and your cost-sharing as a member of our plan. This means you will pay the same amount for the services you receive as part of the study as you would if you received these services from our plan.
  - Here's an example of how the cost-sharing works: Let's say that you have a lab test that costs $100 as part of the research study. Let's also say that your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan's benefits. In this case, Original Medicare would pay $80 for the test and we would pay another $10. This means that you would pay $10, which is the same amount you would pay under our plan's benefits.
- In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the study and how much you owe. Please see Chapter 5 for more information about submitting requests for payment.

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

- Generally, Medicare will *not* pay for the new item or service that the study is testing, unless Medicare would cover the item or service even if you were not in a study.
- Items and services the study gives you or any participant for free.
- Items or services provided only to collect data, and not used in your direct health care. For example, Medicare would not pay for monthly CT scans done as part of the study if your medical condition would normally require only one CT scan.

Do you want to know more?

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

SECTION 6. Rules for getting care covered in a "religious nonmedical health care institution"

Section 6.1 What is a religious nonmedical health care institution?

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

Section 6.2 What care from a religious nonmedical health care institution is covered by our plan?

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

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

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

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

Note: Covered services are subject to the same limitations and cost-sharing required for services provided by network providers as described in Chapters 4 and 10.

SECTION 7. Rules for ownership of durable medical equipment

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

Durable medical equipment (DME) includes items such as oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech-generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for use in the home. The member always owns certain items, such as prosthetics. In this section, we discuss other types of DME that you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. As a member of our plan, however, you will not acquire ownership of rented DME items no matter how many copayments you make for the item while a member of our plan. Even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan, you will not acquire ownership no matter how many copayments you make for the item while a member of our plan.

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

If you did not acquire ownership of the DME item while in our plan, you will have to make 13 new consecutive payments after you switch to Original Medicare in order to own the item. Payments you made while in our plan do not count toward these 13 consecutive payments.

If you made fewer than 13 payments for the DME item under Original Medicare *before* you joined our plan, your previous payments also do not count toward the 13 consecutive payments. You will have to make 13 new consecutive payments after you return to Original Medicare in order to own the item. There are no exceptions to this case when you return to Original Medicare.

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

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

This chapter focuses on your covered services and what you pay for your medical benefits. The Medical Benefits Chart that lists your covered services and shows how much you will pay for each covered service as a member of our plan is found at the front of this **EOC.** Later in this chapter, you can find information about medical services that are not covered. It also explains limits on certain services. In addition, please see Chapters 3, 9, and 10 for additional coverage information, including limitations (for example, coordination of benefits, durable medical equipment, home health care, skilled nursing facility care, and third party liability).

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

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

- A "**copayment**" is the fixed amount you pay each time you receive certain medical services. You pay a copayment at the time you get the medical service, unless we do not collect all cost-sharing at that time and send you a bill later. (The Medical Benefits Chart found at the front of this **EOC** tells you more about your copayments.)
- "**Coinsurance**" is the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service, unless we do not collect all cost-sharing at that time and send you a bill later. (The Medical Benefits Chart found at the front of this **EOC** tells you more about your coinsurance.)

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program should never pay deductibles, copayments or coinsurance. Be sure to show your proof of Medicaid or QMB eligibility to your provider, if applicable. If you think that you are being asked to pay improperly, contact Member Services.

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

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

As a member of our plan, the most you will have to pay out-of-pocket for in-network covered Part A and Part B services in 2020 is stated in the Medical Benefits Chart. The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. In addition, amounts you pay for some services do not count toward your maximum out-of-pocket amount. These services are marked with an asterisk (*) in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount stated in the Medical Benefits Chart, you will not have to pay any out-of-pocket costs for the rest of the year for in-network

covered Part A and Part B services. However, you must continue to pay the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

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

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

Here is how this protection works:

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15.00), then you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), then you never pay more than that percentage. However, your cost depends upon which type of provider you see:
  - If you receive the covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (as determined in the contract between the provider and our plan).
  - If you receive the covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Remember, we cover services from out-of-network providers only in certain situations, such as when you get a referral.)
  - If you receive the covered services from an out-of-network provider who does not participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for nonparticipating providers. (Remember, we cover services from out-of-network providers only in certain situations, such as when you get a referral.)
- If you believe a provider has "balance billed" you, call Member Services (phone numbers are printed on the back cover of this booklet).

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

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

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

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

- Your services (including medical care, services, supplies, and equipment) *must* be medically necessary. "Medically necessary" means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- You receive your care from a network provider. In most cases, care you receive from an out-of-network provider will not be covered. Chapter 3 provides more information about requirements for using network providers and the situations when we will cover services from an out-of-network provider.
- You have a primary care provider (a PCP) who is providing and overseeing your care. In most situations, your PCP must give you approval in advance before you can see other providers in our plan's network. This is called giving you a "referral." Chapter 3 provides more information about getting a referral and the situations when you do not need a referral.
- Some of the services listed in the Medical Benefits Chart found at the front of this **EOC** are covered *only* if your doctor or other network provider gets approval in advance (sometimes called "prior authorization") from us. Covered services that need approval in advance are marked in the Medical Benefits Chart with a footnote (†). In addition, see Chapter 3, Section 2.3, for more information about prior authorization, including other services that require prior authorization that are not listed in the Medical Benefits Chart.

Other important things to know about our coverage:

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay more in our plan than you would in Original Medicare. For others, you pay less. (If you want to know more about the coverage and costs of Original Medicare, look in your **Medicare & You** 2020 handbook. View it online at **https://www.medicare.gov** or ask for a copy by calling **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.)
- For all preventive services that are covered at no cost under Original Medicare, we also cover the service at no cost to you. However, if you also are treated or monitored for an existing medical condition during the visit when you receive the preventive service, cost-sharing will apply for the care received for the existing medical condition.
- Sometimes Medicare adds coverage under Original Medicare for new services during the year. If Medicare adds coverage for any services during 2020, either Medicare or our plan will cover those services.

You will see this apple next to the preventive services in the Medical Benefits Chart found at the front of this **EOC**.

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

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

This section tells you what services are "excluded" from Medicare coverage and, therefore, are not covered by this plan. If a service is "excluded," it means that we don't cover the service.

The chart below lists services and items that either are not covered under any condition or are covered only under specific conditions.

If you get services that are excluded (not covered), you must pay for them yourself. We won't pay for the excluded medical services listed in the chart below except under the specific conditions listed. The only exception is we will pay if a service in the chart below is found upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 7, Section 4, in this booklet.)

All exclusions or limitations on services are described in the Benefits Chart found at the front of this **EOC** or in the chart below. Even if you receive the excluded services at an emergency facility, the excluded services are still not covered and our plan will not pay for them.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to the standards of Original Medicare		√ This exclusion doesn't apply to services or items that aren't covered by Original Medicare but are covered by our plan.
Experimental medical and surgical procedures, equipment and medications • Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		√ May be covered by Original Medicare under a Medicare-approved clinical research study. (See Chapter 3, Section 5 for more information about clinical research studies.)
Private room in a hospital		√ Covered only when medically necessary.
Personal items in your room at a hospital or a skilled nursing facility, such as a telephone or a television	√	
Full-time nursing care in your home	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Custodial care is care provided in a nursing home, hospice, or other facility setting when you do not require skilled medical care or skilled nursing care. • Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	√	
Homemaker services include basic household assistance, including light housekeeping or light meal preparation	√	
Fees charged by your immediate relatives or members of your household	√	
Cosmetic surgery or procedures		√ Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Routine dental care, such as cleanings, fillings, or dentures	√	
Nonroutine dental care		√ Dental care required to treat illness or injury may be covered as inpatient or outpatient care.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Routine chiropractic care		√ Manual manipulation of the spine to correct a subluxation is covered. This exclusion does not apply if your group purchased the Alternative Care Therapies Rider or the Chiropractic Services Rider.
Routine foot care		√ Some limited coverage provided according to Medicare guidelines (for example, if you have diabetes).
Home-delivered meals	√	
Orthopedic shoes		√ If shoes are part of a leg brace and are included in the cost of the brace, or the shoes are for a person with diabetic foot disease.
Supportive devices for the feet		√ Orthopedic or therapeutic footwear for people with diabetic foot disease.
Hearing aids		√ This hearing aid exclusion does not apply if your group purchased the Hearing Aid Rider. **Note:** For all members, this exclusion doesn't apply to cochlear implants and osseointegrated external hearing devices covered by Medicare.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Eyeglasses and contact lenses		√ One pair of eyeglasses (or contact lenses) are covered for people after cataract surgery. No other eyewear is covered unless your group purchased the Prescription Eyewear Rider.
Radial keratotomy, LASIK surgery, and other low-vision aids	√	
Reversal of sterilization procedures and non-prescription contraceptive supplies	√	
Acupuncture		√ This exclusion does not apply if your group purchased the Alternative Care Therapies Rider.
Naturopath services (uses natural or alternative treatments)		√ This exclusion does not apply if your group purchased the Alternative Care Therapies Rider.
Private duty nursing	√	
Elective or voluntary enhancement procedures or services (including weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance)		√ Covered if medically necessary and covered under Original Medicare.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services provided to veterans in Veterans Affairs (VA) facilities		√ When emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we will reimburse veterans for the difference. Members are still responsible for our plan's cost-sharing amounts.
Reconstructive surgery that offers only a minimal improvement in appearance or is performed to alter or reshape normal structures of the body in order to improve appearance		√ We cover reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defect, developmental abnormalities, accidental injury, trauma, infection, tumors, or disease, if a network physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible.
Surgery that, in the judgment of a network physician specializing in reconstructive surgery, offers only a minimal improvement in appearance. Surgery that is performed to alter or reshape normal structures of the body in order to improve appearance	√	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Nonconventional intraocular lenses (IOLs) following cataract surgery (for example, a presbyopia-correcting IOL)		√ You may request and we may provide insertion of a presbyopia-correcting IOL or astigmatism-correcting IOL following cataract surgery in lieu of a conventional IOL. However, you must pay the difference between Plan Charges for a nonconventional IOL and associated services and Plan Charges for insertion of a conventional IOL following cataract surgery.
Directed blood donations including collection, processing, and storage of blood donated by donors whom you designate, and procurement and storage of cord blood		√ Covered if medically necessary for the imminent use at the time of collection for a designated recipient.
Massage therapy		√ Covered when ordered as part of physical therapy program in accord with Medicare guidelines. This exclusion does not apply if your group purchased the Alternative Care Therapies Rider.
Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a network provider	√	
Licensed ambulance services without transport		√ Covered if the ambulance transports you or if covered by Medicare.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
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		√ Covered if a network physician determines that the services are medically necessary or medically appropriate preventive care.
Services related to noncovered services or items		√ When a service or item is not covered, all services related to the noncovered service or item are excluded, (1) except for services or items we would otherwise cover to treat complications of the noncovered service or item, or (2) unless covered in accord with Medicare guidelines.
Services not approved by the federal Food and Drug Administration. Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S., but are not approved by the FDA		√ This exclusion applies to services provided anywhere, even outside the U.S. It doesn't apply to Medicare-covered clinical trials or covered emergency care you receive outside the U.S.
Travel and lodging/living expenses		√ We may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines for transplants. Your transplant coordinator can provide information about covered expenses.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Care in a licensed intermediate care facility, assisted living facility, or adult foster home	√	
Comfort, convenience, or luxury equipment or features	√	
Conception by artificial means, such as in vitro fertilization, zygote intrafallopian transfers, and gamete intrafallopian transfers (artificial insemination is a covered service); and nonprescription contraceptive supplies and devices	√	
Exercise or hygiene equipment	√	
Genetic testing		√ Genetic testing is not covered, except counseling and medically necessary testing for diagnosis and treatment planning are covered subject to payment of cost-sharing.
Hypnotherapy	√	
Modifications to your home or car	√	
More than one corrective appliance or artificial aid or item of durable medical equipment, serving the same function or the same part of the body		√ Only covered when needed for necessary repairs, adjustments, and replacements, or if covered by Medicare.
Nonmedical items, such as wigs, sauna baths, or elevators		√ Wigs are covered only following chemotherapy or radiation therapy (up to $100 benefit maximum per lifetime).

