SCOTT SNYDER
MAYFIELD CITY SCHOOL DISTRICT
1101 S.O.M. CENTER ROAD
MAYFIELD HTS., OH 44124

RE: 0550--000, 418, 436, 500

Non Medicare Group Summary of Benefits

(Please see the Group Evidence of Coverage for complete benefit descriptions)

Benefit:	Member Pays
Outpatient Care*	
Primary Care office visits	$10 per visit
Specialty Care office visits (including post natal visits), Allergy consultations and testing visits, Surgical procedures performed in the office, Anesthesia, Pain Management	$10 per visit
Prenatal office visits	Nothing
Respiratory therapy	Nothing
Chemotherapy, Radiation therapy	$10 per visit
Allergy treatment	Nothing
Outpatient surgery	$10 per visit
House calls by a physician	Nothing
Blood, blood products and their administration,	Nothing
Medical Social Services	Nothing
Hospital Inpatient Care*	Nothing; Unlimited days
Ambulance*	Nothing
Chemical Dependency	
Inpatient Detoxification in a general hospital	Nothing
Inpatient Detoxification in a Specialized Facility	Nothing per admit; Limit one admission per Member per calendar year.
Outpatient Detoxification Outpatient Individual Therapy	$10 per visit $10 per visit
Outpatient Group Therapy	$5 per visit; $5 per day max
Dialysis*	$10 per visit
Drugs and Supplies	See "Benefits" section
Durable Medical Equipment (DME), External Prosthetics and Orthotics	Nothing (items listed in "Benefits" section only)
Emergency Services*	
Emergency Services at a Plan Facility	$10 per visit (waived if admitted)
Emergency Services at a non-Plan Facility	$10 per visit (waived if admitted)
Follow up Care to Emergency Services Outside the Service Area	All charges beyond $500 per calendar year
Family Planning*	$10 per visit
Hearing	Same as Specialty Care office visits
Home Health	Nothing
Hospice	Nothing
Infertility Services*	
Inpatient	30%
Outpatient	30%
Laboratory, X-Ray and Other Diagnostic Services*	Nothing
Mental Health Services	
Biologically Based Mental Illness*	
Inpatient	Nothing
Outpatient Outpatient Group Therapy	$10 per visit $5 per visit
Other Mental Health Illnesses	
Inpatient	Nothing; Limit 45 days per calendar

Benefit:	Member Pays
	year
Outpatient Individual Therapy Outpatient Group Therapy Inpatient Alternative Services	$10 per visit; Limit 20 visits $5 per visit; Limit 20 visits $10 per visit Visit limits are per calendar year
Outpatient Physical, Occupational and Speech Therapy and Multidisciplinary Rehabilitation Physical Therapy	$10 per visit; Limit 30 visits per calendar year
Occupational Therapy	$10 per visit; Limit 30 visits per calendar year
Speech Therapy	$10 per visit; Limit 30 visits per calendar year
Multidisciplinary Rehabilitation	Nothing; Limit up to two consecutive months
Preventive Exams and Services* Well-child care exams for children under 24 months	$10 per visit
Preventive exams performed by a PCP	$10 per visit
Preventive exams performed by a specialist	$10 per visit
Flexible Sigmoidoscopy (individuals age 50 and over)	Same as office visit Copayment if performed in the office; same as outpatient surgery Copayment if performed in an ambulatory surgery center.
Preventive health screening tests Fecal occult blood, Chlamydia, Cholesterol Test (Lipid Profile) Fasting Blood Glucose, Pap Test, PSA and HPV	Nothing
Mammograms	Nothing
Immunizations (except travel immunizations)	Nothing
Prosthetic Devices (Internally Implanted)	Nothing/See Benefit Section
Reconstructive Surgery* Inpatient	Nothing
Outpatient	$10 per visit
Skilled Nursing Facility	Nothing; Limit 100 days per calendar year
Transplant Services* Inpatient	Nothing
Outpatient	$10 per visit
Urgent Care Services * In a Plan urgent care facility within the Service Area or any urgent care facility outside the Service area.	$10 per visit
Vision Services	Same as Specialty Care office visits
Dependent Age Limit	up to age 19 end of birth month
Student Dependent Age Limit	up to age 23 end of birth month
Annual Out of Pocket Maximum Single Family	 $2,000 $6,000

*These are Basic Health Care Services and the Copayment for each will not exceed 40% of the average cost of the Service. The average cost of a Service is calculated by dividing the Eligible Charges by the total number of the Service paid by Kaiser Permanente.

Additional Information and Other Benefits Requested by Group (if any)

OUTPATIENT PRESCRIPTION DRUG BENEFIT

Drugs are covered when a prescription is required by law and when they are listed in the Health Plan Drug Formulary. This includes coverage for off-label formulary drug usage in the treatment of a particular condition for a drug that is approved by the United States Food and Drug Administration and is recognized as safe and effective for that condition in published, authoritative medical, scientific, or pharmaceutical literature.

The formulary includes brand-name and generic drugs. Brand-name drugs are drugs that are produced and sold under the original manufacturer's brand-name. Generic drugs are produced and sold under their chemical names after the patent of the brand-name drug expires. A compounded drug is one in which two or more drugs or pharmaceutical agents are combined together to meet the requirements of a prescription. When there is a Copayment difference between brand-name and generic drugs, the brand-name Copayment applies to brand-name drugs and compounded drugs.

Unless nonformulary drug coverage is available through another benefit offered through Kaiser Permanente, nonformulary drugs will be covered in the same manner as formulary drugs when (i) the Plan Physician documents in the Member's medical record and certifies that the formulary alternative has been ineffective in the treatment of the Member's disease or condition or (ii) that the formulary alternative causes or is reasonably expected by the Plan Physician to cause harmful or adverse reactions and (iii) the use conforms to guidelines and criteria reviewed and approved by the Kaiser Permanente Health Plan of Ohio's Pharmacy and Therapeutics Committee. Coverage of certain formulary medications may also be subject to restrictions established by the Pharmacy and Therapeutics Committee. If prescribed by a physician, a small number of non-prescription drugs (listed in the Health Plan Drug formulary) and accessories are also covered: insulin, disposable insulin syringes/needles and certain cough syrups. Any questions regarding drugs listed in the Health Plan Drug Formulary can be directed to a Kaiser Permanente Pharmacist or an affiliated pharmacist.

Drugs and accessories are covered only when medically necessary for treatment of a specific illness, injury or condition; prescribed by a licensed health care professional authorized to prescribe drugs; and obtained at pharmacies in Kaiser Permanente Facilities or at affiliated pharmacies.

Prescribed covered drugs and accessories are provided at a single Copayment for each prescription, not to exceed the amount prescribed, up to a 31-day supply except that, if the regular charge is less than the Copayment, members pay the regular charge. Each prescription refill is provided on the same basis as the original prescription. If a prescription or refill is for a quantity greater than the limits described above, the charge is an additional Copayment for each multiple quantity or fraction of a 31-day supply. We reserve the right to dispense only a 31-day supply when the prescription or refill is of a quantity greater than a 31-day supply. We provide up to a 31-day supply based upon (a) the prescribed dosage, (b) the standard manufacturers package size, and (c) specified dispensing limits.

Direct Mail Services. Covered prescriptions for maintenance medications may be ordered by mail up to a 62-day supply. A maintenance medication is a prescription drug used on an ongoing basis. A single Copayment amount will be collected for up to a 62-day supply if your Plan Physician writes for the appropriate quantity of medication. With the exception of insulin, certain medications, such as those requiring refrigeration and certain controlled medications are not available through direct mail.

General Exclusions. The following are not covered under this outpatient prescription drug benefit:

(a) Drugs when prescribed for cosmetic purposes.
(b) Drugs that are necessary for or related to an excluded service.
(c) Drugs used for the purpose of weight loss.
(d) Drugs and materials that require administration by medical personnel or observation by medical personnel during or after administration.
(e) Non prescription drugs and medications (however, non prescription nicotine replacement products are covered when on our formulary).
(f) Nonformulary nicotine replacement products.
(g) Investigational or experimental drugs or drugs that are limited to investigational use.
(h) Replacement of lost or damaged prescriptions.
(i) Unless an exception is approved by Health Plan, drugs not approved by the FDA and in general use as of March 1st, of the year immediately preceding the year in which this Agreement became effective or was last renewed.
(j) Nonformulary drugs at the request of the Member, when a Plan Physician believes that the formulary alternative is effective.
(k) Drugs used to enhance athletic performance.
(l) Medical Supplies such as dressings and antiseptics.
(m) Vitamins and nutritional supplements that can be purchased without a prescription.
(n) Special Medication packaging, other than Health Plan standard packaging, unless required by law.
(o) Drugs used to shorten the duration of the common cold.

Prescribed Drugs (Except For Those Prescribed Drugs Used for the Treatment of Involuntary Infertility and for the Treatment of Sexual Dysfunction). Prescribed covered drugs and accessories are provided at a Copayment of $10.00.

Prescribed Drugs Used for the Treatment of Involuntary Infertility. Prescribed covered drugs and accessories used for the treatment of involuntary infertility are provided at a Copayment of 50% of Eligible Charges.

Prescribed Drugs Used for the Treatment of Sexual Dysfunction. Prescribed drugs and accessories used for the treatment of sexual dysfunction are not covered.

Contraceptives. Contraceptives for which a prescription is required by law and which are listed in the Health Plan Drug Formulary are covered as follows:

Prescribed contraceptive drugs are provided at a Copayment of $10.00 per prescription or refill.

Diaphragms are provided upon payment of a $10.00 Copayment, per prescription or refill when prescribed by a Physician and obtained at pharmacies in Kaiser Permanente Facilities or at affiliated pharmacies.

IUDs are provided when prescribed by a Medical Group Physician and obtained at pharmacies in Kaiser Permanente Facilities or at affiliated pharmacies, upon payment of a charge determined by multiplying the $10.00 Copayment by the number of months that the IUD will be effective, as stated by the manufacturer, except that the charge will not exceed the cost of the IUD or $200.00 whichever is less.

Topical or internally implanted time-released or intravaginal contraceptives, are provided when prescribed by a Physician and obtained at pharmacies in Kaiser Permanente Facilities or at affiliated pharmacies, upon payment of a charge determined by multiplying the $10.00 Copayment by the number of months that the contraceptive will be effective, as stated by the manufacturer, except that the charge will not exceed the cost of the contraceptive or $200.00 whichever is less.

Injectable contraceptives, are provided when prescribed by a Physician and obtained at pharmacies in Kaiser Permanente Facilities or at affiliated pharmacies, upon payment of a charge determined by multiplying the $10.00 Copayment by the number of months that the contraceptive will be effective, as stated by the manufacturer, except that the charge will not exceed the cost of the contraceptive.

There will be no refund on any portion of the Copayment applied to a contraceptive described above, if the contraceptive is removed for any reason before the end of its expected life. Other Medical Services associated with providing contraceptives, such as evaluation, instruction, insertion, fitting, laboratory testing, etc. are provided upon payment of a Copayment, if any, as shown on your Copayment chart.

CONTIGUOUS COUNTY

Individuals are accepted for enrollment and continuing coverage under this Evidence of Coverage (EOC) only if they: (i) meet all eligibility requirements established by Group and agreed upon by Health Plan; (ii) meet all applicable requirements set forth in this EOC; (iii) are employees or retirees of Group who reside permanently in the Service Area or (iv) are employees or retirees of Group whose offices or facilities are located in the Service Area and reside in a county that is contiguous to the Service Area. Medicare eligible members, for whom Medicare is primary and who reside in a contiguous county are not eligible for membership under this provision.

Covered Services must be received within the Service Area as described in the EOC with the exception of home-based Services such as home health, hospice or Durable Medical Equipment. When a Member is enrolled under this provision, home-based Services will be provided by Plan Providers within the Service Area or a county that is contiguous to the Service Area.