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Psychological testing for ability, aptitude, intelligence, or interest	√	
Services for patients who, in the judgment of a network provider or other plan mental health professional, are seeking services for other than therapeutic purposes	√	
Services provided or arranged by criminal justice officials or institutions for detained or confined members, unless the services meet the requirements for care that would be covered as emergency care	√	
Supportive care primarily to maintain the level of correction already achieved; care primarily for the convenience of the member; and care on a nonacute, symptomatic basis	√	
Outpatient prescription drugs.		√ Only covered as otherwise described in the Medical Benefits Chart found at the front of this **EOC.**
Generic and therapeutic equivalents as determined by our Regional Formulary and Therapeutics Committee (RFTC)	√	

Services and benefits under an individual Senior Advantage plan are excluded when a member is enrolled under an employer group Senior Advantage plan. Members enrolled in Kaiser Foundation Health Plan of the Northwest employer group Senior Advantage plan cannot be enrolled in individual Senior Advantage Basic or Senior Advantage at the same time.

CHAPTER 5. Asking us to pay our share of a bill you have received for covered medical services

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

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

Sometimes when you get medical care, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of our plan. In either case, you can ask us to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services that are covered by our plan.

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

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

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

You can receive emergency services from any provider, whether or not the provider is a part of our network. When you receive emergency or urgently needed services from a provider who is not part of our network, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill our plan for our share of the cost.

- If you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made.
- At times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made.
  - If the provider is owed anything, we will pay the provider directly.
  - If you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost.

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

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

- You only have to pay your cost-sharing amount when you get services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service, and even if there is a dispute and we

don't pay certain provider charges. For more information about "balance billing," go to Chapter 4, Section 1.3.

- Whenever you get a bill from a network provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem.
- If you have already paid a bill to a network provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

If you are retroactively enrolled in our plan

Sometimes a person's enrollment in our plan is retroactive. ("Retroactive" means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.)

If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered services after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement.

Please call Member Services for additional information about how to ask us to pay you back and deadlines for making your request. Phone numbers for Member Services are printed on the back cover of this booklet.

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. Chapter 7 of this booklet, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)," has information about how to make an appeal.

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

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

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

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

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

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

Kaiser Permanente
Claims Administration - Northwest
P.O. Box 370050
Denver, CO 80237-9998

You must submit your claim to us within 365 days from the date you received the service or item.

Contact Member Services if you have any questions (phone numbers are printed on the back cover of this booklet). If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

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

Section 3.1 We check to see whether we should cover the service and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care is covered and you followed all the rules for getting the care, we will pay for our share of the cost. If you have already paid for the service, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service yet, we will mail the payment directly to the provider. (Chapter 3 explains the rules you need to follow for getting your medical services covered.)
- If we decide that the medical care is not covered, or you did not follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision.

Section 3.2 If we tell you that we will not pay for all or part of the medical care, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details about how to make this appeal, go to Chapter 7 of this booklet, "What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)." The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading Section 4 of Chapter 7. Section 4 is an introductory section that explains the process for coverage decisions and appeals and gives

you definitions of terms such as "appeal." Then, after you have read Section 4, you can go to Chapter 7, Section 5.5, to learn how to make an appeal about getting paid back for a medical service.

CHAPTER 6. Your rights and responsibilities

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

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

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

Our plan has people and free interpreter services available to answer questions from disabled and non-English-speaking members. We can also give you information in large print at no cost if you need it. We are required to give you information about our plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call Member Services (phone numbers are printed on the back cover of this booklet) or contact our Civil Rights Coordinator.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with Member Services (phone numbers are printed on the back cover of this booklet). You may also file a complaint with Medicare by calling **1-800-MEDICARE (1-800-633-4227)** or directly with the Office for Civil Rights. Contact information is included in this **Evidence of Coverage** or with this mailing, or you may contact Member Services for additional information.

Section 1.2 We must ensure that you get timely access to your covered services

As a member of our plan, you have the right to choose a primary care provider (PCP) in our network to provide and arrange for your covered services (Chapter 3 explains more about this). Call Member Services to learn which doctors are accepting new patients (phone numbers are printed on the back cover of this booklet). You also have the right to go to a women's health specialist (such as a gynecologist) without a referral, as well as other providers described in Chapter 3, Section 2.2.

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

If you think that you are not getting your medical care within a reasonable amount of time, Chapter 7, Section 9, of this booklet tells you what you can do. (If we have denied coverage for your medical care and you don't agree with our decision, Chapter 7, Section 4, tells you what you can do.)

Section 1.3 We must protect the privacy of your personal health information

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

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

How do we protect the privacy of your health information?

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

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

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

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

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

Section 1.4 We must give you information about our plan, our network of providers, and your covered services

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

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

- **Information about our plan.** This includes, for example, information about our plan's financial condition. It also includes information about the number of appeals made by members and our plan's performance ratings, including how it has been rated by plan members and how it compares to other Medicare health plans.
- **Information about our network providers.**
  - For example, you have the right to get information from us about the qualifications of the providers in our network and how we pay the providers in our network.
  - For a list of the providers in our network, see the **Provider Directory**.
  - For more detailed information about our providers, you can call Member Services (phone numbers are printed on the back cover of this booklet) or visit our website at **kp.org/directory**.
- **Information about your coverage and the rules you must follow when using your coverage.**
  - In Chapters 3 and 4 of this booklet, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services.
  - If you have questions about the rules or restrictions, please call Member Services (phone numbers are printed on the back cover of this booklet).
- **Information about why something is not covered and what you can do about it.**
  - If a medical service is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service from an out-of-network provider.
  - If you are not happy or if you disagree with a decision we make about what medical care is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see Chapter 7 of this booklet. It gives you the details about how to make an appeal if you want us to change our decision. (Chapter 7 also tells you about how to make a complaint about quality of care, waiting times, and other concerns.)
  - If you want to ask us to pay our share of a bill you have received for medical care, see Chapter 5 of this booklet.

Section 1.5 We must treat you with dignity and respect and support your right to make decisions about your care

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

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely.
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments.
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking a medication, you accept full responsibility for what happens to your body as a result.
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. Chapter 7 of this booklet tells you how to ask us for a coverage decision.

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

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

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

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

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

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

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with (in Oregon) the Division of Financial Regulation, Consumer Advocacy Unit, **503-947-7984** or **1-888-877-4894**; or (in Washington) the Washington Office of the Insurance Commissioner Consumer Protection Division, **1-800-562-6900**.

Section 1.6 You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, Chapter 7 of this booklet tells you what you can do. It gives you the details about how to deal with all types of problems and complaints.

What you need to do to follow up on a problem or concern depends upon the situation. You might need to ask us to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—we are required to treat you fairly.

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

Section 1.7 What can you do if you believe you are being treated unfairly or your rights are not being respected?

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

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

Is it about something else?

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

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

Section 1.8 How to get more information about your rights

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

- You can call Member Services (phone numbers are printed on the back cover of this booklet).
- You can call the SHIP. For details about this organization and how to contact it, go to Chapter 2, Section 3.
- You can contact Medicare:
  - You can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at **https://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf.**)
  - Or you can call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

Section 1.9 Information about new technology assessments

Rapidly changing technology affects health care and medicine as much as any other industry. To determine whether a new drug or other medical development has long-term benefits, our plan carefully monitors and evaluates new technologies for inclusion as covered benefits. These technologies include medical procedures, medical devices, and new drugs.

Section 1.10 You can make suggestions about rights and responsibilities

As a member of our plan, you have the right to make recommendations about the rights and responsibilities included in this chapter. Please call Member Services with any suggestions (phone numbers are printed on the back cover of this booklet).

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

Section 2.1 What are your responsibilities?

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

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

- If you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again.

- **Be considerate**. We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices.
- **Pay what you owe**. As a plan member, you are responsible for these payments:
  - Paying your Medicare premiums to continue being a member of our plan (see Chapter 1, Section 4.1).
  - In order to be eligible for our plan, you must have both Medicare Part A and Medicare Part B. Some plan members must pay a premium for Medicare Part A. Most plan members must pay a premium for Medicare Part B to remain a member of our plan.
  - For most of your medical services covered by our plan, you must pay your share of the cost when you get the service. This will be a copayment (a fixed amount) or coinsurance (a percentage of the total cost). The Medical Benefits Chart found at the front of this **EOC** tells you what you must pay for your medical services.
  - If you get any medical services or drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost.
  - If you disagree with our decision to deny coverage for a service, you can make an appeal. Please see Chapter 7 of this booklet for information about how to make an appeal.
- **Tell us if you move**. If you are going to move, it's important to tell us right away. Call Member Services (phone numbers are printed on the back cover of this booklet).
  - If you move outside of our plan service area, you cannot remain a member of our plan. (Chapter 1 tells you about our service area.) We can help you figure out whether you are moving outside our service area. If you are leaving our service area, you will have a special enrollment period when you can join any Medicare plan available in your new area. We can let you know if we have a plan in your new area.
  - If you move within our service area, we still need to know so we can keep your membership record up-to-date and know how to contact you.
  - If you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in Chapter 2.
- **Call Member Services for help if you have questions or concerns**. We also welcome any suggestions you may have for improving our plan.
  - Phone numbers and calling hours for Member Services are printed on the back cover of this booklet.
  - For more information about how to reach us, including our mailing address, please see Chapter 2.

CHAPTER 7. What to do if you have a problem or complaint (coverage decisions, appeals, and complaints)

Background

Coverage decisions and appeals

Making complaints

Background

SECTION 1. Introduction

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

This chapter explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the process for coverage decisions and appeals.
- For other types of problems, you need to use the process for making complaints.

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by you and us.

Which one do you use?

That depends upon the type of problem you are having. The guide in Section 3 will help you identify the right process to use.

Other dispute resolution options

Your group may have chosen to cover benefits that are not covered by Medicare. For any such benefits, Medicare rules do not apply (including the Medicare appeal process). If you have an issue relating to a benefit covered by your group plan that is not covered by Medicare, please contact Member Services for information about our non-Medicare appeal process for non-Medicare coverage issues.

Section 1.2 What about the legal terms?

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

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

However, it can be helpful, and sometimes quite important, for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation. To help you know which terms to use, we include legal terms when we give the details for handling specific types of situations.

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

Section 2.1 Where to get more information and personalized assistance

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

Get help from an independent government organization

We are always available to help you. But in some situations, you may also want help or guidance from someone who is not connected with us. You can always contact your **State Health Insurance Assistance Program (SHIP)**. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

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

You can also get help and information from Medicare

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

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

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

Section 3.1 Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this chapter that apply to your situation. The guide that follows will help.

To figure out which part of this chapter will help you with your specific problem or concern, *START HERE:*

Is your problem or concern about your benefits or coverage?

(This includes problems about whether particular medical care is covered or not, the way in which it is covered, and problems related to payment for medical care.)

- **Yes, my problem is about benefits or coverage:**

  Go to the next section in this chapter, Section 4: "A guide to the basics of coverage decisions and appeals."

- **No, my problem is not about benefits or coverage:**

  Skip ahead to Section 9 at the end of this chapter: "How to make a complaint about quality of care, waiting times, customer service, or other concerns."

Coverage decisions and appeals

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

Section 4.1 Asking for coverage decisions and making appeals—*The big picture*

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

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services. For example, your network doctor makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your network doctor refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision, if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a service 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 appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we 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. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage 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. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

Section 4.2 How to get help when you are asking for a coverage decision or making an appeal

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

- **You can call Member Services** (phone numbers are printed on the back cover of this booklet).
- To get free help from an independent organization that is not connected with our plan, **contact your State Health Insurance Assistance Program** (see Section 2 in this chapter).
- **Your doctor can make a request for you**.
  - For medical care, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative.
- **You can ask someone to act on your behalf.** If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal.
  - There may be someone who is already legally authorized to act as your representative under state law.
  - If you want a friend, relative, your doctor or other provider, or other person to be your representative, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at **https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **kp.org**.) The form gives that person permission to act on your behalf. It must be signed by you and by the person whom you would like to act on your behalf. You must give us a copy of the signed form.

- **You also have the right to hire a lawyer to act for you.** You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision.

Section 4.3 Which section of this chapter gives the details for your situation?

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

- Section 5 in this chapter: "Your medical care: How to ask for a coverage decision or make an appeal."
- Section 6 in this chapter: "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon."
- Section 7 in this chapter: "How to ask us to keep covering certain medical services if you think your coverage is ending too soon" (applies to these services only: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services).

If you're not sure which section you should be using, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also get help or information from government organizations such as your SHIP (Chapter 2, Section 3, of this booklet has the phone numbers for this program).

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

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

Section 5.1 This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These benefits are described in the Medical Benefits Chart found at the front of this **EOC**. To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time. The term "medical care" includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules

apply to a request for a Part B prescription drug. In those cases, we will explain how the rules for Part B prescription drugs are different from the rules for medical items and services.

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

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

Note: If the coverage that will be stopped is for hospital care, home health care, skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section of this chapter because special rules apply to these types of care. Here's what to read in those situations:

- **Chapter 7, Section 6:** "How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon."
- **Chapter 7, Section 7:** "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 CORF services.

For all other situations that involve being told that medical care you have been getting will be stopped, use this section (Section 5) as your guide for what to do.

Which of these situations are you in?

If you are in this situation:	This is what you can do:
Do you want to find out whether we will cover the medical care or services you want?	You can ask us to make a coverage decision for you. Go to the next section in this chapter, **Section 5.2**.
Have we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for?	You can make an appeal. (This means you are asking us to reconsider.) Skip ahead to **Section 5.3** in this chapter.

If you are in this situation:	This is what you can do:
Do you want to ask us to pay you back for medical care or services you have already received and paid for?	You can send us the bill. Skip ahead to **Section 5.5** in this chapter.

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

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

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

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

How to request coverage for the medical care you want

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

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an **answer within 14 calendar days** after we receive your request for a medical item or service. If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** after we receive your request.

- However, for a request for a medical item or service, we can take up to 14 more calendar days if you ask for more time, or if we need information (such as medical records from out-of-network providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint **within 24 hours**. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see Section 9 in this chapter.)

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

- A fast coverage decision means we will answer **within 72 hours** if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**.
  - However, for a request for a medical item or service, we can take up to 14 more calendar days if we find that some information that may benefit you is missing (such as medical records from out-of-network providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see Section 9 in this chapter.) We will call you as soon as we make the decision.
- **To get a fast coverage decision, you must meet two requirements:**
  - You can get a fast coverage decision only if you are asking for coverage for medical care you have not yet received. (You cannot get a fast coverage decision if your request is about payment for medical care you have already received.)
  - You can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function.
- **If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision.**
- **If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision.**
  - If we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead).
  - This letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision.
  - The letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see Section 9 in this chapter.)

Step 2: We consider your request for medical care coverage and give you our answer.

Deadlines for a "fast coverage decision"

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer **within 72 hours**. If your request is for a Medicare Part B prescription drug, we will answer **within 24 hours**.
  - As explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint **within 24 hours**. (For more information about the process for making complaints, including fast complaints, see Section 9 in this chapter.)
  - If we do not give you our answer **within 72 hours** (or if there is an extended time period, by the end of that period), or **24 hours** if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells you how to make an appeal.
- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the medical care coverage we have agreed to provide **within 72 hours** after we received your request. If we extended the time needed to make our coverage decision on your request for a medical item or service, we will authorize or provide the coverage by the end of that extended period.
- If our answer is ***no*** to part or all of what you requested, we will send you a detailed written explanation as to why we said no.

Deadlines for a "standard coverage decision"

- Generally, for a standard coverage decision on a request for a medical item or service, we will give you our answer **within 14 calendar days** of receiving your request. If your request is for a Medicare Part B prescription drug, we will give you an answer **within 72 hours** of receiving your request.
  - For a request for a medical item or service, we can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint **within 24 hours**. (For more information about the process for making complaints, including fast complaints, see Section 9 in this chapter.)
  - If we do not give you our answer **within 14 calendar days** (or if there is an extended time period, by the end of that period), or **72 hours** if your request is for a Part B prescription drug, you have the right to appeal. Section 5.3 below tells you how to make an appeal.

- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide **within 14 calendar days**, or **72 hours** if your request is for a Part B prescription drug, after we received your request. If we extended the time needed to make our coverage decision on your request for a medical item or service, we will authorize or provide the coverage by the end of that extended period.
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said no.

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

- If we say ***no***, you have the right to ask us to reconsider, and perhaps change this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want.
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see Section 5.3 below).

Section 5.3 Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)

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

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

What to do:

- **To start an appeal, you, your doctor, or your representative must contact us.** For details about how to reach us for any purpose related to your appeal, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care."
- **If you are asking for a standard appeal, make your standard appeal in writing by submitting a request.**

If you have someone appealing our decision for you other than your doctor, your appeal must include an "Appointment of Representative" form authorizing this person to represent you. To get the form, call Member Services (phone numbers are printed on the back cover of this booklet) and ask for the "Appointment of Representative" form. It is also available on Medicare's website at **https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf**. While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice

explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal.

- **If you are asking for a fast appeal, make your appeal in writing or call us** at the phone number shown in Chapter 2, Section 1, "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care."
- **You must make your appeal request within 60 calendar days from the date on the written notice** we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal.
- **You can ask for a copy of the information regarding your medical decision and add more information to support your appeal.**
  - You have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you.
  - If you wish, you and your doctor may give us additional information to support your appeal.

If your health requires it, ask for a "fast appeal" (you can make a request by calling us)

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

- If you are appealing a decision we made about coverage for care you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal."
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section.)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal.

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

- When we are reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said ***no*** to your request.
- We will gather more information if we need it. We may contact you or your doctor to get more information.

Deadlines for a "fast appeal"

- When we are using the fast deadlines, we must give you our answer **within 72 hours** after we receive your appeal**.** We will give you our answer sooner if your health requires us to do so.
  - However, if you ask for more time, or if we need to gather more information that may benefit you, we can take up to 14 more calendar days if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing.

We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

- 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 automatically send 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 on a request for a medical item or service **within 30 calendar days** after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug, we will give you our answer **within 7 calendar days** after we receive your appeal if your appeal is about coverage for a Part B prescription drug 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 your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.
  - If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint **within 24 hours**. (For more information about the process for making complaints, including fast complaints, see Section 9 in this chapter.)
  - If we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an independent, outside organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process.
- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide **within 30 calendar days**, or within **7 calendar days** if your request is for a Medicare Part B prescription drug after we receive your appeal.
- If our answer is ***no*** to part or all of what you requested, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal.

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

- To make sure we were following all the rules when we said ***no*** to your appeal, we are required to send your appeal to the Independent Review Organization. When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2.

Section 5.4 Step-by-step: How a Level 2 Appeal is done

If we say ***no*** to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews our decision for your first appeal. This organization decides whether the decision we made should be changed.

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

Step 1: The Independent Review Organization reviews your appeal.

- **The Independent Review Organization is an independent organization that is hired by Medicare**. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- We will send the information about your appeal to this organization. This information is called your "case file." You have the right to ask us for a copy of your case file. We are allowed to charge you a fee for copying and sending this information to you.
- You have a right to give the Independent Review Organization additional information to support your appeal.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.

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

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal **within 72 hours** of when it receives your appeal**.**
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. If your request is for a medical item or service, the review organization

must give you an answer to your Level 2 Appeal **within 30 calendar days** of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal **within 7 calendar days** of when it receives your appeal.

- However, if your request is for a medical item or service, the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug.

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 a request for a medical item or service, we must authorize the medical care coverage **within 72 hours** or provide the service **within 14 calendar days** after we receive the decision from the review organization for standard requests or **within 72 hours** from the date we receive the decision from the review organization for expedited requests.
- If the review organization says ***yes*** to part or all of a request for a Medicare Part B prescription drug, we must authorize the Part B prescription drug under dispute **within 72 hours** after we receive the decision from the review organization for standard requests or **within 24 hours** from the date we receive the decision from the review organization for expedited requests.
- If this organization says ***no*** to part or all of your appeal, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal.")
  - If the Independent Review Organization "upholds the decision," you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal).
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you got after your Level 2 Appeal.
- The Level 3 Appeal is handled by an administrative law judge or attorney adjudicator. Section 8 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

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

If you want to ask us for payment for medical care, start by reading Chapter 5 of this booklet: "Asking us to pay our share of a bill you have received for covered medical services." Chapter 5 describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells you how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see Section 4.1 in this chapter). To make this coverage decision, we will check to see if the medical care you paid for is a covered service; see the Medical Benefits Chart found at the front of this **EOC**. We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in Chapter 3 of this booklet: "Using our plan's coverage for your medical services").

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

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care **within 60 calendar days** after we receive your request. Or if you haven't paid for the services, we will send the payment directly to the provider. (When we send the payment, it's the same as saying ***yes*** to your request for a coverage decision.)
- If the medical care is not covered, or you did not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the services and the reasons why in detail. (When we turn down your request for payment, it's the same as saying ***no*** to your request for a coverage decision.)

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

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

To make this appeal, follow the process for appeals that we describe in Section 5.3 . Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer **within 60 calendar days** after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal.)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider **within 30 calendar days**. If the answer to your appeal is ***yes*** at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider **within 60 calendar days**.

SECTION 6. How to ask us to cover a longer inpatient hospital stay if you think the doctor is discharging you too soon

When you are admitted to a hospital, you have the right to get all of your covered hospital services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see the Medical Benefits Chart found at the front of this **EOC**.

During your covered 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**."
- When your discharge date has been decided, your doctor or the hospital staff will let you know.
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask.

Section 6.1 During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your covered hospital stay, you will be given a written notice called **An Important Message from Medicare about Your Rights**. Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call Member Services (phone numbers are printed on the back cover of this booklet). You can also call **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

- Read this notice carefully and ask questions if you don't understand it. It tells you about your rights as a hospital patient, including:
  - Your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them.
  - Your right to be involved in any decisions about your hospital stay, and know who will pay for it.
  - Where to report any concerns you have about quality of your hospital care.
  - Your right to appeal your discharge decision if you think you are being discharged from the hospital too soon.

Legal Terms

The written notice from Medicare tells you how you can "**request an immediate review**." Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. (Section 6.2 below tells you how you can request an immediate review.)