Medicare Plus Group Benefit Chart

(Please see the Medicare Plus Group Evidence of Coverage for complete benefit descriptions)

Benefit	Member Pays
Ambulance Services	You pay nothing.
Blood & Blood Components Blood Transfusions	You pay nothing. You pay nothing per transfusion.
Chiropractic Services (manual manipulation of the spine)	You pay $10 per visit.
Comprehensive Outpatient Rehabilitation Facility (CORF)	You pay $10 per visit.
Dental Services (Medically Necessary)	See "Outpatient Physician or Medical Services" for the applicable Copayment.
Diagnostic Lab Testing	You pay nothing.
Durable Medical Equipment, Diabetic Equipment & Supplies, Prosthetics & Orthotics	You pay nothing for internally implanted prosthetics. You pay 20% Coinsurance of Medicare allowable charges and you pay all non-covered charges.
Emergency Care	You pay $10 per visit to the emergency room which is waived if you are immediately admitted.
Urgently Needed Care Urgent Care Inside the Service Area	You pay $10 per visit.
Glasses and Contact Lenses following Cataract Surgery	You pay 20% Coinsurance of Medicare allowable charges and you pay all non-covered charges.
Hearing Evaluations	See "Outpatient Physician or Medical Services" for the applicable Copayment.
Home Health Services	You pay nothing.
Hospice Services Part A entitlement or Part A benefits purchased from the Social Security Administration Part A equivalent benefit purchased from Kaiser Permanente	 You pay Original Medicare out-of-pocket amounts for outpatient drugs and inpatient respite care and you must receive care from a Medicare-certified Hospice. You pay nothing.
Immunizations	You pay nothing per service unless the service is provided during an Office Visit with other procedures being performed. If a service is provided during an Office Visit with other procedures being performed, you pay the copay for the Office Visit.
Inpatient Care In A Skilled Nursing Facility	You pay nothing.
Inpatient Chemical Dependency Detoxification & Rehabilitation Services	You pay nothing.
Inpatient Hospital Services	You pay nothing.
Inpatient Hospital Mental Health Services	You pay nothing.
Medicare-covered Drugs & Biologicals	You pay $10 per prescription for up to a 31 day supply. The drug cost does not apply to any applicable Outpatient Prescription Drug Rider annual benefit limit.
Out-of-Country Emergency Care	You pay $10 per visit to the emergency room which is waived if you are immediately admitted.
Out-of-Country Urgently Needed Care	You pay $10 per visit.

Benefit	Member Pays
Outpatient Chemical Dependency Services	Individual Therapy You pay $10 per visit. Group Therapy You pay $5 per visit, $5 per day max.
Outpatient Hospital Services	See "Outpatient Physician or Medical Services" for the applicable Copayment.
Outpatient Surgical Services	You pay $10 per visit.
Outpatient Mental Health Services	Individual Therapy You pay $10 per visit. Group Therapy You pay $5 per visit.
Outpatient Physician or Medical Services	You pay $10 per Primary Care visit.
Outpatient Physician or Medical Services	You pay $10 per Specialist visit.
Outpatient Therapy • Occupational • Physical • Speech • Cardiac	You pay $10 per visit.
Partial Hospitalization	You pay $10 per Specialist visit.
Podiatry Services (Medically Necessary)	See "Outpatient Physician or Medical Services" for the applicable Copayment.
Preventive Physical Exam (routine physical exam)	See "Outpatient Physician or Medical Services" for the applicable Copayment.
Preventive Services	You pay nothing per service unless the service is provided during an Office Visit with other procedures being performed. If a service is provided during an Office Visit with other procedures being performed, you pay the copay for the Office Visit.
Radiological Testing & X-rays	You pay nothing.
Renal Dialysis	You pay nothing.
Transplant Services	Inpatient: Same as Hospital Inpatient Services. Outpatient: You pay $10 per visit.
Vision Services	See "Outpatient Physician or Medical Services" for the applicable Copayment.
Dependent Age Limit	19 end of month.
Student Dependent Age Limit	23 end of month.
Annual Out-of-Pocket Maximum	$2500 per Member /$6000 per Family.

Additional Information and Other Benefits Requested by Group (if any)

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documents in the Member's medical record and certifies that the formulary alternative has been ineffective in the treatment of the Member's disease or condition or (ii) that the formulary alternative causes or is reasonably expected by the Plan Physician to cause harmful or adverse reactions and (iii) the use conforms to guidelines and criteria reviewed and approved by the Kaiser Permanente Health Plan of Ohio's Pharmacy and Therapeutics Committee. Coverage of certain formulary medications may also be subject to restrictions established by the Pharmacy and Therapeutics Committee. If prescribed by a physician, a small number of non-prescription drugs (listed in the Health Plan's drug formulary) and accessories are also covered: insulin, disposable insulin syringes/needles and certain cough syrups. Any questions regarding drugs listed in the Health Plan's drug formulary can be directed to a Kaiser Permanente Pharmacist or an affiliated pharmacist.

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(f) Nonformulary nicotine replacement products.
(g) Investigational or experimental drugs or drugs that are limited to investigational use.
(h) Replacement of lost or damaged prescriptions.
(i) Unless an exception is approved by Health Plan, drugs not approved by the FDA and in general use as of March 1st, of the year immediately preceding the year in which this Agreement became effective or was last renewed.
(j) Nonformulary drugs at the request of the Member, when a Plan Physician believes that the formulary alternative is effective.
(k) Drugs used to enhance athletic performance.
(l) Medical Supplies such as dressings and antiseptics.
(m) Vitamins and nutritional supplements that can be purchased without a prescription.
(n) Special Medication packaging, other than Health Plan standard packaging, unless required by law.
(o) Drugs and supplies used in connection with covered, prescribed Durable Medical Equipment.
(p) Drugs used to shorten the duration of the common cold.

Prescribed Drugs (Except For Those Prescribed Drugs Used for the Treatment of Involuntary Infertility and for the Treatment of Sexual Dysfunction). Prescribed covered drugs and accessories are provided at a Copayment of $10.00.

Prescribed Drugs Used for the Treatment of Involuntary Infertility. Prescribed covered drugs and accessories used for the treatment of involuntary infertility are provided at a Copayment of 50% of the Eligible Charge.

Prescribed Drugs Used for the Treatment of Sexual Dysfunction. Prescribed covered drugs and accessories used for the treatment of sexual dysfunction are provided at Copayment of $10.00.

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Topical or internally implanted time-released contraceptives, are provided when prescribed by a Physician and obtained at pharmacies in Kaiser Permanente Facilities or at affiliated pharmacies, upon payment of a charge determined by multiplying the $10.00 Copayment for each prescription, by the number of months that the contraceptive will be effective, as stated by the manufacturer, except that the charge will not exceed the cost of the contraceptive or $200.00 whichever is less.

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There will be no refund on any portion of the Copayment applied to a contraceptive described above, if the contraceptive is removed for any reason before the end of its expected life. Other Medical Services associated with providing contraceptives, such as evaluation, instruction, insertion, fitting, laboratory testing, etc. are provided upon payment of a Copayment, if any, as shown in your Evidence of Coverage.

KAISER PERMANENTE®

2008 GROUP

Evidence of Coverage

GRP

Table of Contents

Notice: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and hospitals, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the "Coordination of Benefits" section, and compare them with the rules of any other plan that covers you or your family.

Introduction

Welcome to Kaiser Permanente

Welcome to Kaiser Foundation Health Plan of Ohio. Kaiser Foundation Health Plan of Ohio is a Health Insuring Corporation. We are pleased that you have selected us as your health care provider. Please take a few minutes to review this Evidence of Coverage (EOC). If you have questions about your benefits or accessing care, please call Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired).

About This Evidence of Coverage (EOC)

This Evidence of Coverage (EOC) describes the "Kaiser Permanente Traditional" health care coverage you have through a contract between Kaiser Foundation Health Plan of Ohio and your employer or association (Group) that pays us your monthly Premium.

The information in this EOC replaces all previous EOC information. It is important that you use only the latest EOC as your reference because benefits may change. We may modify this EOC in the future. If your Group continues to pay monthly Premiums or accepts benefits after the changes have gone into effect, Group thereby agrees to the changes. This consent covers you and your enrolled Family Dependents.

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

A "Copayments and Out-of-Pocket Maximum" section is included in the back of this EOC. It gives you information about the limits and maximums of your coverage in addition to those mentioned in the "Benefits" section. It also tells you what amounts, if any, you must pay. Your Group may have purchased benefits in addition to those listed on the chart in the "Copayments and Out-of-Pocket Maximum" section. Summaries of your Group's additional benefits (if any) will also follow the "Copayments and Out-of-Pocket Maximum" section.

Eligibility and Enrollment

Who Is Eligible

General

To be eligible to enroll and remain enrolled, you must meet the following requirements:

- You must meet your Group's eligibility requirements that we have approved (your Group is required to inform Subscribers of the Group's eligibility requirements), and you must also meet the Subscriber or Dependent eligibility requirements that follow.
- You must live in our Service Area (our Service Area is described in the "Definitions" section). To find out if your Group has chosen an expanded enrollment provision, refer to the section following the Copayment chart. However, the Subscriber's or the Subscriber's Spouse's otherwise eligible children who live outside our Service Area may be eligible to enroll if (1) they are attending an accredited college or accredited vocational school, or (2) you are required to cover them pursuant to a Qualified Medical Child Support Order (QMCSO).
- Neither you nor any member of your family may enroll under this EOC if you or any dependent have ever had entitlement to receive Services through Health Plan terminated for:
  - Being disruptive, unruly or abusive.
  - Misrepresenting membership status, presenting an invalid prescription or physician order, misusing (or letting someone else misuse) a Member ID card, or committing any other type of fraud or misrepresentation.
  - Furnishing incorrect or incomplete information or failing to give notice of changes in family status or Medicare coverage.
- You must continue to meet your Group's eligibility requirements. You are required to notify Health Plan of any changes in eligibility. Failure to notify may result in termination.

Subscribers

You may be eligible to enroll as a Subscriber if you are:

- An employee of your Group who works at least the number of hours specified by your Group.

- Otherwise entitled to coverage under a trust agreement, retirement benefit program, or employment contract (unless the Internal Revenue Service (IRS) considers you self-employed).
- Entitled to Subscriber coverage under your Group's eligibility requirements that we have approved.

Dependents
If you are a Subscriber, the following persons may be eligible to enroll as your Dependents:
- Your Spouse.
- Your or your Spouse's unmarried children (including adopted children) who are under age 19 (unless changed to a different age by the Group), or if a student as defined by your Group and as approved by Health Plan.
- Other unmarried dependent persons (but not including foster children) who meet all of the following requirements:
  - They are under age 19 (unless changed to a different age by the Group), or if a student as defined by your Group and as approved by Health Plan; and
  - They receive from you or your Spouse substantially all of their support and maintenance (as defined by the IRS); and
  - They legally reside with you (the Subscriber); and
  - You or your Spouse is the court-appointed guardian (or was before the person reached age 18).

Continuation of Coverage
Persons who meet the Dependent eligibility requirements except for the age limit may be eligible if all the following requirements are met:
- They are incapable of self-sustaining employment because of mental retardation or physical handicap that occurred prior to reaching the age limit of Group; and
- They receive from you or your Spouse substantially all of their support and maintenance (as defined by the IRS); and
- You give us proof of their incapacity and dependency within 31 days of the child reaching the limiting age and annually thereafter, if requested by Health Plan. Coverage terminates when the Dependent child no longer meets all of the criteria specified in this section.

Note: The limiting age for Dependents and student Dependents set by your Group can be found in the Copayment chart in the back of this EOC.