- **You must sign the written notice** to show that you received it and understand your rights.
  - You or someone who is acting on your behalf must sign the notice. (Section 4 in this chapter tells you how you can give written permission to someone else to act as your representative.)
  - Signing the notice shows **only** that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice does not mean you are agreeing on a discharge date.
- **Keep your copy of the signed notice** so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it.
  - 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 Member Services (phone numbers are printed on the back cover of this booklet) or **1-800-MEDICARE** (**1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**. You can also see it online at **https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html**.

Section 6.2 Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do.
- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 in this chapter).

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Step 1: Contact the Quality Improvement Organization for 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 Chapter 2, Section 4, of this booklet.)

Act quickly:

- To make your appeal, you must contact the Quality Improvement Organization **before** you leave the hospital and **no later than your planned discharge date.** (Your "planned discharge date" is the date that has been set for you to leave the hospital.)
  - **If you meet this deadline,** you are allowed to stay in the hospital after your discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization.
  - **If you do not meet this deadline,** and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you receive after your planned discharge date.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to our plan instead. For details about this other way to make your appeal, see Section 6.4.

Ask for a "fast review":

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

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

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.

- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them.
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives you your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

Legal Terms
This written explanation is called the "**Detailed Notice of Discharge**." You can get a sample of this notice by calling Member Services (phone numbers are printed on the back cover of this booklet) or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. (TTY users should call **1-877-486-2048**.) Or you can see a sample notice online at **https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html**.

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal.

*What happens if the answer is **yes**?*

- If the review organization says ***yes*** to your appeal, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered hospital services. (See the Medical Benefits Chart found at the front of this **EOC**.)

*What happens if the answer is **no**?*

- If the review organization says ***no*** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your **inpatient** hospital services will end at noon on the day after the Quality Improvement Organization gives you its answer to your appeal.
- If the review organization says ***no*** to your appeal and you decide to stay in the hospital, then you may have to pay the full cost of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal.

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

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

Section 6.3 Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

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

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

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

- You must ask for this review within 60 calendar days after the day 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 of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision.

*If the review organization says **yes**:*

- We must reimburse you for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary.
- You must continue to pay your share of the costs and coverage limitations may apply.

*If the review organization says **no**:*

- It means they agree with the decision they made on your Level 1 Appeal and will not change it. 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 an administrative law judge or attorney adjudicator.

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 an administrative law judge or attorney adjudicator.

- Section 8 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 6.4 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 6.2, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

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

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

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

Legal Terms
A "fast review" (or "fast appeal") is also called an "**expedited appeal**."

Step 1: Contact us and ask for a "fast review."

- For details about how to contact us, **go to Chapter 2**, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care."
- **Be sure to ask for a** "**fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast review" of your planned discharge date, checking to see if it was medically appropriate.

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules.
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say *yes* to your fast appeal,** it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said

your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)

- **If we say *no* to your fast appeal,** we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end.
- **If you stayed in the hospital after your planned discharge date, then you may have to pay the full cost of hospital care you received after the planned discharge date.**

*Step 4: If we say **no** to your fast appeal, your case will automatically be sent on to the next level of the appeals process.*

- To make sure we were following all the rules when we said ***no*** to your fast appeal**,** we are required to send your appeal to the Independent Review Organization. When we do this, it means that you are **automatically** going on to Level 2 of the appeals process.

Step-by-step: Level 2 Alternate Appeal Process

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, an **Independent Review Organization** reviews the decision we made when we said ***no*** to your "fast appeal." This organization decides whether the decision we made should be changed.

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

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization **within 24 hours** of when we tell you that we are saying ***no*** to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeals process. Section 9 in this chapter tells you how to make a complaint.)

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

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge.
- If this organization says ***yes*** to your appeal, then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue our plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are

coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.

- If this organization says ***no*** to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by an administrative law judge or attorney adjudicator.

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say ***no*** to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal.
- Section 8 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

SECTION 7. How to ask us to keep covering certain medical services if you think your coverage is ending too soon

Section 7.1 *This section is about three services only:* Home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

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

- **Home health care services** you are getting.
- **Skilled nursing care** you are getting as a patient in a skilled nursing facility. (To learn about requirements for being considered a "skilled nursing facility," see Chapter 10, "Definitions of important words.")
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see Chapter 10, "Definitions of important words.")

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information about your covered services, including your share of the cost and any limitations to coverage that may apply, see the Medical Benefits Chart found at the front of this **EOC**.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, **we will stop paying our share of the cost for your care.**

If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

Section 7.2 We will tell you in advance when your coverage will be ending

- **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice.
  - The written notice tells you the date when we will stop covering the care for you.
  - The written notice also tells you what you can do if you want to ask us to change this decision about when to end your care, and keep covering it for a longer period of time.

Legal Terms

In telling you what you can do, the written notice is telling how you can request a "**fast-track appeal**." Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. (Section 7.3 below tells you how you can request a fast-track appeal.)

The written notice is called the "**Notice of Medicare Non-Coverage**." To get a sample copy, call Member Services (phone numbers are printed on the back cover of this booklet) or **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. (TTY users should call **1-877-486-2048**.) Or see a copy online at **https://www.cms.gov/Medicare/Medicare-General-Information/BNI/MAEDNotices.html**.

- You must sign the written notice to show that you received it.
  - You or someone who is acting on your behalf must sign the notice. (Section 4 tells you how you can give written permission to someone else to act as your representative.)
  - Signing the notice shows **only** that you have received the information about when your coverage will stop. **Signing it does <u>not</u> mean you agree** with us that it's time to stop getting the care.

Section 7.3 Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

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

- **Follow the process.** Each step in the first two levels of the appeals process is explained below.
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. Section 9 in this chapter tells you how to file a complaint.)

- **Ask for help if you need it**. If you have questions or need help at any time, please call Member Services (phone numbers are printed on the back cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see Section 2 in this chapter).

If you ask for a Level 1 Appeal on time, 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 for your state and ask for a review. You must act quickly.

What is the Quality Improvement Organization?

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

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2, Section 4, of this booklet.)

What should you ask for?

- Ask this organization for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services.

Your deadline for contacting this organization.

- You must contact the Quality Improvement Organization to start your appeal no later than noon of the day after you receive the written notice telling you when we will stop covering your care.
- If you miss the deadline for contacting the Quality Improvement Organization about your appeal, you can make your appeal directly to us instead. For details about this other way to make your appeal, see Section 7.5 in this chapter.

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish.
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them.
- By the end of the day the reviewers inform us of your appeal, you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services.

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

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision.

*What happens if the reviewers say **yes** to your appeal?*

- If the reviewers say ***yes*** to your appeal, then **we must keep providing your covered services for as long as it is medically necessary.**
- You will have to keep paying your share of the costs (such as deductibles or copayments, if these apply). In addition, there may be limitations on your covered services (see the Medical Benefits Chart found at the front of this **EOC**).

*What happens if the reviewers say **no** to your appeal?*

- If the reviewers say ***no*** to your appeal, then **your coverage will end** on the date we have told you. We will stop paying our share of the costs of this care on the date listed on the notice.
- If you decide to keep getting the home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after this date when your coverage ends, **then you will have to pay the full cost of this care yourself**.

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

- This first appeal you make is "Level 1" of the appeals process. If reviewers say ***no*** to your Level 1 Appeal, and you choose to continue getting care after your coverage for the care has ended, then you can make another appeal.
- Making another appeal means you are going on to "Level 2" of the appeals process.

Section 7.4 Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end.

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

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

- **You must ask for this review within 60 days** after the day when the Quality Improvement Organization said ***no*** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended.

Step 2: The Quality Improvement Organization does a second review of your situation.

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal.

Step 3: Within 14 days of receipt of your appeal request, 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 an administrative law judge or attorney adjudicator.

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 an administrative law judge or attorney adjudicator.
- Section 8 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

Section 7.5 What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained above in Section 7.3, you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.

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

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

Here are the steps for a Level 1 Alternate Appeal:

Legal Terms
A "fast review" (or "fast appeal") is also called an "**expedited appeal**."

Step 1: Contact us and ask for a "fast review."

- For details about how to contact us, go to Chapter 2, Section 1, and look for the section called "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care."
- **Be sure to ask for a "fast review**." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines.

Step 2: We do a "fast review" of the decision we made about when to end coverage for your services.

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending our plan's coverage for services you were receiving.
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review.

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal").

- **If we say *yes* to your fast appeal,** it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply.)
- **If we say *no* to your fast appeal,** then your coverage will end on the date we told you and we will not pay any share of the costs after this date.
- If you continued to get home health care, or skilled nursing facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end, **then you will have to pay the full cost of this care yourself**.

*Step 4: If we say **no** to your fast appeal, your case will automatically go on to the next level of the appeals process.*

- To make sure we were following all the rules when we said ***no*** to your fast appeal, **we are required to send your appeal to the Independent Review Organization**. When we do this, it means that you are automatically going on to Level 2 of the appeals process.

Step-by-step: Level 2 Alternate Appeal Process

If we say ***no*** to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the **Independent Review Organization** reviews the decision we made when we said ***no*** to your "fast appeal." This organization decides whether the decision we made should be changed.

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

Step 1: We will automatically forward your case to the Independent Review Organization.

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization **within 24 hours** of when we tell you that we are saying ***no*** to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeals process. Section 9 in this chapter tells you how to make a complaint.)

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

- The **Independent Review Organization** is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work.
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal.
- **If this organization says *yes*** to your appeal, then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services.
- **If this organization says *no* to your appeal,** it means they agree with the decision our plan made to your first appeal and will not change it.
  - The notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal.

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

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say ***no*** to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an administrative law judge or attorney adjudicator.
- Section 8 in this chapter tells you more about Levels 3, 4, and 5 of the appeals process.

SECTION 8. Taking your appeal to Level 3 and beyond

Section 8.1 Levels of Appeal 3, 4, and 5 for Medical Service Appeals

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

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: A judge (called an administrative law judge) or an attorney adjudicator who works for the federal government will review your appeal and give you an answer.

- **If the administrative law judge or attorney adjudicator 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 administrative law judge's or attorney adjudicator'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 or attorney adjudicator 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 or attorney adjudicator 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** (Council) will review your appeal and give you an answer. The Council is part of the federal government.

- **If the answer is *yes*, or if the 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 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 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 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 appeals process.

Making complaints

SECTION 9. How to make a complaint about quality of care, waiting times, customer service, or other concerns

? If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to Section 4 in this chapter.

Section 9.1 What kinds of problems are handled by the complaint process?

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

Here are examples of the kinds of problems handled by the complaint process.

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

- **Quality of your medical care**
  - Are you unhappy with the quality of care you have received (including care in the hospital)?
- **Respecting your privacy**
  - Do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
- **Disrespect, poor customer service, or other negative behaviors**
  - Has someone been rude or disrespectful to you?
  - Are you unhappy with how our Member Services has treated you?
  - Do you feel you are being encouraged to leave our plan?
- **Waiting times**
  - Are you having trouble getting an appointment, or waiting too long to get it?
  - Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by Member Services or other staff at our plan?
  - Examples include waiting too long on the phone, in the waiting room, or in the exam room.
- **Cleanliness**
  - Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
- **Information you get from our plan**
  - Do you believe we have not given you a notice that we are required to give?
  - Do you think written information we have given you is hard to understand?

Timeliness (these types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)

The process of asking for a coverage decision and making appeals is explained in Sections 4–8 of this chapter. If you are asking for a decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint.
- If you believe our plan is not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint.
- When a coverage decision we made is reviewed and our plan is told that we must cover or reimburse you for certain medical services, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint.
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint.