Enrollment and Effective Date of Coverage

Eligible people may enroll as follows, and membership begins at 12:00 a.m. on the membership effective date. If you or any eligible Dependent is confined to a hospital, skilled nursing facility or other institution on your effective date, you must notify us immediately so that we can transfer your covered Medically Necessary care to a Plan Facility and Plan Physician. However, coverage is limited to Services rendered on or after your effective date and time.

New Employees and Their Dependents
If you are a new employee, you may enroll yourself and any eligible Dependents by submitting a Health Plan-approved enrollment application to your Group within 31 days after you become eligible (you should check with your Group to see when new employees become eligible). Your membership will become effective the first of the month following the date the enrollment application is received by Health Plan unless otherwise specified by your Group and approved by Health Plan.

Special Enrollment Due to Newly Acquired Dependents
You may enroll as a Subscriber (along with any eligible Dependents) and existing Subscribers may add newly eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after a Dependent becomes newly eligible.

The membership effective date for the Dependents will be:
- For newborn children of the Subscriber or the Subscriber's Spouse, the moment of birth. A newborn child is automatically covered for the first 31 days, subject to coordination of benefits rules, but must be enrolled within 31 days after birth and an additional Premium may be due for membership to continue.
- For newly adopted children (including children newly placed for adoption), the date of the adoption or legal placement for adoption.
- For all other Dependents, the first of the month following the date the change of enrollment form is received by Health Plan, unless otherwise specified by your Group and approved by Health Plan.

Note: Children born to an eligible Dependent other than the Subscriber or the Subscriber's Spouse are not eligible for coverage unless the Subscriber or the Subscriber's Spouse adopts them or becomes their court appointed guardian.

Special Enrollment Due to Loss of Other Coverage
You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group within 31 days after the enrolling persons lose other coverage, if:

- The enrolling persons had other coverage when you previously declined Health Plan coverage for them (some groups require you to have stated in writing when declining Health Plan coverage that other coverage was the reason).
- The loss of the other coverage is due to (i) exhaustion of COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) coverage, or (ii) in the case of non-COBRA coverage, loss of eligibility or termination of employer contributions, and the loss is not due to individual nonpayment or cause.

Exception: If you are enrolling yourself as a Subscriber along with at least one eligible Dependent, it is necessary for only one of you to lose other coverage and only one of you to have had other coverage when you previously declined Health Plan coverage.

Your Group will let you know the membership effective date, which will be no later than the first day of the month following the date Health Plan receives the enrollment application.

Open Enrollment
You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan-approved enrollment application to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the membership effective date.

Genetic Screening and Testing Prohibition
Renewal of this contract is not subject to genetic screening or testing or the results of genetic screening or testing.

How to Obtain Services

Important Information About Our Providers
As a Member, you are selecting our medical care program to provide your health care. The Services described in this EOC are benefits ONLY if they are provided, prescribed or directed by a Plan Physician. We will not pay for Services received from non-Plan Physicians or from non-Plan Facilities that have not been provided, prescribed, or directed by a Plan Physician. These charges are your financial responsibility. You must receive all covered care from Plan Providers, except as described under the following headings:

- Emergency Services.
- Getting a Referral.

We contract with the Ohio Permanente Medical Group, Inc. (Medical Group) to provide care to our Members in the Service Area. In addition, Medical Group has contracted with selected physicians and allied professionals in the community to provide covered Services directly to Members in their private offices; these are called "Affiliated Physicians." Collectively, we refer to Medical Group Physicians and Affiliated Physicians as "Plan Physicians." Plan Physicians provide or arrange all of your non-emergency care. A most recent list of these Plan and Affiliated Physicians can be found in the Provider Directory.

A list of our Plan Providers is available in the Provider Directory, which you may have received when you enrolled in the Plan. In addition, Kaiser Permanente Members may receive a Provider Directory at any time through one of the following methods:

1. You can call Member Support Services to have the most recent printed copy of the Provider Directory sent to you or to verify availability of various Plan Providers. Just call us at one of the following numbers: 216-524-5001 or 1-877-524-5001 (216-389-3187 or 1-877-389-3187 – TTY for the hearing/speech impaired); or,
2. For the most up to date list of our Plan Providers you can visit our website at www.kaiserpermanente.org. You can search for a Plan Provider on the website or view, print, or download an electronic version of our most current printed Provider Directory.

We will notify you 30 days in advance if you are receiving Services from a Plan Physician or Plan Facility and that provider's association with us ends. We will continue to cover Services rendered by that provider until we can arrange for the transfer of your care to another Plan Physician or Plan Facility.

Kaiser Permanente is not a member of the guaranty fund. Except for Copayments, if any, owed by you, the providers that contract with us to provide covered Services to you seek compensation for covered Services solely from us and not from you. In addition, in the case of our insolvency, you may be financially responsible for health care services rendered by a provider that is not under contract with us, whether or not we authorized the use of the non-contracted provider. Additionally, in the case of our insolvency or discontinuance of operations, providers and/or health care facilities shall continue to provide covered Services to you as needed to complete any Medically Necessary procedure which started prior to but is unfinished at the time of the insolvency or discontinuance of operations. If you are hospitalized at the time of the insolvency or discontinuance of operations, then providers and/or health care facilities shall continue to provide covered Services to you as needed, upon payment of Copayments, if any, up to the occurrence of any one of the following: (1) the end of the 30-day period following a liquidation order; (2) the end of your period of coverage for a contractual prepayment or membership charges; (3) you obtain equivalent coverage with another health plan or insurer, or your employer obtains such coverage for you; (4) you or your employer terminates coverage under the contract; or (5) a liquidation effects a transfer of Health Plan's obligation under the contract under Ohio law. Contact Customer Relations for further information at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired).

Your Primary Care Physician

Your Primary Care Physician (PCP) plays an important role in coordinating your health care needs, including hospital stays and Referrals to specialists. We encourage you to choose a PCP when you enroll. You may select a PCP from family practice, pediatrics, or internal medicine. Every Member of your family should have his or her own PCP. If you did not select a PCP upon enrollment, we will assign you one located near your home.

When choosing your PCP, please keep in mind that your choice will determine where you will receive specialty and hospital care. Your PCP has an established relationship with a specific group of specialty care physicians and hospitals with whom he or she works. By referring only to a select group of specialists and hospitals, your PCP is better able to coordinate and oversee your medical care. If there are specific specialists you want to be referred to, find out whether your PCP works with those specialists or hospitals. You can change your PCP at any time if you want to be referred to a specialist or hospital that does not have a relationship with your current PCP. Changing your PCP is not a guarantee that you will receive a Referral to the doctor or hospital that you request. See "Getting a Referral" below, for more information.

Note: If you wish to change your PCP, you must notify us first before scheduling treatment. If you do not notify us in advance that you are changing your PCP, you may be responsible for paying full charges for the care you receive from the new physician. Call us at 216-524-5001 or 1-877-524-5001 (216-389-3187 or 1-877-389-3187 – TTY for the hearing/speech impaired) to change your PCP. Generally, changes to a PCP are effective the first of the month following the request for change. It is important to remember that switching to a new PCP may also change the specialty physicians and hospitals available to you.

Getting a Referral

Plan Physicians offer primary medical and pediatric care, as well as specialty care in areas such as obstetrics/gynecology, general surgery, orthopedic surgery, and dermatology. In order to receive covered Services from a provider other than your PCP, except for covered Plan obstetrical or gynecological Services, outpatient mental health and chemical dependency Services, and optometry Services from a Plan optometrist, you must have a Referral. Although no Referral is needed for obstetrical or gynecological Services, you must seek this care from a specialist who works with your PCP.

A Referral is a written recommendation by a Plan Physician for you to receive a covered Service from a designated referral provider. A Referral is limited to a specific Service, treatment, series of treatments, or period of time. All Referral Services must be requested and approved in advance by your Plan Physician. A Referral does not guarantee that the Services or supplies requested will be covered. The Medical Group reserves the right to review and approve each Referral through our utilization review process. We will issue a written Authorization for Medical Care for Referrals we approve. We will not pay for any care rendered or recommended by a referral provider beyond the limits of the original Referral unless we specifically authorize the care. Please see the "Utilization Review" section in the Appendix of this EOC for more information on how we conduct reviews. Copayments apply to Referral Services. A written or verbal recommendation by a Plan Physician that you obtain non-covered Services (whether Medically Necessary or not) is not considered a Referral, and the Service is **not covered**.

If your Plan Physician decides that you require covered Services not available from us, he or she will refer you to a non-Plan Provider inside or outside our Service Area. The appropriate Medical Group designee will review the request to determine if the Service is Medically Necessary and whether it is available from a Plan Provider. If the Service is Medically Necessary and otherwise covered, but not available from a Plan Provider, the request will be approved. Medical Group must authorize

the Referral in writing in order for us to cover the Services.

If you require specialized care for a condition or a disease, and your Plan Physician determines that such specialty care is appropriate over a long period of time, you may receive a Referral to a specialist who has expertise in treating your condition or disease. This Referral applies only if your condition or disease is life threatening, degenerative, or disabling. However, such Services are subject to the terms of a treatment plan and the applicable covered benefits you are enrolled under at the time of the Service. The specialist will also coordinate your other health care needs. The specialist will then provide or direct your health care needs in the same manner as your Plan Physician.

Unless otherwise specified, if you receive Services from any doctor, hospital or other health care provider without first following the Referral and utilization review process you will be financially responsible. If you intend to use other health insurance coverage to pay for non-referred Services, please remember that we will not pay any residual amounts (such as deductibles or coinsurance) that are **not covered** or not paid by the other insurance plan. If you are planning to receive Services outside our Plan, or to learn more about Referrals, please contact Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired).

Note: Any dissatisfaction that you may have with our providers does not give you the right to self-refer outside the Plan to receive Services from non-Plan Providers and expect payment or reimbursement from us. See the "Getting Assistance, Claims and Appeals Procedure, and Dispute Resolution" section for ways to express your dissatisfaction.

Second Opinions

Upon request and subject to payment of any applicable Copayments, you may get a second opinion from a Plan Physician about any proposed covered Services. If the first two physicians disagree, you may request a third opinion. A Referral to a non-Plan Physician for a second or third opinion will only be made if we are unable to provide a second or third opinion in-Plan. If you elect to obtain a second opinion from a non-Plan Physician without a Referral, or a third opinion when the first two physicians agree, you must pay for such Services yourself.

Plan Facilities

We operate several outpatient treatment facilities throughout the Service Area, which are staffed by Medical Group Physicians. These facilities are referred to as "Medical Offices." In addition, we contract with some facilities, including Plan Hospitals, to provide specific Services for Members when provided or authorized by a Plan Physician. These facilities are referred to as "Plan Facilities." Collectively, we refer to Medical Offices and Plan Facilities as "Plan Facilities."

Plan Medical Offices and Plan Hospitals are listed in the Provider Directory. You can get a current copy by calling Member Support Services at 216-524-5001or 1-877-524-5001 (216-389-3187 or 1-877-389-3187 – TTY for the hearing/speech impaired or accessing the Provider Directory online at www.kaiserpermanente.org.

Getting the Care You Need

Contact the office of your PCP for all of your routine or urgent needs. For coverage information about urgent care, refer to "Urgent Care Services" in the "Benefits" section. Emergency care is covered 24 hours a day, seven (7) days a week, anywhere in the world. If you think you have a medical emergency, call 911 or go to the nearest emergency room. For coverage information about emergency care, including emergency benefits away from home, refer to "Emergency Services" in the "Benefits" section. If you are unsure whether you are experiencing an emergency and have selected a Medical Group Physician as your PCP, call our 24-hour Advice Line at 216-445-4900 or 1-800-686-2240 (216-398-3187 – TTY for the hearing/speech impaired) for assistance. If you have selected an Affiliated Physician as your PCP, call that office for assistance.

Visiting Other Kaiser Foundation Health Plan or Allied Plan Service Areas

If you visit a different Kaiser Foundation Health Plan or allied plan service area temporarily (not more than 90 days), you can receive visiting member care from designated providers in that area. Visiting member care is described in our visiting member brochure. Visiting member care and your out-of-pocket costs may differ from the covered Services, and Copayments described in this EOC. The 90-day limit on visiting member care does not apply to a Dependent child who attends an accredited college or accredited vocational school.

Service areas and facilities where you may obtain visiting member care may change at any time. To receive more information about visiting member care, including facility locations in other service areas, call Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired).

Using Your Identification Card

Each Member has a Health Plan ID card with a medical record number on it. Take your ID card with you when you go to a Plan Provider for care or have it handy when you call for advice or make an appointment. The medical record number is used to identify your medical records and membership information. You should always have the same medical record number. If we ever inadvertently issue you more than one medical record number, or if you need to replace your card, please let us know by calling Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired).

Your ID card is for identification only. To receive covered Services, you must be a current Health Plan Member. Anyone who is not a Member will be financially responsible for any Services we provide and claims for emergency or urgent care Services from non-Plan Providers will be denied. If you let someone else use your ID card, we will keep your card and terminate your membership. Lost or stolen cards must be reported immediately to Customer Relations.

Benefits

The benefits and Services your coverage provides are defined below. **Copayments, visit limits, quantity limits or time limits, if any, are listed in the "Copayments and Out-of-Pocket Maximum" section or this "Benefits" section.** Unless otherwise specified, visit or day limits are calculated on a calendar year basis. Visit limits for these Services may be reduced by the number of visits incurred during the same calendar year that you are enrolled through the same employer. Any additional benefits your Group may have purchased and any Copayments are described on the pages immediately following the "Copayments and Out-of-Pocket Maximum" section.

The benefits and Services described in this EOC are covered only when:

- Listed as covered Services and;
- Determined by a Plan Physician to be Medically Necessary to prevent, diagnose, or treat a medical condition. A Service is Medically Necessary only if a Plan Physician determines that it is medically appropriate for you and that its omission would adversely affect your health and;
- Provided, prescribed, or authorized by a Plan Physician and;
- Provided at a Plan Facility or Skilled Nursing Facility in the Service Area or provided by Plan Providers (unless otherwise noted).

We will not cover Services or supplies that do not meet these criteria. Non-covered Services are your financial responsibility.

Exclusions and limitations that apply only to a particular benefit are described in this "Benefits" section. Exclusions, limitations and reductions that apply to all benefits are described in the "General Exclusions/Limitations/Reductions" section.

Your Plan Physician must obtain approval from us for certain Services for coverage. Before giving approval, we consider if the Services meet the criteria above. We call this review the pre-service review. Your Plan Physician must obtain a pre-service review for Services such as:

- Hospital admissions.
- Referrals to specialists.
- Recommendations for follow-up care.
- Skilled nursing care.
- Surgical procedures.
- Durable Medical Equipment.

For a complete list of Services requiring pre-service review, call Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired). If Services are not precertified they will not be covered. If Services are approved you will receive a written Authorization for Medical Care. See "Getting a Referral" in the "How to Obtain Services" section.

This "Benefits" section includes both basic and supplemental health care services. Basic Health Care Services are defined as the following Services when Medically Necessary:

- Plan Physician Services (except those associated with Supplemental Health Care Services).
- Inpatient Hospital Services.
- Outpatient Medical Services.
- Emergency Services.

- Urgent Care Services.
- Diagnostic laboratory Services and diagnostic and therapeutic radiological Services.
- Diagnostic and treatment Services, other than prescription drug Services, for biologically based mental illnesses.
- Preventive health care services including but not limited to voluntary family planning Services, infertility Services, periodic physical examinations, prenatal obstetrical care, and well-child care.

Supplemental Health Care Services which may be covered under this EOC include:

- Dental care.
- Vision care and optometry Services.
- Podiatric care or foot care Services.
- Home health Services.
- Outpatient prescription drug Services.
- Nursing Services.
- Services of a dietician.
- Physical therapy and chiropractic Services.
- Mental Health Services, excluding diagnostic and treatment Services for biologically based mental illnesses.
- Medical or psychological and Referral Services for alcohol and drug abuse or addiction.

Outpatient Care

We cover the following outpatient care in our Plan Facilities for preventive medicine, diagnosis, education and treatment including professional medical Services of physicians and other health care professionals:

- Primary care office visits for internal medicine, family practice, and pediatrics.
- Specialty care office visits, including consultation and second opinions with Plan Physicians in departments other than those listed under "Primary care office visits" above.
- Allergy consultations, testing, and treatment (immunotherapy).
- Minor surgical procedures performed in the office.
- Anesthesia and pain management Services.
- Respiratory therapy.
- Chemotherapy.
- Radiation therapy.
- Blood and blood products (whole blood, packed red cells, cryoprecipitates, platelets, plasma, and fresh frozen plasma), and their administration.
- Medical social Services.
- Outpatient surgery (Services performed in a hospital or ambulatory surgical center).
- House calls by a Plan Physician when care can best be provided in your home, as determined by a Plan Physician.
- Obstetrical Department prenatal and postnatal visits.

Note: See "Preventive Exams and Services" for more information on preventive Services covered under this plan.

Hospital Inpatient Care

All hospital admissions, except for Emergency Services as described in "Emergency Services" in this "Benefits" section, must be arranged and approved by your Plan Physician prior to your admission. Inpatient hospital care for conditions other than Other Mental Health Illnesses is provided with no limitation on covered days.

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

- Room and board, including a private room, if Medically Necessary.
- Specialized care and critical care units.
- General nursing care and special duty nursing care, if Medically Necessary.
- Special diet.
- Operating and recovery room.
- Obstetrical care and delivery (including cesarean section).
- Anesthesia.
- Plan Physician and surgeon Services and supplies, including consultation and treatment by specialists.
- Medical supplies and equipment, including oxygen.
- Blood and blood products (whole blood, packed red cells, cryoprecipitates, platelets, plasma, and fresh frozen plasma) and their administration.
- Respiratory therapy.
- Physical, occupational, and speech therapy for the purpose of restoring previously existing function.
- Medical social Services and discharge planning.

Note: Women, at their option, who undergo a covered mastectomy may have this procedure performed on an inpatient basis. They may receive inpatient Services for up to 48 hours or longer, if Medically Necessary, after the procedure.

Note: In the case of a normal delivery, the mother, at her option, may receive up to 48 hours of inpatient Services for her and normal routine nursery care for the newborn. In the case of a cesarean delivery, the mother, at her option, may receive up to 96 hours of inpatient Services for her, and normal routine nursery care for the newborn. Should the mother elect to leave the hospital prior to the expiration of the applicable number of hours of inpatient care, follow-up care will be provided for the mother and newborn within 72 hours of discharge according to state law. This follow-up visit may occur in a medical setting or the home and applicable Copayments will apply.

Note: Separate Copayments, if any, for inpatient hospital stays apply to the mother and the newborn.

Note: Health Plan will pay for health care services limited to delivery and up to 48 hours of normal routine nursery care for a newborn of a Dependent who is not otherwise eligible for coverage.

Other Benefits

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

- Ambulance.
- Chemical Dependency Services.
- Dialysis.
- Drugs and Supplies.
- Durable Medical Equipment (DME), External Prosthetics and Orthotics.
- Emergency Services.
- Family Planning.
- Hearing.
- Home Health.
- Hospice.
- Infertility Services.
- Laboratory, X-ray, and Other Diagnostic Services.
- Mental Health Services.
- Outpatient Physical, Occupational, and Speech Therapy, and Multidisciplinary Rehabilitation.
- Preventive Exams and Services.
- Prosthetic Devices (Internally Implanted).
- Reconstructive Surgery.
- Skilled Nursing Facility Services.
- Transplant Services.
- Urgent Care Services.
- Vision Services.

Ambulance

We cover the Services and supplies of a licensed ambulance, only if, in the judgment of a Plan Physician, your condition requires the use of medical Services and supplies that only a licensed ambulance can provide and the use of other means of transportation would endanger your health. We will not cover ambulance Services in any other circumstances, even if no other transportation is available. We cover ambulance Services only inside our Service Area, except as covered under "Emergency Services" in this "Benefits" section.

Exclusion:
Transportation by car, taxi, bus, gurney van, wheelchair van, minivan, and any other type of transportation (other than a licensed ambulance) is not covered, even if it is the only way to travel to a facility.

Chemical Dependency Services

Outpatient Detoxification
We cover Services for the medical management of withdrawal symptoms.

Outpatient Therapy
We cover individual or group therapy sessions for the treatment of chemical dependency. This includes visits for the purpose of monitoring drug therapy.

Inpatient (Detoxification Only)
All hospital admissions, except for Emergency Services as described in "Emergency Services" in this "Benefits" section, must be arranged and approved by your Plan Physician prior to your admission.

In a general hospital:
We cover an unlimited number of days and admissions for medical management of withdrawal symptoms in a general Plan Hospital when a Plan Physician deems this setting Medically Necessary.

In a specialized facility:
If prescribed by a Plan Physician, medical management of withdrawal symptoms in a specialized chemical dependency treatment facility or program is covered in a facility that we designate.

Exclusions**:**

- More admissions to a specialized facility for the medical management of withdrawal symptoms than is designated in the "Copayments and Out-of-Pocket Maximum" section are not covered.
- Inpatient/residential rehabilitation is not covered.
- Treatment in a specialized facility or program is not covered for a Member who has not been or would not be responsive to therapeutic management or who has not been or is not motivated.
- Continuation in a course of counseling is not covered for patients who are disruptive or abusive.
- Services as a condition of probation, parole, or any other third party or court order are not covered unless a Plan Physician determines such Services to be Medically Necessary and appropriate.
- Methadone maintenance is not covered.
- Long-term rehabilitative Services are not covered for the treatment of chemical dependency, including rehabilitation Services in a specialized inpatient or residential facility.

Your Group may have requested other Chemical Dependency benefits. Refer to the "Additional Information or Other Benefits Requested by Your Group" section to find out.

Dialysis

We cover dialysis Services related to acute renal failure and end-stage renal disease if the following criteria are met:

- The Services are provided inside our Service Area.
- You satisfy all medical criteria developed by Medical Group and by the facility providing the dialysis.
- The facility is certified by Medicare.
- A Plan Physician provides a written Referral for care at the facility.

We also cover equipment, training, and medical supplies required for home dialysis. Home dialysis includes home hemodialysis, intermittent peritoneal dialysis, and home continuous ambulatory peritoneal dialysis.

Drugs and Supplies

We use a drug formulary. The medications included in the Kaiser Permanente Formulary are chosen by a group of Kaiser Permanente physicians, pharmacists, and nurses known as the Pharmacy and Therapeutics Committee. This Committee meets regularly to evaluate and choose those medications that are effective, safe, and useful in caring for our Members. You may obtain a copy of the Member Drug Formulary at any Kaiser Permanente pharmacy located in a Kaiser Medical Office Building, by calling Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired) or by writing to:

Pharmacy Administration
Kaiser Permanente
5420 Lancaster Drive
Brooklyn Heights, Ohio 44131

Drugs are covered when a prescription is required by law and when they are listed in the Health Plan Drug Formulary. This includes coverage for off-label formulary drug usage in the treatment of a particular condition for a drug that is approved by the Food and Drug Administration (FDA) and is recognized as safe and effective for that condition in published, authoritative medical, scientific, or pharmaceutical literature. Unless nonformulary drug coverage is available through another benefit offered through Kaiser Permanente, nonformulary drugs will be covered in the same manner as formulary drugs when (i) the Plan Physician documents in the Member's medical record and certifies that the formulary alternative has been ineffective in the treatment of the Member's disease or condition or (ii) that the formulary alternative causes or is reasonably expected by the Plan Physician to cause harmful or adverse reactions and (iii) the use conforms to guidelines and criteria reviewed and approved by the Kaiser Foundation Health Plan of Ohio's Pharmacy and Therapeutics Committee.