Section 9.2 The formal name for "making a complaint" is "filing a grievance"

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

Section 9.3 Step-by-step: Making a complaint

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

- **Usually calling Member Services is the first step.** If there is anything else you need to do, Member Services will let you know. Call toll-free **1-877-221-8221** (TTY **711**), 7 days a week, 8 a.m. to 8 p.m.
- **If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we will respond to you in writing. We will also respond in writing when you make a complaint by phone if you request a written response or your complaint is related to quality of care.
- **If you have a complaint, we will try to resolve your complaint over the phone.** If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. Your grievance must explain your concern, such as why you are dissatisfied with the services you received. Please see Chapter 2 for whom you should contact if you have a complaint.
  - You must submit your grievance to us (orally or in writing) within 60 calendar days of the event or incident. We must address your grievance as quickly as your health requires, but no later than 30 calendar days after receiving your complaint. We may extend the time frame to make our decision by up to 14 calendar days if you ask for an extension, or if we justify a need for additional information and the delay is in your best interest.
  - You can file a fast grievance about our decision not to expedite a coverage decision or appeal, or if we extend the time we need to make a decision about a coverage decision or appeal. We must respond to your fast grievance **within 24 hours**.
- **Whether you call or write, you should contact Member Services right away.** 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 coverage decision"** or a "**fast appeal**," we will automatically give you a "fast complaint." If you have a "fast complaint," it means we will give you an answer **within 24 hours**.

Legal Terms
What this section calls a "**fast complaint**" is also called an "**expedited grievance**."

Step 2: We look into your complaint and give you our answer.

- **If possible, we will answer you right away.** If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that.
- **Most complaints are answered in 30 calendar days.** If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing.
- **If we do not agree** with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not.

Section 9.4 You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about quality of care, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (without making the complaint to us).
  - The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.
  - To find the name, address, and phone number of the Quality Improvement Organization for your state, look in Chapter 2, Section 4, of this booklet. If you make a complaint to this organization, we will work with them to resolve your complaint.
- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization.

Section 9.5 You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to **https://www.medicare.gov/MedicareComplaintForm/home.aspx**. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you have any other feedback or concerns, or if you feel the plan is not addressing your issue, please call **1-800-MEDICARE (1-800-633-4227)**. TTY/TDD users can call **1-877-486-2048**.

CHAPTER 8. Ending your membership in our plan

SECTION 1. Introduction

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

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

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

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

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

You may terminate (disenroll from) your Senior Advantage membership at any time. However, before you request disenrollment, please check with your group to determine if you are able to continue your group membership. If you request disenrollment during your group's open enrollment, your disenrollment effective date is determined by the date your written request is received by us and the date your group coverage ends. The effective date will not be earlier than the first day of the following month after we receive your written request, and no later than three months after we receive your request.

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

Other Medicare health plans

If you want to enroll in another Medicare Advantage 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 Advantage health plan, so you will not need to send us a disenrollment request. If you enroll in some other type of Medicare Supplemental coverage, a signed disenrollment request must be received prior to the date of your new coverage, requesting your specific disenrollment date.

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 get Medicare Part D prescription drug coverage, you will need to enroll in a prescription drug plan.

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

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

- Contact your group's benefits administrator.
- You can call Member Services (phone numbers are printed on the back cover of this booklet).
- You can find the information in the **Medicare & You** 2020 handbook.
  - Everyone with Medicare receives a copy of **Medicare & You** each fall. Those new to Medicare receive it within a month after first signing up.
  - You can also download a copy from the Medicare website (**https://www.medicare.gov**). Or you can order a printed copy by calling Medicare at the number below.
- You can contact **Medicare** at **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users should call **1-877-486-2048**.

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

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

You may request disenrollment by:

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

  Kaiser Permanente
  Medicare Department
  P.O. Box 232407
  San Diego, CA 92193-9914

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

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

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

If you are hospitalized on the day that your membership ends, your hospital stay will usually be covered by our plan until you are discharged (even if you are discharged after your new health coverage begins).

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

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

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

- If you no longer have Medicare Part A and Part B.
- If you move out of our service area.
- If you are away from our service area for more than six months.
  - If you move or take a long trip, you need to call Member Services to find out if the place you are moving or traveling to is in our plan's area. Phone numbers for Member Services are printed on the back cover of this booklet.
  - If you have been a member of our plan continuously since before January 1999, and you were living outside of our service area before January 1999, you are still eligible as long as you have not moved since before January 1999. However, if you move and your move is to another location that is outside of our service area, you will be disenrolled from our plan.
- If you become incarcerated (go to prison).
- If you are not a United States citizen or lawfully present in the United States.
- If you lie about or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you are enrolling in our plan and that information affects your eligibility for our plan. We cannot make you leave our plan for this reason unless we get permission from Medicare first.
- If you continuously behave in a way that is disruptive and makes it difficult for us to provide medical care for you and other members of our plan. We cannot make you leave our plan for this reason unless we get permission from Medicare first.

- If you let someone else use your membership card to get medical care. We cannot make you leave our plan for this reason unless we get permission from Medicare first.
  - If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

Where can you get more information?

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

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

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

We are not allowed to ask you to leave our plan for any reason related to your health.

What should you do if this happens?

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

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

If we end your membership in our plan, we must tell you our reasons in writing for ending your membership. We must also explain how you can file a grievance or make a complaint about our decision to end your membership. You can look in Chapter 7, Section 9, for information about how to make a complaint.

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

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

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

CHAPTER 9. Legal notices

SECTION 1. Notice about governing law

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

SECTION 2. Notice about nondiscrimination

Our plan must obey laws that protect you from discrimination or unfair treatment. We don't discriminate based on race, ethnicity, national origin, color, religion, sex, gender, age, mental or physical disability, health status, claims experience, medical history, genetic information, evidence of insurability, or geographic location within the service area. All organizations that provide Medicare Advantage plans, like our plan, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, Section 1557 of the Affordable Care Act, all other laws that apply to organizations that get federal funding, and any other laws and rules that apply for any other reason.

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

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

SECTION 3. Notice about Medicare Secondary Payer subrogation rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Kaiser Permanente Senior Advantage, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

SECTION 4. Administration of this Evidence of Coverage

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

SECTION 5. Amendment of Agreement

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

SECTION 6. Applications and statements

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

SECTION 7. Assignment

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

SECTION 8. Attorney and advocate fees and expenses

In any dispute between a member and Health Plan, Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses except as otherwise required by law.

SECTION 9. Litigation venue

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

SECTION 10. Coordination of benefits

As described in Chapter 1 (Section 7) "How other insurance works with our plan," if you have other insurance, you are required to use your other coverage in combination with your coverage as a Senior Advantage member to pay for the care you receive. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you. You will get your covered care as usual from network providers, and the other coverage you have will simply help pay for the care you receive.

If your other coverage is the primary payer, it will often settle its share of payment directly with us, and you will not have to be involved. However, if payment owed to us by a primary payer is sent directly to you, you are required by Medicare law to give this primary payment to us. For

more information about primary payments in third party liability situations, see Section 18, and for primary payments in workers' compensation cases, see Section 20.

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

SECTION 11. Employer responsibility

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

SECTION 12. Evidence of Coverage binding on members

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

SECTION 13. Government agency responsibility

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

SECTION 14. Member nonliability

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

SECTION 15. No waiver

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

SECTION 16. Notices

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

SECTION 17. Overpayment recovery

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

SECTION 18. Third party liability

As stated in Chapter 1, Section 7, third parties who cause you injury or illness (and/or their insurance companies) usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue these primary payments. If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered services, you must ensure we receive reimbursement for those services. **Note:** This Section 18 does not affect your obligation to pay cost-sharing for these services.

To the extent permitted or required by law, we shall be 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.

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain against a third party that results in any settlement proceeds or judgment, from other types of coverage that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, worker's compensation, personal injury, medical payments and all other first party types. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether you are made whole and regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred. We are not required to pay attorney fees or costs to any attorney hired by you to pursue your damages claim.

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

Patient Business Services—TPL
Kaiser Foundation Health Plan of the Northwest
7201 N Interstate Avenue
Portland, OR 97217

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

If your estate, parent, guardian, or conservator asserts a claim against a third party based on your injury or illness, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other

rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

SECTION 19. U.S. Department of Veterans Affairs

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

SECTION 20. Workers' compensation or employer's liability benefits

As stated in Chapter 1, Section 7.1, workers' compensation usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue primary payments under workers' compensation or employer's liability law. You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered services from the following sources:

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

CHAPTER 10. Definitions of important words

Allowance – A specified credit amount that you can use toward the cost of an item. If the cost of the item(s) you select exceeds the allowance, you will pay the amount in excess of the allowance, which does not apply to the annual maximum out-of-pocket amount.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center does not exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or payment for services you already received. You may also make an appeal if you disagree with our decision to stop services that you are receiving. For example, you may ask for an appeal if we don't pay for an item, or service you think you should be able to receive. Chapter 7 explains appeals, including the process involved in making an appeal.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than the plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We do not allow providers to "balance bill" or otherwise charge you more than the amount of cost-sharing your plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measure your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a hospital or skilled nursing facility. The benefit period ends when you haven't received any inpatient hospital care (or skilled care in a SNF) for 60 days in a row. If you go into a hospital or a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare. Chapter 2 explains how to contact CMS.

The CHP Group – A network of alternative care and chiropractic providers that we contract with to provide covered chiropractic services (Medicare-covered manual manipulation of the spine). You can contact The CHP Group by calling **1-800-449-9479** (TTY users call **711**), 8 a.m. to 5 p.m., Monday through Friday.

Coinsurance – An amount you may be required to pay as your share of the cost for services. Coinsurance is usually a percentage (for example, 20%) of Plan Charges.

Complaint – The formal name for "making a complaint" is "filing a grievance." 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. See also "Grievance," in this list of definitions.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, and provides a variety of services, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Coordination of Benefits (COB) – Coordination of Benefits is a provision used to establish the order in which claims are paid when you have other insurance. If you have Medicare and other health insurance or coverage, each type of coverage is called a "payer." When there is more than one payer, there are "coordination of benefits" rules that decide which one pays first. The "primary payer" pays what it owes on your bills first, and then sends the rest to the "secondary payer" to pay. If payment owed to us is sent directly to you, you are required under Medicare law to give the payment to us. In some cases, there may also be a third payer. See Chapter 1 (Section 7) and Chapter 9 (Section 10) for more information.

Copayment (or "copay") – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, or hospital outpatient visit. A copayment is a set amount, rather than a percentage. For example, you might pay $10 or $20 for a doctor's visit.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services are received. Cost-sharing includes any combination of the following three types of payments: (1) any deductible amount a plan may impose before services are covered; (2) any fixed "copayment" amount that a plan requires when a specific service is received; or (3) any "coinsurance" amount, a percentage of the total amount paid for a service that a plan requires when a specific service is received. Note: In some cases, you may not pay all applicable cost-sharing at the time you receive the services, and we will send you a bill later for the cost-sharing. For example, if you receive nonpreventive care during a scheduled preventive care visit, we may bill you later for the cost-sharing applicable to the nonpreventive care. For items ordered in advance, you pay the copayment in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the copayment when the item is ordered.

Covered Services – The general term we use to mean all of the health care services and items that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you do not need skilled medical care or skilled nursing care. Custodial care is personal care that can be provided by people who don't have professional skills or training, such as help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Deductible – The amount you must pay for health care before our plan begins to pay.

Dependent – A member who meets the eligibility requirements as a dependent (for dependent eligibility requirements, see Chapter 1, Section 2).

Disenroll or **Disenrollment** – The process of ending your membership in our plan. Disenrollment may be voluntary (your own choice) or involuntary (not your own choice).

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech-generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

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

Emergency Care – Covered services that are (1) rendered by a provider qualified to furnish emergency services; and (2) needed to treat, evaluate, or stabilize an emergency medical condition.

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

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, riders, or other optional coverage selected, which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

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.

Grievance – A type of complaint you make about us, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Group – The entity with which we have entered into the **Agreement** that includes this **Evidence of Coverage.**

Home Health Aide – A home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (for example, bathing, using the toilet, dressing, or carrying out the prescribed exercises). Home health aides do not have a nursing license or provide therapy.

Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Medical Benefits Chart found at the front of this **EOC**. We cover home health care in accord with Medicare guidelines. Home health care can include services from a home health aide if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you are also getting a covered skilled service. Home health services do not include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Hospice – A member who has six months or less to live has the right to elect hospice. We, your plan, must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you are still a member of our plan. You can still obtain all medically necessary services as well as the supplemental benefits we offer. The hospice will provide special treatment for your state.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an "outpatient."

Initial Enrollment Period – When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. For example, if you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the seven-month period that begins three months before the month you turn 65, includes the month you turn 65, and ends three months after the month you turn 65.

Inpatient Hospital Care – Health care that you get during an inpatient stay in an acute care general hospital.

Kaiser Foundation Health Plan (Health Plan) – Kaiser Foundation Health Plan of the Northwest, is a Northwest nonprofit corporation and a Medicare Advantage organization. This **Evidence of Coverage** sometimes refers to Health Plan as "we" or "us."

Kaiser Foundation Hospital – A network hospital owned and operated by Kaiser Foundation Hospitals.

Kaiser Permanente – Kaiser Foundation Hospitals, Health Plan, and Medical Group.

Kaiser Permanente Region – A Kaiser Foundation Health Plan organization that conducts a direct-service health care program. When you are outside our service area, you can get medically necessary health care and ongoing care for chronic conditions from designated providers in another Kaiser Permanente region's service area. For more information, please refer to Chapter 3, Section 2.4.

Long-Term Care Hospital – A Medicare-certified acute-care hospital that typically provide Medicare covered services such as comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management. They are not long-term care facilities such as convalescent or assisted living facilities.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for any contributions to your group’s monthly premium and your Medicare Part A and Part B premiums do not count toward the maximum out-of-pocket amount. See Chapter 4, Section 1.2, for information about your maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. Medicaid programs vary from state to state, but most health care costs are covered if you qualify for both Medicare and Medicaid. See Chapter 2, Section 6, for information about how to contact Medicaid in your state.

Medical Care or Services – Health care services or items. Some examples of health care items include durable medical equipment, eyeglasses, and drugs covered by Medicare Part A or Part B.

Medical Group – It is the network of plan providers that our plan contracts with to provide covered services to you. The name of our medical group is Northwest Permanente, P.C., Physicians and Surgeons, a for-profit professional corporation.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). People with Medicare can get their Medicare health coverage through Original Medicare, a PACE plan, or a Medicare Advantage Plan.

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be an HMO, a PPO, a Private Fee-for-Service (PFFS) plan, or a Medicare Medical Savings Account (MSA) plan. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan and are not paid for under Original Medicare. In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. Everyone who has Medicare Part A and Part B is eligible to join any Medicare health plan that is offered in their area, except people with End-Stage Renal Disease (unless certain exceptions apply).

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans, including our plan, must cover all of the services that are covered by Medicare Part A and B.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Demonstration/ Pilot Programs, and Programs of All-Inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

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

Member (Member of our Plan, or "Plan Member") – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals. See Chapter 2 for information about how to contact Member Services.

Network Physician – Any licensed and Kaiser Foundation Health Plan of the Northwest credentialed (KFHPNW) physician who is an employee of Medical Group, or any licensed and

KFHPNW credentialed physician who contracts with KFHPNW or Medical Group to provide services to KFHPNW members as a provider participating in the KFHPNW provider network.

Network Provider – "Provider" is the general term we use for doctors, other health care professionals (including, but not limited to, physician assistants, nurse practitioners, and nurses), hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them "**network providers**" when they have an agreement with our plan to accept our payment as payment in full, and in some cases, to coordinate as well as provide covered services to members of our plan. We pay network providers based on the agreements it has with the providers or if the providers agree to provide you with plan-covered services. Network providers may also be referred to as "plan providers."

Organization Determination – The Medicare Advantage plan has made an organization determination when it makes a decision about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called "coverage decisions" in this booklet. Chapter 7 explains how to ask us for a coverage decision.

Original Medicare ("Traditional Medicare" or "Fee-for-Service" Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility with which we have not arranged to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that are not employed, owned, or operated by our plan or are not under contract to deliver covered services to you. Using out-of-network providers or facilities is explained in this booklet in Chapter 3.

Out-of-Pocket Costs – See the definition for "Cost-Sharing" above. A member's cost-sharing requirement to pay for a portion of services received is also referred to as the member's "out-of-pocket" cost requirement.

PACE Plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term care (LTC) services for frail people to help people stay independent and living in their community (instead of moving to a nursing home) for as long as possible, while getting the high-quality care they need. People enrolled in PACE plans receive both their Medicare and Medicaid benefits through the plan.

Part C – See **"Medicare Advantage (MA) Plan."**

Part D – The voluntary Medicare Prescription Drug Benefit Program. (For ease of reference, we will refer to the prescription drug benefit program as Part D.)

Plan Charges – Plan Charges means the following:

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

Post-Stabilization Care – Medically necessary services related to your emergency medical condition that you receive after your treating physician determines that this condition is clinically stable. You are considered clinically stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you are safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they are received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are received from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services received from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both network (preferred) and out-of-network (nonpreferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health care coverage.

Primary Care Provider (PCP) – Your primary care provider is the doctor or other provider you see first for most health problems. He or she makes sure you get the care you need to keep you healthy. He or she also may talk with other doctors and health care providers about your care and refer you to them. In many Medicare health plans, you must see your primary care provider before you see any other health care provider. See Chapter 3, Section 2.1, for information about primary care providers.

Prior Authorization – Approval in advance to get services. Some in-network medical services are covered only if your doctor or other network provider gets "prior authorization" from our plan. Covered services that need prior authorization are marked in the Medical Benefits Chart found at the front of this **EOC** and described in Chapter 3, Section 2.3.

Prosthetics and Orthotics – These are medical devices ordered by your doctor or other health care provider. Covered items include, but are not limited to, arm, back, and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. See Chapter 2, Section 4, for information about how to contact the QIO for your state.

Rehabilitation Services – These services include physical therapy, speech and language therapy, and occupational therapy.

Service Area – A geographic area where a health plan accepts members if it limits membership based on where people live. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (nonemergency) services. Our plan may disenroll you if you permanently move out of our plan's service area.

Services – Health care services or items.

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of skilled nursing facility care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Special Needs Plan – A special type of Medicare Advantage Plan that provides more focused health care for specific groups of people, such as those who have both Medicare and Medicaid, who reside in a nursing home, or who have certain chronic medical conditions.

Subscriber – A member who is eligible for membership on his or her own behalf and not by virtue of dependent status (for subscriber eligibility requirements, see Chapter 1, Section 2).

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Services – Urgently needed services are provided to treat a nonemergency, unforeseen medical illness, injury, or condition that requires immediate medical care. Urgently needed services may be furnished by network providers or by out-of-network providers when network providers are temporarily unavailable or inaccessible.

Utilization Review – The formal application of criteria and techniques designed to ensure that each member is receiving services at the appropriate level. Utilization review is used as a technique to monitor the use of or evaluate the medical necessity, appropriateness, effectiveness, or efficiency of a specific service, procedure, or setting. See Chapter 3, Section 2.3, for more information.

PRA Disclosure Statement *According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.*

Notice of nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex.

Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, call Member Services at **1-877-221-8221** (TTY **711**), 8 a.m. to 8 p.m., seven days a week.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to 500 NE Multnomah St., Suite 100, Portland OR 97232 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **https://ocrportal.hhs.gov/ocr/portal/lobby.jsf**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

Multi-language Interpreter Services

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-877-221-8221** (TTY: **711**).

Spanish: ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-877-221-8221** (TTY: **711**).

Chinese: 注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-877-221-8221**（TTY：**711**）。

Vietnamese: CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-877-221-8221** (TTY: **711**).

Tagalog: PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-877-221-8221** (TTY: **711**).

Korean: 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. **1-877-221-8221** (TTY: **711**)번으로 전화해 주십시오.

Russian: ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-877-221-8221** (телетайп: **711**).

Japanese: 注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。 **1-877-221-8221**（TTY:**711**）まで、お電話にてご連絡ください。

Punjabi: ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ। **1-877-221-8221**（TTY:**711**） 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian: ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-877-221-8221** (TTY: **711**)។

Thai: เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-877-221-8221**（TTY:**711**).

Farsi: **وجه:** اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-877-221-8221** (TTY: **711**) تماس بگیرید.

Arabic:

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم **1-877-221-8221** (رقم هاتف الصم والبكم: -**711**).

Amharic: **ማስታወሻ: የሚናገሩት ቋንቋ አማርኛ ከሆነ የትርጉም እርዳታ ድርጅቶች፣ በነጻ ሊያግዝዎት ተዘጋጀተዋል፡ ወደ ሚከተለው ቁጥር ይደውሉ 1-877-221-8221** (**መስማት ለተሳናቸው: 711**).

German: ACHTUNG: Wenn Sie Deutsch sprechen, stehen Ihnen kostenlos sprachliche Hilfsdienstleistungen zur Verfügung. Rufnummer: **1-877-221-8221** (TTY: **711**).

French: ATTENTION : Si vous parlez français, des services d'aide linguistique vous sont proposés gratuitement. Appelez le **1-877-221-8221** (ATS : **711**).

Cushite-Oromo: XIYYEEFFANNAA: Afaan dubbattu Oroomiffa, tajaajila gargaarsa afaanii, kanfaltiidhaan ala, ni argama. Bilbilaa **1-877-221-8221** (TTY: **711**).

Lao: ໂປດຊາບ: ຖ້າວ່າ ທ່ານເວົ້າພາສາ ລາວ, ການບໍລິການຊ່ວຍເຫຼືອດ້ານພາສາ, ໂດຍບໍ່ເສັງຄ່າ, ແມ່ນມີພ້ອມໃຫ້ທ່ານ. ໂທຣ **1-877-221-8221** (TTY: **711**).

Ukrainian: УВАГА! Якщо ви розмовляєте українською мовою, ви можете звернутися до безкоштовної служби мовної підтримки. Телефонуйте за номером **1-877-221-8221** (телетайп: **711**).

Romanian: ATENȚIE: Dacă vorbiți limba română, vă stau la dispoziție servicii de asistență lingvistică, gratuit. Sunați la **1-877-221-8221** (TTY: **711**).

KAISER PERMANENTE®

Kaiser Permanente Senior Advantage Member Services

METHOD	Member Services – contact information
CALL	**1-877-221-8221** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
WRITE	Member Services Kaiser Foundation Health Plan of the Northwest 500 NE Multnomah St., Suite 100 Portland, OR 97232-2099
WEBSITE	**kp.org**

State Health Insurance Assistance Program

A State Health Insurance Assistance Program (SHIP) is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. Please see Chapter 2, Section 3, for SHIP contact information.