Administered Drugs
The following drugs and supplies are covered during an approved inpatient stay in a Plan Hospital or Skilled Nursing Facility. They are also covered if they require administration or observation by medical personnel and are

administered to you in a Plan Medical Office, emergency facility, urgent care facility or during home visits and physician house calls.

The following drugs are covered at no charge:

- All prescribed drugs, except those used for the evaluation or treatment of involuntary infertility.
- Injectables.
- Radioactive materials used for therapeutic purposes.
- Vaccines and immunizations approved for use by the Federal Food and Drug Administration (FDA) and which are medically indicated and consistent with accepted medical practice. See "Preventive Exams and Services" for more information on immunizations.
- Allergy test and treatment materials.

Member pays 30% of Eligible Charges for drugs for the further evaluation or treatment of involuntary infertility.

Exclusions:

- Unless an exception is approved by Health Plan, drugs not approved by the FDA are not covered.
- If a Service is not covered under this EOC, any drugs or supplies needed in connection with that Service are not covered.
- Internally implanted and injectable contraceptives are not covered.

Drugs Purchased by Members
Drugs purchased by Members are not covered.

Your Group may have requested other Prescription Drug benefits. Refer to the "Additional Information or Other Benefits Requested by Your Group" section to find out.

Durable Medical Equipment (DME), External Prosthetics and Orthotics

DME is Medically Necessary equipment appropriate for use in your home and able to withstand repeated use. It is equipment that would not be of use to you in the absence of illness or injury and it must be on our DME formulary. In order to have coverage, you must meet our Health Plan criteria for use of any equipment. Coverage is limited to the standard item of equipment that adequately meets your medical needs. We will decide whether to rent or purchase the covered equipment for your use. You will have to pay for non-covered equipment. When the item continues to be Medically Necessary, coverage includes repair and replacement of the standard item in cases of loss, irreparable damage, wear or replacement required because of a change in the Member's condition. We cover the following DME items when provided by Plan Providers and prescribed by Plan Physicians in accord with Health Plan guidelines:

- Apnea monitors for infants for a period of up to six (6) months of use.
- Oxygen dispensing equipment and oxygen; this includes pulse oximetry for infants.
- Bilirubin lights for home photo therapy for infants.
- Traction equipment.
- Negative pressure wound dressings.

A prosthetic device is a device that replaces all or part of a body organ or that replaces all or part of the function of a permanently inoperative or malfunctioning body organ. We cover external breast prostheses following a covered mastectomy. Coverage is limited to one (1) prosthesis per Member every 12 months (or two (2) per Member every 12 months in cases of covered bilateral mastectomy). We also cover up to four (4) mastectomy bras every 12 months, unless more are Medically Necessary due to changes in your condition.

Orthotics are rigid or semi-rigid external devices that are used for the purpose of supporting a weak or deformed body member or for restricting or eliminating motion in a diseased or injured part of the body. Orthotic devices are not covered.

Exclusions:

- Convenience and luxury items and features are not covered.
- Replacements necessitated by misuse are not covered.
- All other external prosthetics not listed above are not covered.
- All orthotic devices are not covered.

- All other DME items not listed above are not covered.

Note: Although certain devices are not covered, Services your Plan Physician may provide which are necessary to determine your need for a prosthetic or orthotic device are covered.

Your Group may have requested other DME, External Prosthetics and Orthotics benefits. Refer to the "Additional Information or Other Benefits Requested by Your Group" section to find out.

Emergency Services

If you have an emergency, call 911 or go to the nearest emergency room. An emergency is Medically Necessary health care services that are immediately required for acute symptoms of sufficient severity, including severe pain, that a prudent lay person who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in any of the following:

- Serious jeopardy to the mental or physical health of the individual, or with respect to a pregnant woman, the health of the woman or her unborn child; or,
- Serious impairment of the individual's bodily functions; or,
- Serious dysfunction of any body organ or part.

Emergency Services are covered when you present to an emergency facility with an emergency medical condition or when a person authorized by us refers you to an emergency facility. If you are unsure whether you are experiencing an emergency and have selected a Medical Group Physician as your PCP, call our 24-hour Advice Line for assistance at 216-445-4900 or 1-800-686-2240 (216-398-3187 – TTY for the hearing/speech impaired). If you have selected an Affiliated Physician as your PCP, call that office for assistance. Refer to the Provider Directory for the emergency number of your physician's office. To better coordinate your emergency care, if you are inside the Service Area, you should go to a Plan Facility, if possible.

If you are admitted to a non-Plan Hospital, you, a member of your family or the admitting physician must notify us by calling 1-877-676-6270 either before you are admitted, or if that is not possible, within 24 hours or as soon as medically possible after you are admitted. We will decide whether to make arrangements for necessary continued hospitalization or transfer you to a designated hospital. If you do not notify us or refuse to be transferred, we will not cover any Services you receive after transfer would have been possible.

- **Inside Our Service Area.** If you are inside our Service Area, we will cover In-Plan or Out-of-Plan Emergency Services as defined above.

- **Outside Our Service Area.** If you are injured or become unexpectedly ill while you are outside of our Service Area, we will cover Out-of-Plan Emergency Services that could not reasonably be delayed until you could get to a Plan Hospital or Plan Medical Office. This includes Out-of-Plan Emergency Services for conditions which arise unexpectedly. Medically Necessary Services for conditions which you are aware of and should have known might require treatment while outside the Service Area will not be covered, such as dialysis for end-stage renal disease, post-operative care following surgery performed by Plan Physicians, full-term delivery and treatment for continuing infections, unless Health Plan determines that you were temporarily outside the Service Area because of extreme personal emergency.

    - **Follow-up Care to Emergency Services Outside the Service Area**. We will pay up to $500 per Member per calendar year for follow-up care received outside of our Service Area if the treatment is:

        - Otherwise covered under this plan; and
        - Received after the initial Emergency Services were received or is received in a setting other than the setting where the Emergency Services were received; and
        - Performed on an outpatient basis outside our Service Area pursuant to a covered out-of-area Emergency Service.

Payment will be limited to Emergency Services required before your medical condition permits your travel or transfer to a Plan Facility. When approved by Health Plan or by a Plan Physician in this Service Area or in another Kaiser Foundation Health Plan or allied plan service area, we will cover ambulance Services or other transportation medically required to move you to a designated facility for continuing or follow-up care. Continuing or follow-up

care from non-Plan Providers is not covered unless we decide not to transfer you to a Plan Facility except as specified above. We will reduce our payments for Out-of-Plan Emergency Services by the following amounts:

- Applicable Copayments.
- Any amounts paid or payable (or that in the absence of this plan would have been payable) for the Services under any insurance policy, or any other contract or coverage, or any government program except Medicaid. If payment under the other insurance or program is not made within a reasonable period of time, we will pay for covered Out-of-Plan Emergency Services if you:
  - Agree to cooperate with us in obtaining payment. Health Plan has reimbursement rights limited to the amount we have paid for covered Services.
  - Allow us to obtain any relevant information from the other insurance or program.
  - Provide us with any information and assistance we need to obtain payment from the other insurance or program.

Note: The procedure for receiving reimbursement for Out-of-Plan Emergency Services is described in the "Getting Assistance, Claims and Appeals Procedure, and Dispute Resolution" section.

Note: The Emergency Services Copayment, if any, is waived when you are admitted as an inpatient to the hospital directly from the Emergency Department, emergency facility or observation unit. Transfer to, or an overnight stay in, an observation unit or observation bed of a hospital for any duration of time does not qualify as an inpatient admission to a hospital and your Emergency Services Copayment, if any, will not be waived.

Family Planning

We cover family planning counseling, voluntary terminations of pregnancy, including pre and post termination counseling, information on birth control, tubal ligations, and vasectomies. See the section titled: "Laboratory, X-ray, and Other Diagnostic Services" for information regarding those Services.

Exclusion:

- Contraceptive devices are not covered.

Your Group may have requested other Family Planning benefits. Refer to the "Additional Information or Other Benefits Requested by Your Group" section to find out.

Hearing

We cover medical Services necessary for the diagnosis and treatment of illness or injury to the ear. This includes hearing tests to determine the need for hearing correction.

Exclusions:

- Tests to determine an appropriate hearing aid are not covered.
- Hearing aids or tests to determine their efficacy are not covered.

Your Group may have requested other Hearing benefits. Refer to the "Additional Information or Other Benefits Requested by Your Group" section to find out.

Home Health

We cover skilled, part-time or intermittent Medically Necessary home health Services within the Service Area when you are confined to your home. The Services are covered only if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home. These Services must be prescribed or directed by a Plan Physician, as recommended by our Home Care Agency. Covered Services and items include skilled nursing care, home health aide Services, medical social Services, intravenous fluids and drugs, additives and nutrients administered therewith, and I.V. equipment and infusion pumps, physical, occupational, and speech therapy.

Unless mentioned above, the following types of Services and supplies are covered as part of home health Services and supplies only as described under these headings in this "Benefits" section:

- Drugs and Supplies.
- Durable Medical Equipment (DME), External Prosthetics and Orthotics.

Exclusions:
- Custodial care is not covered.
- Full time nursing care in the home is not covered.
- Homemaker services and supplies, including meals delivered to your home, are not covered.
- Home health care that a Plan Physician determines may be appropriately provided for you in a Plan Facility, hospital or a Skilled Nursing Facility is not covered.

Hospice

We cover hospice care only within our Service Area and if a Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home. If a Plan Physician diagnoses you with a terminal illness and determines that your life expectancy is six months or less, you can choose home-based hospice care instead of traditional Services and supplies otherwise provided for your illness. If you elect hospice care, you are not entitled to any other benefits for the terminal illness under this EOC. You may continue to receive Plan benefits for conditions other than the terminal illness. You may change your decision to receive hospice care at any time.

We cover the following Services and supplies when approved by a Plan Physician and provided by an approved hospice agency.

- Plan Physician and nursing care.
- Counseling and bereavement Services.
- Physical, occupational, speech or respiratory therapy.
- Medical social Services.
- Home health aide and homemaker Services.
- Medical supplies and appliances.
- Palliative drugs, in accord with our drug formulary guidelines.
- Short-term inpatient care, limited to respite care and care for pain control, and acute and chronic symptom management.

Infertility Services

We cover the following Services:
- Inpatient and outpatient Services after diagnosis, for the further evaluation to determine the cause of infertility, and Services for the treatment of involuntary infertility. This includes necessary laboratory and radiology Services. A diagnosis of infertility is made when a couple has not been able to conceive after 12 months of unprotected intercourse (six (6) months if the woman is over 35 years of age).
- Artificial insemination for the treatment of involuntary infertility.

Exclusions: (See "General Exclusions/Limitations/Reductions" section also.)
- Donor semen or eggs, and Services related to their procurement and storage, are not covered.
- Services to reverse voluntary, surgically induced infertility (for example, because of a vasectomy or tubal ligation) are not covered.
- Services related to a surrogacy arrangement, including but not limited to conception, pregnancy or delivery are not covered as a means to correct a Member's infertility. A surrogacy arrangement is one in which a woman agrees to become pregnant and to surrender the baby to person or persons who intend to raise the child.
- Drugs are not covered under this benefit. See "Drugs and Supplies" to find out if drugs for the treatment of infertility are covered.

Your Group may have requested other benefits for Infertility Services. Refer to the "Additional Information or Other Benefits Requested by Your Group" section to find out.

Laboratory, X-ray, and Other Diagnostic Services

We cover the following laboratory, radiology, and diagnostic Services:
- Laboratory tests, including tests for specific genetic disorders for which genetic counseling is available.
- X-rays and diagnostic imaging.
- Special procedures such as electrocardiograms and electroencephalograms.

Note: See "Preventive Exams and Services" for additional information on preventive Services that may be covered under this plan. Different Copayments may apply.

Limitation:
Laboratory, X-ray, and other diagnostic Services related to infertility are listed under "Infertility Services."

Exclusion:
Testing provided for family members who are not Members is not covered.

Mental Health Services

Biologically Based Mental Illnesses

"Biologically Based Mental Illnesses" means schizophrenia, schizoaffective disorder, major depressive disorder, bipolar disorder, paranoia and other psychotic disorders, obsessive-compulsive disorder, and panic disorder, as these terms are defined in the most recent edition of the Diagnostic and Statistical Manual of Mental Disorders published by the American Psychiatric Association. Diagnostic and treatment Services for these illnesses are covered as a Basic Health Care Service, such as:

Inpatient
Inpatient Services for the diagnosis and treatment of Biologically Based Mental Illnesses are covered including the Services of Plan Physicians and other mental health professionals when performed, prescribed or directed by a Plan Physician. Such Services may include individual therapy, group therapy, shock therapy, drug therapy, and psychiatric nursing care.

Outpatient Therapy
Outpatient Services for the diagnosis and treatment of Biologically Based Mental Illnesses are covered including Services provided by Plan Providers such as psychiatrists, psychologists, psychiatric social workers, and clinical nurse specialists, such as:

- Individual and group therapy visits for diagnostic evaluation and psychiatric treatment.
- Visits for the purpose of monitoring drug therapy.
- Treatment in a partial hospitalization program as an alternative to inpatient care.

Other Mental Health Illnesses
Other Mental Health Illnesses are mental health illnesses that are not Biologically Based Mental Illnesses and that a Plan Physician believes will significantly improve with short-term therapy. We cover evaluation, crisis intervention, and treatment for Other Mental Health Illnesses.

Inpatient
We cover short-term psychiatric hospitalization in a Hospital for the diagnosis and treatment of Other Mental Health Illnesses including the Services of Plan Physicians and other mental health professionals when performed, prescribed or directed by a Plan Physician. Such Services include individual therapy, group therapy, shock therapy, drug therapy, and psychiatric nursing care. See the "Copayments and Out-of-Pocket Maximum" section for day limits and Copayments.

Outpatient Therapy
Outpatient mental health care services for the diagnosis and treatment of Other Mental Health Illnesses are provided by Plan Providers such as psychiatrists, psychologists, psychiatric social workers, and clinical nurse specialists. The following Services are covered:

- Individual therapy visits for diagnostic evaluation and psychiatric treatment. See the "Copayments and Out-of-Pocket Maximum" section for visit limits and Copayments.
- Group therapy visits. Two (2) group therapy visits count as one (1) individual therapy visit toward visit maximums.
- Visits for the purpose of monitoring drug therapy. These visits are not subject to any visit limits.

Inpatient Alternative Services
If a Plan Physician prescribes it, we cover treatment in a partial hospitalization program as an alternative to inpatient care. You may receive two (2) sessions (visits) in a partial hospitalization program in place of one (1) day of inpatient hospital care. We also cover home psychiatric care if a Plan Physician prescribes it instead of inpatient hospitalization. You may receive up to eight (8) sessions (visits) of home psychiatric care in exchange for up to eight (8) days of inpatient mental health Services.

Exclusions for Other Mental Health Illnesses (Not Biologically Based Mental Illnesses)**:**

- Services after diagnosis for Other Mental Health Illnesses that, in the judgment of the Plan Physician, are not subject to significant improvement through relatively short-term therapy are not covered. Such conditions include chronic organic brain syndrome, and mental retardation. Outpatient drug therapy management will be provided for these conditions.
- Occupational therapy as part of outpatient mental health treatment is not covered.
- Recreational therapy as part of either inpatient or outpatient mental health treatment is not covered.

Your Group may have requested other Mental Health benefits. Refer to the "Additional Information or Other Benefits Requested by Your Group" section to find out.

Outpatient Physical, Occupational, and Speech Therapy, and Multidisciplinary Rehabilitation

Outpatient Physical, Occupational, and Speech Therapy

Prescribed outpatient physical therapy, occupational therapy, and speech therapy to restore previously existing function is covered when provided in Plan Facilities.

Multidisciplinary Rehabilitation

Multidisciplinary rehabilitation Services are provided to restore previously existing physical function when a Plan Physician determines that your condition may be significantly improved within two (2) months. You are covered for up to two (2) consecutive months of treatment per calendar year for care that is received in an approved organized inpatient multidisciplinary program or facility.

Limitations:

- Occupational therapy is limited to treatment to achieve and maintain improved self-care and other customary activities of daily living.
- Physical, speech, occupational therapy, and multidisciplinary rehabilitation are limited to the restoration of previously existing physical function which have been lost due to illness or injury when a Plan Physician determines that your condition may be significantly improved within a specific period of time or a specific number of visits per calendar year. Visit limits and/or time limits, if any, are listed in the "Copayments and Out-of-Pocket Maximum" section.
- Massage therapy is not covered except when part of a physical therapy treatment plan, ordered by a Plan Physician and provided by a physical therapist.

Exclusions:

- Long-term physical rehabilitation Services are not covered.
- Cognitive therapy Services are not covered.
- Cardiac rehabilitation is not covered.
- Comprehensive outpatient rehabilitation facility Services are not covered.
- Therapy primarily indicated for vocational training or re-training purposes, including sports physical therapy, is not covered.

Your Group may have requested other Outpatient Physical, Occupational, and Speech Therapy, and Multidisciplinary Rehabilitation benefits. Refer to the "Additional Information or Other Benefits Requested by Your Group" section to find out.

Preventive Exams and Services

We cover routine outpatient preventive Services such as the following. Depending on your Group's plan, the following preventive exams and Services may have different Copayments. Refer to the Copayment chart to find out what Copayments, if any, apply.

- Well-child care exams for children under 24 months.
- All other otherwise covered preventive physical exams performed by a PCP or specialist, including well-woman exams.
- Flexible Sigmoidoscopy when performed as a preventive health screening procedure for individuals age 50 and over.

- Preventive health screening tests:
  Fecal occult blood,
  Chlamydia screening,
  Cholesterol screening,
  Diabetes screening fasting blood glucose test,
  Human Papillomavirus Detection (HPV) screening,
  PAP smear (cytologic screening to detect cervical cancer),
  Prostate specific antigen (PSA) test,
  Screening Mammograms (A physician's order or Referral is not required for screening mammograms at Plan facilities.).
- Immunizations (except travel immunizations).

Any other covered preventive Services or covered non-preventive Services provided during a preventive exam will be subject to the applicable Copayments. Please consult with your personal physician to determine what preventive Services are appropriate for you.

Exclusion:
Physical examinations or other Services: (a) required for obtaining or maintaining employment, or participation in employee programs; (b) required for insurance or licensing; or (c) on court order or required for parole or probation, are not covered unless a Plan Physician determines the Services to be Medically Necessary.

Prosthetic Devices (Internally Implanted)

A prosthetic device is a device that replaces all or part of a body organ or that replaces all or part of the function of a permanently inoperative or malfunctioning body organ. We cover internally implanted prosthetic devices that replace the function of all or part of an internal body organ, including internally implanted breast prostheses following a covered mastectomy. The devices must be approved for general use by the Federal Food and Drug Administration (FDA).

Reconstructive Surgery

We cover inpatient and outpatient Services that:

- Will result in significant improvement in physical function, including correction of congenital defect, disease or anomaly when there will be significant improvement in physical function; or,
- Treat congenital hemangioma, known as port wine stain, on the face of Members age 18 or younger; or,
- Will correct significant disfigurement resulting from an injury or covered surgery, such as a covered mastectomy. Following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast as well as surgery and reconstruction of the other breast to produce a symmetrical appearance. Treatment of physical complications at all stages of mastectomy, including lymphedemas, is covered.

Note: Outpatient surgical procedures performed in an ambulatory surgical care center for reconstructive surgery are covered under "Outpatient Care."

Skilled Nursing Facility Services

We cover skilled inpatient Services and supplies at an approved Skilled Nursing Facility when prescribed by a Plan Physician and approved by Medical Group. The skilled inpatient Services and supplies must be Medically Necessary, customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

We cover the following Services and supplies:

- Plan Physician and nursing Services.
- Room and board.
- Medical social Services.
- Prescribed drugs as described under "Drugs and Supplies."
- Respiratory therapy.
- Short term physical, occupational, and speech therapy.
- Medical equipment ordinarily furnished by the Skilled Nursing Facility.

Your Group may have requested other benefits for Skilled Nursing Facility Services. Refer to the "Additional Information or Other Benefits Requested by Your Group" section to find out.

Transplant Services

We cover transplants of organs, tissues (including stem cell rescue) or bone marrow that are not experimental or investigational in nature if:

- Medical Group has determined that you meet certain medical criteria for patients needing transplants; and
- Medical Group provides a written Referral to an approved transplant facility. The facility may be located outside the Service Area. Transplants are covered only at a facility approved by Medical Group, even if another facility within the Service Area could perform the transplant.

Covered Services include:

- Inpatient Services as described under "Hospital Inpatient Care."
- Outpatient Services as described under "Outpatient Care."
- Reasonable transportation and lodging expenses outside of the Service Area when arranged in advance by us. Coverage will include the Member, one parent or guardian if the Member is a minor or one other person if the Member is an adult.
- Reasonable medical and hospital expenses of an organ/tissue donor which are directly related to a covered transplant for a Member are covered only if such expenses are incurred for Services within the United States or Canada. Coverage of expenses for these Services is subject to Donor Service Guidelines. To obtain a copy, contact Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired). Limitations and exclusions apply to donor Services.

Limitations and Exclusions:

- We do not assume responsibility for providing or assuring the availability of a donor or donor tissue/organs.
- Organ/tissue transplants which are experimental or investigational are not covered.
- Non-human and artificial organs and their implantation are not covered.

Urgent Care Services

Urgent care Services are Services for unexpected illness or injury that require prompt medical attention but do not meet the definition of Emergency Services.

In Our Service Area

Urgent care Services are covered and may be provided in your doctor's office or a Plan urgent care facility. Contact your PCP's office 24 hours a day if you need urgent care. Your PCP may direct you to obtain urgent care Services at a Plan urgent care facility. A list of Plan urgent care facilities can be found in the Provider Directory or on our Web site kp.org. If Plan urgent care Services are received in your doctor's office, you will pay the office visit Copayment, however, if urgent care Services are received at a Plan urgent care facility, you will pay the Plan urgent care facility Copayment, which may be different. See the Copayment chart for the Copayment that applies to Services provided in a doctor's office or Plan urgent care facility.

Exclusion:

Except as noted below, urgent care Services from non-Plan providers are not covered.

Outside of Our Service Area

Urgent care Services are also covered when you are temporarily away from the Service Area. Urgent care Services are covered when they are Medically Necessary and it is not reasonable given the circumstances to obtain the Service

Vision Services

We cover routine eye exams (eye refractions) without a Referral from Plan Optometrists designated by Health Plan to determine the need for vision correction and to provide a prescription for eyeglasses or contact lenses. However, Services, including routine eye exams, performed by a Plan Ophthalmologist require a Referral. The Copayments, if any, you must pay for these Services are listed in the "Copayments and Out-of-Pocket Maximum" section in the back of this EOC.

Exclusions:

- Corrective lenses, eyeglasses, frames, and contact lenses (including the fitting of contact lenses) are not covered.
- All Services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia or astigmatism (for example, radial keratotomy, photo-refractive keratectomy, and similar procedures) are not covered.
- Orthoptic (eye training) therapy is not covered.

- Low vision aids and Services are not covered.

Your Group may have requested other Vision benefits. Refer to the "Additional Information or Other Benefits Requested by Your Group" section to find out.