Chiropractic Services Rider
Kaiser Permanente Senior Advantage (HMO)

This rider is part of the **Kaiser Permanente Senior Advantage (HMO) Evidence of Coverage** (**EOC**) to which it is attached. All provisions of this rider become part of the **EOC** "Chapter 4: Medical Benefits Chart (what is covered and what you pay)" section. This entire benefit rider is therefore subject to all the terms and provisions of the **EOC**.

Services described in this rider are provided by The CHP Group, a network of alternative care and chiropractic providers that we contract with to provide covered services. For a list of network providers, go online to **http://www.chpgroup.com**. You may contact The CHP Group at **1-800-449-9479** (TTY users call **711**), 8 a.m. to 5 p.m., Monday through Friday.

General benefit requirements

We cover the services described in this "Chiropractic Services Rider" only if all of the following requirements are met:

- Services are received from network providers and provided as outpatient services in the network provider's office.
- You are required to pay the copayment or coinsurance amount to the network provider at the time of service.
- You are responsible for paying the full amount for services after you reach the benefit maximum listed in the Medical Benefits Chart "Alternative care therapies (self-referred)" section.

Chiropractic services

We cover self-referred chiropractic services described in this "Chiropractic Services Rider," subject to any visit limits and applicable copayment or coinsurance listed in the Medical Benefits Chart "Alternative care therapies (self-referred)" section.

Chiropractic and manual manipulation of the spine, joints, or soft tissue focuses on reducing pain and improving the function and structure of the body. It is a system of therapy that involves non-invasive care promoting science-based approaches to a variety of ailments. Covered services include:

- Evaluation and management.
- Musculoskeletal treatments.
- Physical therapy modalities such as hot and cold packs.

When prescribed by a network provider, X-ray procedures are covered as described in the Medical Benefits Chart "Outpatient diagnostic tests and therapeutic services and supplies" section.

Chiropractic services exclusions

- Acupressure.
- Acupuncture services.

- Behavioral training and modification, including but not limited to biofeedback, hypnotherapy, play therapy, and sleep therapy.
- Chiropractic services in excess of those necessary for maximum chiropractic improvement. This includes supportive care when physician dependence, somatization, illness behavior, or secondary gain exists.
- Cosmetics, dietary supplements, recreation, health or beauty classes, aids, or equipment.
- Costs or charges incurred for which the member is not legally required to pay, or for professional services rendered by a person who resides in the member's home, or who is related to the member by marriage or blood (including parents, children, sisters, brothers, or foster children).
- Cupping.
- Dental services, including temporomandibular (TMJ) services.
- Dermal friction technique.
- Disorders connected to military service, any treatment or service to which the member is legally entitled through the United States Government or for which facilities are available.
- Durable medical equipment, devices, appliances, orthotics, or prosthetics.
- Environmental enhancements, modifications to dwellings, property or motor vehicles, adaptive equipment, personal lodgings, travel expenses, meals.
- Expenses incurred as a result of treatment or service for pre-employment, school entrance, or athletic physical examinations.
- Experimental treatment including laboratory tests, X-rays, and services that are provided primarily for medical research purposes.
- Fertility services, including reversal of sterilizations.
- Gynecological services.
- Health or exercise classes, aids, or equipment.
- Hearing exams.
- Infertility services.
- The following laboratory services:
  - Comprehensive digestive stool analysis.
  - Cytotoxic food allergy test.
  - Darkfield examination for toxicity or parasites.
  - EAV and electronic tests for diagnosis or allergy.
  - Fecal transient and retention time.
  - Henshaw test.
  - Intestinal permeability.
  - Loomis 24-hour urine nutrient/enzyme analysis.
  - Melatonin biorhythm challenge.
  - Salivary caffeine clearance.
  - Sulfate/creatine ratio.

    - Thermography, hair analysis, heavy metal screening, and mineral studies.
    - Tryptophan load test.
    - Urinary sodium benzoate.
    - Urine saliva pH.
    - Zinc tolerance test.
- Laserpuncture.
- Massage therapy.
- Mental health services of any kind.
- Moxibustion.
- MRIs, diagnostic ultrasounds, CT scans, bone scans, and other special imaging studies.
- Nambudripad allergy eliminated technique (NAET).
- Naturopathic medicine.
- Nerve conduction studies, electromyography, computerized muscle testing or range of motion testing.
- Obstetrical services.
- Over-the-counter drugs, medications (prescription or non-prescription) including vitamins, minerals, nutritional or dietary supplements, or any other supply or product, whether or not prescribed.
- Personal or comfort items, environmental enhancements, modifications to dwellings, property or motor vehicles, adaptive equipment, and training in the use of the equipment, personal lodging, travel expenses, or meals.
- Physical examinations for evaluations and reports for licensing, school, sports, premarital, or those required for court proceedings.
- Point injection therapy.
- Preventive care, educational programs, non-medical self-care, self-help training, or any related diagnostic training, except that which occurs during the normal course of covered alternative care therapy services.
- Proctology services.
- Public facility care in which services or care is required by federal, state, or local law.
- Radiological procedures performed on equipment not certified, registered, or licensed by the State of Oregon or Washington, and/or radiological procedures that, when reviewed by The CHP Group are determined to be of such poor quality that they cannot safely be utilized in diagnosis or treatment.
- Services considered experimental or investigational.
- Services designed to maintain optimal health in the absence of symptoms.
- Smoking cessation.
- Sonopuncture.
- Surgery.
- Transportation services, including ambulances and care cars.

- Treatment for purposes of obesity or weight control, to include any weight control supplies or products.
- Vocational rehabilitation.
- X-ray documentation and/or interpretation when prescribed by an acupuncturist or naturopathic physician.

Hearing Aid Rider

Kaiser Permanente Senior Advantage (HMO)

This rider is part of the **Kaiser Permanente Senior Advantage (HMO) Evidence of Coverage** (**EOC**) to which it is attached. All provisions of this rider become part of the **EOC** "Chapter 4: Medical Benefits Chart (what is covered and what you pay)" section. This entire benefit rider is therefore subject to all the terms and provisions of the **EOC**. The hearing aids exclusion in the **EOC** "Chapter 4: Section 3.1, Services we do *not* cover (exclusions)" section does not apply to services we cover under this rider.

Hearing aids

We provide an allowance toward the price of a hearing aid or aids prescribed by a network provider and dispensed by a licensed hearing aid vendor. The allowance and your cost-sharing, if any, are listed in the Medical Benefits Chart "Hearing services, Hearing aids" section. You do not have to use the allowance for both ears at the same time, but we will not provide the allowance for an ear if we have previously covered a hearing aid for that ear within the allowance period under this or any other evidence of coverage (including riders) with the same group number printed on the Medical Benefits Chart.

The date we cover a hearing aid is the date on which you are fitted for the hearing aid. If you are fitted for a hearing aid while you are covered under this **EOC**, and if we would otherwise cover the hearing aid, we will cover the hearing aid even if you do not receive the hearing aid until after you are no longer covered under this **EOC**.

We select the vendor that supplies the covered hearing aid. Covered hearing aids are electronic devices worn on the person for the purpose of amplifying sound and assisting in the process of hearing, including an ear mold, if necessary, and are limited to one of the following digital models: (i) in-the-ear; (ii) behind-the-ear; (iii) on-the-body (Body Aid Model); or (iv) canal/CIC aids.

Note: Hearing exams to determine the need for hearing correction and to provide a prescription for hearing aids are not covered under this "Hearing Aid Rider" (see "Hearing services" in the Medical Benefits Chart for routine hearing exams, and evaluation and fitting for hearing aids).

Hearing aid exclusions

- Bone anchored hearing aids.
- Cleaners, moisture guards, and assistive listening devices (for example, FM systems, cell phone or telephone amplifiers, and personal amplifiers designed to improve your ability to hear in a specific listening situation).
- Hearing aids that were fitted before you were covered under this **EOC** (for example, a hearing aid that was fitted during the previous contract year will not be covered under this **EOC**, though it might be covered under your evidence of coverage for the previous contract year).
- Internally implanted hearing aids.
- Repair of hearing aids beyond the warranty period.
- Replacement of lost or broken hearing aids, if you have exhausted (used up) your allowance.
- Replacement parts and batteries.

Outpatient Prescription Drug Rider
Kaiser Permanente Senior Advantage (HMO)

This rider is part of the **Kaiser Permanente Senior Advantage (HMO) Evidence of Coverage** (**EOC**) to which it is attached. All provisions of this rider become part of the **EOC** "Chapter 4: Medical Benefits Chart (what is covered and what you pay)" section. This entire benefit rider is therefore subject to all the terms and provisions of the **EOC**.

Note: We also cover some outpatient drugs as listed in the Medical Benefits Chart "Medicare Part B prescription drugs" section.

Covered Drugs and Supplies

We cover outpatient prescription drugs and supplies as described in this "Outpatient Prescription Drug Rider," and only if all of the following conditions are met:

- The drug or supply is prescribed by a network provider or any licensed dentist in accordance with our drug formulary guidelines. Over-the-counter contraceptive drugs, devices, and products, approved by the FDA, do not require a prescription in order to be covered.
- The law requires the drug or supply to bear the legend "Rx only," or the drug or supply is a non-prescription item that our drug formulary lists for your condition. These items include glucagon emergency kits, insulin, ketone test strips for urine-testing, and disposable needles and syringes when prescribed for the treatment of diabetes. We cover additional diabetic equipment and supplies as listed in the Medical Benefits Chart "Diabetes self-management training and diabetic services and supplies" section.
- You obtain the drug or supply at a network pharmacy (including our mail-order pharmacy) or in a prepackaged take-home supply from a network facility or network medical office.

Copayments and Coinsurance for Covered Drugs and Supplies

When you get a prescription from a network pharmacy, network facility or network medical office, or order a prescription through our mail-order pharmacy, you pay the copayment or coinsurance listed in the Medical Benefits Chart "Prescription drugs" section. This applies for each prescription consisting of up to the day supply listed in the Medical Benefits Chart. If plan charges for the drug or supply are less than your copayment or coinsurance, you pay the lesser amount.

Day Supply Limit

The prescribing provider determines how much of a drug or supply to prescribe. For purposes of day supply coverage limits, the prescribing provider determines the amount of a drug or supply that constitutes a medically necessary 30-day (or any other number of days) supply for you. When you pay the copayment or coinsurance listed in the Medical Benefits Chart, you will receive the prescribed supply up to the day supply limit. If you wish to receive more than the covered day supply limit, then you must pay plan charges for any prescribed quantity that exceeds the day supply limit.

Medication Synchronization

Medication synchronization is the coordination of medication refills, if you are taking two or more medications for a chronic condition, so that your medications are refilled on the same

schedule. You may request medication synchronization for a new prescription from the prescribing provider or a network pharmacy who will determine the appropriateness of medication synchronization for the drugs being dispensed and inform you of the decision.

How to Get Covered Drugs or Supplies

Network pharmacies are located in many network facilities. To find a network pharmacy, visit **kp.org/directory**, or contact Member Services to ask us to mail you a pharmacy directory.

Network pharmacies include our mail-order pharmacy. This pharmacy offers postage-paid delivery to addresses in Oregon and Washington. Some drugs and supplies are not available through our mail-order pharmacy, for example, drugs that require special handling or refrigeration, or are high cost. Drugs and supplies available through our mail-order pharmacy are subject to change at any time without notice.

If you would like to use our mail-order pharmacy, call **1-800-548-9809** or order online at **kp.org/refill**.