General Exclusions/Limitations/Reductions

Exclusions

With reference to all exclusions mentioned in this EOC, the word "Service" means any treatment, therapeutic or diagnostic procedure, drug, facility, equipment, device, or supply, or use of any of them. When a Service is excluded, all Services that are necessary for the excluded Service and that would otherwise be covered under this Agreement are also excluded except for Services required because of complications. Also see the "Benefits" section for exclusions and limitations listed under specific benefits. The following are **not covered** unless otherwise provided by your Group as described in the "Additional Information or Other Benefits Requested by Your Group" section following the "Copayments and Out-of-Pocket Maximum" section:

1. Services that are not Medically Necessary - for example, paternity testing, etc., are not covered.
2. Except for Emergency Services and Referral Services, Services and supplies not provided, arranged, or authorized by a Plan Physician are not covered.
3. Alternative medical Services including acupuncture, naturopathy, and massage therapy are not covered. However, massage therapy may be covered when part of a physical therapy treatment plan, ordered by a Plan Physician, and provided by a physical therapist.
4. Air casts are not covered.
5. Artificial Conception: Services, other than artificial insemination, for conception by artificial means, including, but not limited to, procedures related to pre-implantation genetic diagnosis prior to in vitro fertilization, in vitro fertilization, ovum transplants, gamete intrafallopian transfer, zygote intrafallopian transfer, all Services related to non-covered methods, drugs, donor semen, donor eggs and Services related to their procurement and storage are not covered. This exclusion applies to fertile and infertile individuals or couples.
6. Specialized behavioral modification programs to maximize a person's ability to control pain, obesity, eating disorders or other chronic conditions are not covered. However, biofeedback is covered when administered by the Mental Health Department as part of a prescribed pain management program or as part of a treatment regimen for other physical symptoms that are not responsive to usual medical treatment.
7. Blood and blood products not listed as covered in the "Benefits" section are not covered. The collection, transportation, storage, and processing of donor directed blood or blood products, are not covered. Procurement and storage of cord blood for a possible future need or for a yet to be determined Member recipient, is not covered.
8. Chiropractic Services are not covered.
9. Comfort or convenience items such as, but not limited to, telephone or television service during an inpatient stay are not covered.
10. Cosmetic Services are not covered. Plastic surgery or any other Services that are indicated primarily to change your appearance, and will not result in significant improvement in physical function, are not covered. This exclusion does not apply to "Reconstructive Surgery" described in the "Benefits" section.
11. Non-Plan Provider Services provided or arranged by criminal justice institutions for Members in the custody of law enforcement officers are not covered unless care would be covered as an Emergency Service.
12. Custodial or intermediate care is not covered. Custodial care includes assistance with activities of daily living or care that can be performed safely and effectively by people who, in order to provide care, do not require medical licenses or certificates or the presence of a supervising nurse. Other non-covered custodial or intermediate care Services include activities such as walking, bathing, getting in and out of bed, dressing, feeding, toileting, and taking medications.
13. Dental Services, including dental x-rays are not covered. Dental Services are those Services rendered in connection with the care, treatment, filling or removal or replacement of teeth or structures directly supporting the teeth. Structures supporting the teeth mean the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth, and alveolar process. Dental Services following accidental injury to teeth; dental appliances, and orthodontia are not covered. Dental Services associated with medical treatment, such as surgery and dental Services associated with radiation treatment are not covered. Dental Services for cosmetic purposes or correction of malocclusion and dental treatment of temporomandibular joint (TMJ) dysfunction syndrome are not covered. Also excluded is hospitalization for extraction of teeth or any other dental procedure, except when a Plan Physician determines there is a need for hospitalization for reasons unrelated to the dental procedure. In this case, we will cover the hospitalization, but will not cover the cost of the professional dental Services.

14. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, appliances or devices not specifically listed as covered in the "Benefits" section are not covered.
15. Experimental or investigational Services are not covered. A Service or supply is experimental or investigational if we, in consultation with Medical Group, determine that:
    a) Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question; or,
    b) It cannot be legally marketed in the United States without the approval of the Food and Drug Administration (FDA) and such approval has not been granted; or,
    c) It requires government approval that has not been obtained when the Service or supply is to be provided; or,
    d) It is the subject of a current new drug or new device application on file with the FDA; or,
    e) It is provided as part of a Phase I or Phase II clinical trial, as the experimental or research arm of a Phase III clinical trial, or in any other manner that is intended to evaluate the safety, toxicity or efficacy of the Service; or,
    f) It is provided pursuant to a written protocol or other document that lists an evaluation of the Service's safety, toxicity or efficacy as among its objectives; or,
    g) It is subject to the approval or review of an Institutional Review Board (IRB) or other body that approves or reviews research concerning the safety, toxicity or efficacy of Services; or,
    h) It is provided pursuant to informed consent documents that describe the Service as experimental or investigational, or in other terms that indicate that the Service is being evaluated for its safety, toxicity or efficacy; or,
    i) The prevailing opinion among experts is that the Service should be substantially confined to research settings or further research is necessary to determine the safety, toxicity or efficacy of the Service; or,
    j) There is no prevailing opinion among experts as expressed in the published authoritative medical, scientific or pharmaceutical literature describing that the Service is safe and effective.
16. Hypnotherapy and hypnotic anesthesia are not covered.
17. Services for military service-connected illness, injury or conditions when care from the Department of Veteran Affairs is reasonably available are not covered.
18. Routine foot care Services that are not Medically Necessary are not covered.
19. All Services related to sexual reassignment are not covered.
20. Services that are the financial responsibility of an employer or Services that a government agency is required by law to provide are not covered.
21. Services are not covered for any illness, injury or condition, to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as "Financial Benefit"), is provided or payable under any workers' compensation or employer's liability law. We will provide Services in Plan operated facilities even if it is unclear whether you are entitled to a Financial Benefit, but we may recover Eligible Charges for any such Services from the following sources:
    a) Any source providing a Financial Benefit or from whom a Financial Benefit is due; or,
    b) 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.
22. Travel and lodging expenses are not covered, except that in some situations, if a Plan Physician refers you to a non-Plan Provider outside our Service Area as described under "Getting a Referral" in the "How to Obtain Services" section , we may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines.
23. Services to patients who are seeking Services for other than therapeutic purposes or who are not responsive to therapeutic management are not covered.
24. Testing for ability, aptitude, intelligence or interest is not covered.
25. Care, as a condition of probation, parole or any other third party or court order is not covered unless a Plan Physician determines such Services to be Medically Necessary and appropriate.
26. Services provided by a Residential Treatment Center are not covered. This includes specialized behavioral programs in for eating disorders.

Limitations

We will use our best efforts to provide or arrange for our Members' health care needs in the event of unusual circumstances that delay or render impractical the provision of Services and supplies under this EOC, such as major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor disputes not involving Health Plan or Medical Group. However, Health Plan, Medical Group, and Medical Group Physicians will not have any liability for any delay or failure in providing covered Services and supplies. In the case of a labor dispute involving Health Plan or Medical Group, we may provide alternative care until the dispute is resolved.

Reductions

Coordination of Benefits (COB)

Coordination of benefits is the procedure used to pay health care expenses when a person is covered by more than one plan. The Services covered under this EOC are subject to coordination of benefits (COB) rules. If you have health care coverage with another health plan or insurance company, we will coordinate benefits with the other coverage under the COB rules of the State of Ohio. The objective is to make sure the combined payments of all plans are no more than your actual bills. The COB rules determine which coverage pays first, or is "primary," and which coverage pays second, or is "secondary." The secondary coverage may take into account the payment made by the primary coverage when determining payment. You must give us any information we request to help us coordinate benefits.

You must submit all bills to the primary plan first. The primary plan must pay its full benefits as if you had no other coverage. If the primary plan denies the claim or does not pay the full bill, you may then submit the balance to the secondary plan for consideration. Health Plan pays for care only when you follow our rules and procedures. Coordination of benefits does not change how you receive your Health Plan benefits. You must still receive covered Services (except for certain Emergency Services), directly from or through Plan Physicians. If our rules conflict with those of another plan, it may not be possible to receive benefits from both plans. If you have any questions about COB, please call Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired).

Plans That Do Not Coordinate

Kaiser Permanente will pay benefits without regard to benefits paid by the following kinds of coverage:

1. Individual (not group) policies or contracts.
2. Medicaid.
3. Group hospital indemnity plans which pay less than $100 per day.
4. School accident coverage.
5. Some supplemental sickness and accident policies. Health Plan will pay as primary when the other policy is a supplemental sickness and accident insurance policy to which all of the following apply:
   - The policy covers a specified disease or a limited plan of coverage and;
   - The policy is specifically designed, advertised, represented, and sold as a supplement to other basic sickness and accident insurance coverage and;
   - The entire premium for the policy is paid by the insured, their family, or their guardian.

How Kaiser Permanente Pays as Primary Plan

When we are primary, we will pay the full benefit allowed by your contract as if you had no other coverage.

How Kaiser Permanente Pays as Secondary Plan

When we are secondary, our payments will be based on the balance left after the primary plan has paid. We will pay no more than that balance. In no event will we pay more than we would have paid had we been primary. We will pay only for health care expenses that are covered by Kaiser Permanente. We will pay only if you have followed all of our procedural requirements.

We will pay no more than the "allowable expenses" for the health care involved. If our allowable expense is lower than the primary plan's, we will use the primary plan's allowable expense. That may be less than the actual bill.

Which Plan Is Primary?

To decide which plan is primary, we have to consider both the coordination provisions of the other plan and which member of your family is involved in a claim. The Primary Plan will be determined by the first of the following which applies:

1. Non-coordinating Plan. If you have another group plan which does not coordinate benefits, it will always be primary.
2. Employee. The plan which covers you as an employee (neither laid off nor retired) is always primary.
3. Children (Parents Divorced or Separated). If the court decree makes one parent responsible for health care expenses, that parent's plan is primary. If the court decree gives joint custody and does not mention health care, we follow the "Birthday Rule." If neither of those rules applies, the order will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.
4. Children and the "Birthday Rule." When your children's health care expenses are involved, we follow the "Birthday Rule." The plan of the parent with the first birthday in a calendar year is always primary for the children. If your

birthday is in January and your Spouse's birthday is in March, your plan will be primary for all of your children. However, if your Spouse's plan has some other coordination rule (for example, a "gender rule" which says the father's plan is always primary), we will follow the rules of that plan.

5. Other Situations. For all other situations not described above, the order of benefits will be determined in accordance with the Ohio Insurance Department rule on Coordination of Benefits.

Coordination Disputes
If you believe that we have not paid a claim properly, you should first attempt to resolve the problem by contacting Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired). If you are still not satisfied, you may call the Ohio Department of Insurance at 614-644-2673 or 1-800-686-1526 for instructions on filing a consumer Complaint.

Injuries or Illnesses Alleged To Be Caused By Third Parties
Where a Member has benefits paid by Health Plan for the treatment of sickness or injury caused by a third party, there are conditional payments that must be reimbursed by the Member if the Member receives compensation, damages or other payment as a result of the sickness or injury from any person, organization or insurer, including a Member's own insurer and any uninsured and/or underinsured motorist insurance. Health Plan may subrogate to the Member's rights of recovery. Health Plan has reimbursement and subrogation rights equal to the value of medical benefits paid for covered Services provided to the Member. Health Plan's reimbursement and subrogation rights are a first priority lien claim on any proceeds of any judgment or settlement the Member obtains against a third party organization or person. Such proceeds must be applied to pay Health Plan's lien claim before any other claims, including claims by the Member for damages (with the exception of claims by the Member pursuant to the property damage provisions of any insurance policy). This means the Member must reimburse Health Plan, in an amount not to exceed the total recovery, even when the Member's settlement or judgment is for less than the Member's total damages and must be paid without any reductions for attorneys' fees.