Definitions

The following terms, when used in this "Outpatient Prescription Drug Rider" and in the Medical Benefits Chart mean:

- **Brand-Name Drug ("brand").** The first approved version of a drug. Marketed and sold under a proprietary, trademark-protected name by the pharmaceutical company that holds the original patent.
- **Generic Drug ("generic").** A drug that contains the same active ingredient as a brand-name drug and is approved by the U.S. Food and Drug Administration (FDA) as being therapeutically equivalent and having the same active ingredients(s) as the brand-name drug. Generally, generic drugs cost less than brand-name drugs, and must be identical in strength, safety, purity, and effectiveness.
- **Non-Preferred Brand-Name Drug.** A brand-name drug or supply that is not approved by Health Plan’s Regional Formulary and Therapeutics Committee and requires prior authorization for coverage.
- **Preferred Brand-Name Drug.** A brand-name drug or supply that Health Plan’s Regional Formulary and Therapeutics Committee has approved. Marketed and sold under a proprietary, trademark-protected name by the pharmaceutical company that holds the original patent.
- **Specialty Drug.** A drug or supply, including many self-injectables as well as other medications, often used to treat complex chronic health conditions, is generally high cost, and is approved by the U.S. Food and Drug Administration. Specialty drug treatments often require specialized delivery, handling, monitoring, and administration.

About Our Drug Formulary

Our drug formulary is a list of drugs that our Regional Formulary and Therapeutics Committee has reviewed and approved for our members and includes drugs covered under this rider. Drugs on the formulary have been approved by the FDA.

Our Regional Formulary and Therapeutics Committee is made up of network physicians, other network providers including pharmacists, and administrative staff. The committee chooses drugs for the formulary based on several factors, including safety and effectiveness as determined from

a review of the scientific literature. They may not approve a drug if there is not enough scientific evidence that it is clinically effective. They may also exclude a drug if it does not have a clinical or cost advantage over comparable formulary drugs.

The Regional Formulary and Therapeutics Committee meets to review new drugs and reconsider drugs currently on the market. After this review, they may add drugs to the formulary or remove drugs from it. If a drug is removed from the formulary, you will need to switch to another comparable drug that is on the drug formulary, unless your old drug meets exception criteria. Refer to the "Drug Formulary Exception Process" in this rider for more information.

If a formulary change affects a prescription drug you are taking, we encourage you to discuss any questions or concerns with your network provider or another member of your health care team.

Drugs on our formulary may move to a different drug tier during the year. For example, a drug could move from the Non-Preferred Brand-Name Drug list to the Preferred Brand-Name Drug list. If a drug you are taking is moved to a different drug tier, this could change the copayment or coinsurance amount you pay for that drug.

To see if a drug or supply is on our drug formulary, or to find out what drug tier the drug is in, go online to **kp.org/formulary**. You may also call our Formulary Application Services Team (FAST) at **503-261-7900** or toll free at **1-888-572-7231**. If you would like a copy of our drug formulary or additional information about the formulary process, please call Member Services at **1-877-221-8221**. The presence of a drug on our drug formulary does not necessarily mean that your network provider will prescribe it for a particular medical condition.

Prior Authorization and Step Therapy Prescribing Criteria

Prior authorization is required when you are prescribed certain drugs or supplies before they can be covered. A network provider may request prior authorization if he or she determines that the drug or supply is medically necessary. Prescribing network providers must supply to our plan the medical information necessary for our plan to make the prior authorization determination. Coverage for a prescribed drug or supply that is approved for prior authorization begins on the date our plan approves the request.

A list of those drugs and supplies that require prior authorization is available online at **kp.org** or you may contact Member Services at **1-877-221-8221**.

We apply step therapy prescribing criteria, developed by Medical Group and approved by our plan, to certain drugs and supplies. The step therapy prescribing criteria require that you try a therapeutically similar drug (step 1) for a specified length of time before we will cover another drug (step 2) prescribed for the same condition. A list of drugs and supplies subject to step therapy prescribing criteria, and the requirements for moving to the next step drug, is available online at **kp.org** or you may contact Member Services at **1-877-221-8221**.

Drug Formulary Exception Process

Our drug formulary guidelines include an exception process that is available when a network provider or any licensed dentist prescribes a drug or supply that our drug formulary does not list for your condition, if the law requires the item to bear the legend "Rx only." The exception process is not available for drugs and supplies that the law does not require to bear this legend, or for any drug or supply prescribed by someone other than a network provider or any licensed dentist.

A network provider or any licensed dentist may request an exception if he or she determines that the non-formulary drug or supply is medically necessary. We will make a coverage determination within 72 hours of receipt for standard requests and within 24 hours of receipt for expedited requests.

We will approve the exception if all of the following requirements are met:

- We determine that the drug or supply meets all other coverage requirements except for the fact that our drug formulary does not list it for your condition.
- Medical Group or a designated physician makes the following determinations:
  - The drug or supply is medically necessary because you are allergic to, or intolerant of, or have experienced treatment failure with, any alternative drugs or supplies that our drug formulary lists for your condition.
  - Your condition meets any additional requirements that the Regional Formulary and Therapeutics Committee has approved for the drug or supply. For this drug or supply, the pharmacy can provide a copy of the additional criteria upon request. In some cases, there may be a short delay in filling your prescription while your information is being reviewed.

If we approve an exception through this exception process, then we will cover the drug or supply at the copayment or coinsurance listed in the Medical Benefits Chart. If we do not approve the formulary exception request, we will send you a letter informing you of that decision. You may request a review by an independent review organization. The process is explained in our denial letter.

Your Prescription Drug Rights

You have the right to safe and effective pharmacy Services. You also have the right to know what drugs are covered under this plan and the limits that apply. If you have a question or a concern about your prescription drug benefits, please contact Member Services at **1-877-221-8221** or visit us online at **kp.org**.

Medication Management Program

We have a Medication Management Program. The program's primary focus is on reducing cardiovascular risk, especially by controlling lipid levels and high blood pressure. Network providers, including pharmacists, nurse care managers and other staff work with members to educate, and monitor and adjust medication doses. There is no extra copayment or coinsurance for the Medication Management Program.

Outpatient Prescription Drug Rider Limitations

- If your prescription allows refills, there are limits to how early you can receive a refill. We will refill your prescription when you have used at least 75 percent of the quantity, unless the law or your prescribing provider prohibits an early refill. Please ask your network pharmacy if you have questions about when you can get a covered refill.
- The network pharmacy may reduce the day supply dispensed at the copayment or coinsurance to a 30-day supply in any 30-day period if it determines that the drug or supply is in limited supply in the market or for certain other items. Your network pharmacy can tell you if a drug or supply you use is one of these items.

- For certain drugs or supplies we may limit the amount of a drug or supply that is covered for a specified time frame. Quantity limits are in place to ensure safe and appropriate use of a drug or supply. Drugs and supplies subject to quantity limits are indicated on our drug formulary, available at **kp.org /formulary**. You may also contact Member Services at **1-877-221-8221** for more information.

Outpatient Prescription Drug Rider Exclusions

- Any packaging, such as blister or bubble repacking, other than the dispensing pharmacy's standard packaging.
- Brand-name drugs for which a generic drug is available, unless approved. Refer to the "Prior Authorization and Step Therapy Prescribing Criteria" section in this rider.
- Drugs prescribed for an indication if the U.S. Food and Drug Administration (FDA) has determined that use of that drug for that indication is contraindicated.
- Drugs prescribed for an indication if the FDA has not approved the drug for that indication, except that this exclusion does not apply if our Regional Formulary and Therapeutics Committee determines that the drug is recognized as effective for that use (i) in one of the standard reference compendia, or (ii) in the majority of relevant peer-reviewed medical literature, or (iii) by the Secretary of the U.S. Department of Health and Human Services.
- Drugs and supplies ordered from the mail-order pharmacy to addresses outside of Oregon or Washington.
- Drugs and supplies that are available without a prescription, even if the nonprescription item is in a different form or different strength (or both), except that this exclusion does not apply to nonprescription drugs or supplies that our drug formulary lists for your condition.
- Drugs, biological products, and devices that the FDA has not approved.
- Drugs used for the treatment of infertility.
- Drugs used for the treatment or prevention of sexual dysfunction disorders.
- Drugs used in weight management.
- Drugs used to enhance athletic performance.
- Extemporaneously compounded drugs, unless the formulation is approved by our Regional Formulary and Therapeutics Committee.
- Internally implanted time-release drugs, except that internally implanted time-release contraceptive drugs are covered.
- Non-formulary drugs that have not been approved (refer to the "Drug Formulary Exception Process" in this rider).
- Nutritional supplements.
- Outpatient drugs that require special handling, refrigeration, or high cost drugs are not provided through the mail-order pharmacy.
- Outpatient drugs that require professional administration by medical personnel or observation by medical personnel during self-administration (refer instead to the Medical Benefits Chart

"Medicare Part B prescription drugs" section for information about drugs that usually are not self-administered).

- Replacement of drugs and supplies due to loss, damage, or carelessness.

Prescription Eyewear Rider

Kaiser Permanente Senior Advantage (HMO)

This rider is part of the **Kaiser Permanente Senior Advantage (HMO) Evidence of Coverage** (**EOC**) to which it is attached. All provisions of this rider become part of the **EOC** "Chapter 4: Medical Benefits Chart (what is covered and what you pay)" section. This entire benefit rider is therefore subject to all the terms and provisions of the **EOC**.

We cover the services listed in this rider at network optical centers when prescribed by a network provider or an out-of-network provider. The eyeglasses and contact lenses exclusion in the **EOC** "Chapter 4: Section 3.1, Services we do *not* cover (exclusions)" section does not apply to services we cover under this rider.

Eyeglasses and contact lenses

We provide an allowance toward the price of prescription eyeglass lenses and a frame, or conventional or disposable prescription contact lenses, including medically necessary contact lenses. The allowance and your cost-sharing, if any, are listed in the Medical Benefits Chart "Vision care, Prescription eyewear" section. If the covered eyewear item you purchase costs more than the allowance for that item, you pay the difference. We will not provide the allowance if we have previously covered an eyewear item under this rider within the same allowance period.

The date we cover any of these prescription eyewear items is the date on which you order the item. If you order the item while you are covered under this **EOC**, and if we would otherwise cover the item, we will cover the prescription eyewear item even if you do not receive it until after you are no longer covered under this **EOC**.

If a network provider determines that one or both of your eyes has had a change in prescription of at least .50 diopters within 12 months after the date of your last exam where the "Prescription Eyewear Rider" benefit was used, we will provide an allowance toward the price of a replacement eyeglass lens or contact lens for each qualifying eye at the following maximum values:

- $60 for single vision eyeglass lenses
- $60 for single vision contact lenses
- $90 for multifocal eyeglass lenses
- $90 for multifocal contact lenses

This replacement lens allowance is the same total amount whether you replace one lens or two. The replacement lenses must be the same type as the lenses you are replacing (eyeglass lenses or contact lenses).

Medically Necessary Contact Lenses

Contact lenses may be determined to be medically necessary and appropriate in the treatment of the following conditions:

- Keratoconus.
- Pathological myopia.
- Aphakia.

- Anisometropia.
- Aniseikonia.
- Aniridia.
- Corneal disorders.
- Post-traumatic disorders.
- Irregular astigmatism.

Prescription eyewear exclusions

- Low vision aids.
- Non-prescription products (other than eyeglass frames), such as eyeglass holders, eyeglass cases, repair kits, contact lens cases, contact lens cleaning and wetting solution, and lens protection plans.
- Non-prescription sunglasses.
- Optometric vision therapy and orthoptics (eye exercises).
- Plano contact lenses or glasses (non-prescription).
- Professional services for evaluation, fitting and follow-up care for contact lenses, except that this exclusion does not apply to medically necessary contact lenses.
- Replacement of lost, broken, or damaged lenses or frames.