Surrogacy Arrangements
A surrogacy arrangement is one in which you agree to become pregnant and to surrender the baby to another person or persons who intend to raise the child. If you receive covered Services through us related to conception, pregnancy or delivery in connection with a surrogacy arrangement (Surrogacy Health Services) you must pay us the lesser of the compensation you are entitled to receive under the surrogacy arrangement or the Eligible Charges for the covered Surrogacy Health Services rendered.

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or your chosen payee under the surrogacy arrangement. To secure our rights, we will also have a lien on those payments to the extent of health care services provided by or paid for by Health Plan. Those payments shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

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

Patient Accounting
Kaiser Foundation Health Plan of Ohio
P.O. Box 5388
Cleveland, Ohio 44101

You must complete and send us all consents, releases, authorizations, assignments, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy Arrangements" section and to satisfy those rights. You must not take any action prejudicial to our rights.

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

Getting Assistance, Claims and Appeals Procedure, and Dispute Resolution

Getting Assistance

Customer Relations can answer questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain your Health Plan benefits, how to make your first medical appointment, what to do if you move, what to do if you need care while you are traveling, and how to replace an ID card. These representatives can also help you if you need to file a claim or to initiate a Grievance for an unresolved problem or initiate an appeal for denial of payment or Services.

We want you to be satisfied with your health care. Call Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired).

Claims and Appeals Procedure

Claims and Internal Appeals. Health Plan will review claims and appeals that you make for Services or payment, and we may use medical experts to help us review claims and appeals.

A **claim**, as used in this section, is a request for us to provide a Service or pay for a Service that you have already received. You or your health care provider may make a claim. Depending on your situation, your physician or other health care provider may ask us whether we will authorize or pay for a Service for you. If you want to make a claim, you may follow the procedures described below.

An **appeal** is a request for a reconsideration of our decision when we have decided not to provide or pay for all or part of a Service in your claim. You or someone you appoint can make an appeal. If you would like to appoint someone to act as your authorized representative to make an appeal for you, you must provide us with a signed dated statement telling us whom you authorize to act on your behalf.

If your health benefits are provided through an "ERISA" covered employer Group, you can file a demand for civil action under ERISA § 502(a)(1)(B) but you must meet any deadlines and exhaust the claims and internal appeals procedures before you can do so. If you are not sure if your Group is an "ERISA" Group, or you would like more information about your ERISA rights, you should contact your employer. We do not charge you for claims or appeals, but you must bear the cost of anyone you hire to represent or help you. If you miss a deadline for making a claim or appeal, we may decline to review it.

There are several types of claims and appeals, each of which has a different procedure described below:

- Pre-Service Claims and Appeals (Urgent and Non-Urgent)
- Concurrent Care Claims and Appeals
- Post-Service Claims and Appeals

- **Pre-Service Claims and Appeals**. Pre-service claims are requests that Health Plan provide or pay for a Service that you have not yet received. We will decide whether your claim or appeal is urgent or non-urgent. A claim or appeal is urgent only if using the procedure for non-urgent claims or appeals (a) could seriously jeopardize your life, health, or ability to regain maximum function, or (b) would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without the Services you are requesting. If you receive any of the Services you are requesting before we make our decision, your pre-service claim or appeal will become a post-service claim or appeal with respect to those Services. If you have any general questions about pre-service claims or appeals, please call Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired).

  NON-URGENT CLAIM - Procedure for making a non-urgent pre-service claim.

  1. Tell us that you want to make a claim for Health Plan to provide or pay for a Service you have not yet received. Your written or oral request and any related documents you give us constitute your claim. You may call Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-–6677 – TTY for the hearing/speech

impaired) or mail a letter to: Customer Relations, Kaiser Foundation Health Plan of Ohio, P.O. Box 5309, Cleveland, Ohio 44101.

2. We will review your claim, and if we have all the information we need we will make a decision within two (2) business days. We will notify you and your provider via phone, fax, or in writing with our decision within three (3) business days of making our decision. If we tell you we need more time and ask you for more information, we will ask you for the information within two (2) business days of receipt of your request. We will make a decision within two (2) business days of receiving the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after our request, we will make a decision based on the information we have within two (2) business days and notify you and your provider of our decision via phone, fax, or in writing within three (3) business days after making the decision.

3. If we deny your claim (if we do not agree to provide or pay for all the Services you requested), we will notify you of our decision in writing and we will tell you why we denied your claim, and how you can appeal.

NON-URGENT APPEAL - Procedure for appealing our denial of a non-urgent pre-service claim.

1. Within 180 days after you receive our written decision denying your claim, you or your authorized representative must tell us that you want to appeal our denial of your claim for Health Plan to provide or pay for a Service you have not yet received. Explain all of the reasons why you disagree with our denial of your claim, and include all supporting documents. Your signed written request and the supporting documents constitute your appeal. You may call the Appeals Unit at 440-846-2882 or 1-888-479-5333 (440-846-2883 or 1-888-479-5371 – TTY for the hearing/speech impaired) or mail a letter to: Appeals Unit, Kaiser Foundation Health Plan of Ohio, P.O. Box 93764, Cleveland, Ohio 44101-5764.

2. We will review your appeal and send you a written decision within 30 days after we receive your appeal.

3. If we deny your appeal, our written decision will tell you why we denied your appeal, and will include further options that may be available to you.

URGENT CLAIM - Procedure for making an urgent pre-service claim.

1. Tell us that you want to make an urgent claim for Health Plan to provide or pay for a Service you have not yet received. Your written or oral request and any related documents you give us constitute your claim. You may call Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired) or mail a letter to: Customer Relations, Kaiser Foundation Health Plan of Ohio, P.O. Box 5309, Cleveland, Ohio 44101.

2. If we determine that your claim is not urgent, we may treat your claim as non-urgent.

3. We will review your claim, and if we have all the information we need we will notify you of our decision orally or in writing within a time frame appropriate to your clinical condition but not more than 72 hours after we receive your claim. If we notify you orally, we will send you written confirmation of our decision within three (3) calendar days after that. Within 24 hours after we receive your claim, we may ask you for more information. If we do not receive the requested information (including documents) within 48 hours after our request, we will notify you of our decision orally or in writing within 48 hours after that. If we notify you orally, we will send you written confirmation of our decision within three (3) calendar days after that.

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

URGENT APPEAL - Procedure for appealing our denial of an urgent pre-service claim.

1. You or your authorized representative must tell us that you want to appeal our denial of your urgent claim for Health Plan to provide or pay for a Service you have not yet received. Explain all of the reasons why you disagree with our denial of your claim, and include all supporting documents. Your written or oral request and the supporting documents constitute your appeal. You may call the Appeals Unit at 440-846-2882 or

1-888-479-5333 (440-846-2883 or 1-888-479-5371 – TTY for the hearing/speech impaired) or mail a letter to: Appeals Unit, Kaiser Foundation Health Plan of Ohio, P.O. Box 93764, Cleveland, Ohio 44101-5764.

2. If we determine that your appeal is not urgent, we may treat your appeal as non-urgent.

3. We will review your appeal and notify you of our decision orally or in writing as expeditiously as your clinical conditions requires, but no more than 72 hours after we received your appeal request. If we notify you orally, we will send you a written confirmation of our decision within three (3) calendar days after that.

4. If we deny your appeal, our written decision will tell you why we denied your appeal, and will include further options that may be available to you.

- **Concurrent Care Claims and Appeals.** Concurrent care claims are requests that Health Plan continue to approve an ongoing course of covered treatment to be provided over a period of time or number of treatments, when either (a) the course of treatment your physician prescribed will expire, or (b) your physician decides to shorten the course of treatment. If you have any general questions about concurrent care claims or appeals, please call Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired).

CLAIM - Procedure for making a concurrent care claim when your course of treatment will expire.

1. At least 24 hours before the expiration of the course of treatment, tell us that you want to make a concurrent care claim for Health Plan to continue to approve the course of treatment that is expiring. Your written or oral request and any related documents you give us constitute your claim. You may call Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired), or mail a letter to: Customer Relations, Kaiser Foundation Health Plan of Ohio, P.O. Box 5309, Cleveland, Ohio 44101.

2. We will review your claim and notify you of our decision orally or in writing within 24 hours after we receive your claim. If we notify you orally, we will send you a written confirmation of our decision within three (3) calendar days after receipt of your claim.

3. If we deny your claim (if we do not agree to continue approval of all the Services you requested), our written decision will tell you why we denied your claim, and how you can appeal.

APPEAL - Procedure for appealing our denial of a concurrent care claim when your course of treatment will expire.

1. You or your authorized representative must tell us that you want to appeal our denial of your concurrent care claim for Health Plan to continue to approve a course of treatment that is expiring. Explain all of the reasons why you disagree with our denial of your claim, and include all supporting documents. Your written or oral request and the supporting documents constitute your appeal. If we do not receive your appeal within 48 hours after you receive our written decision denying your claim, we may treat your appeal as non-urgent. You may call the Appeals Unit at 440-846-2882 or 1-888-479-5333 (440-846-2883 or 1-888-479-5371 – TTY for the hearing/speech impaired) or mail a letter to: Appeals Unit, Kaiser Foundation Health Plan of Ohio, P.O. Box 93764, Cleveland, Ohio 44101-5764.

2. We will review your appeal and notify you of our decision orally or in writing within 72 hours after we receive your appeal. If we notify you orally, we will send you a written decision within three (3) calendar days after that.

3. If we deny your appeal, our written decision will tell you why we denied your appeal, and will include further options that may be available to you.

APPEAL - Procedure for appealing your physician's decision to shorten your course of treatment.

1. If you receive a written decision from Health Plan that says that your physician has decided to shorten your course of treatment, you or your authorized representative must tell us that you want to appeal the decision. Explain all of the reasons why you disagree with your physician's decision to shorten your course of treatment, and include all supporting documents. Your written or oral request and the supporting documents constitute your

appeal. You may call the Appeals Unit at 440-846-2882 or 1-888-479-5333 (440-846-2883 or 1-888-479-5371 – TTY for the hearing/speech impaired) or mail a letter to: Appeals Unit, Kaiser Foundation Health Plan of Ohio, P.O. Box 93764, Cleveland, Ohio 44101-5764.

2. We will review your appeal and notify you of our decision orally or in writing within 72 hours after we receive your appeal. If we notify you orally, we will send you a written decision within three (3) calendar days after that.

3. If we deny your appeal, our written decision will tell you why we denied your appeal, and will include further options that may be available to you.

- **Post-Service Claims and Appeals.** Post-service claims are requests for payment for Services you already received, including claims for Out-of-Plan Emergency Services. If you have any general questions about post-service claims or appeals, please call Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired).

CLAIM - Procedure for making a post-service claim.

1. Within one (1) year from the date of Service, mail us a letter explaining the Services, the date you received them, where you received them, who provided them, and why you think we should pay for them. Include a copy of the bill and any supporting documents. Your letter and the related documents constitute your claim. Mail your claim to: Kaiser Permanente, P.O. Box 5316, Cleveland, Ohio 44101-9774. Claims received from you or the health care provider after one (1) year from the date of Service will not be accepted.

2. We will review your claim, and if we have all the information we need we will send you a written decision within 30 calendar days after we receive your claim. If we tell you we need more time and ask you for more information, we will send you a written decision within 15 days after we receive the first piece of information (including documents) we requested. We encourage you to send all the requested information at one time, so that we will be able to consider it all when we make our decision. If we do not receive any of the requested information (including documents) within 45 days after our request, we will make a decision based on the information we have and send you a written decision within 15 days after the end of the 45 days.

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

APPEAL - Procedure for appealing our denial of a post-service claim.

1. Within 180 days after you receive our written decision denying your claim, you or your authorized representative must tell us that you want to appeal our denial of your claim for Health Plan to pay for a Service you already received. Explain all of the reasons why you disagree with our denial of your claim, and include all supporting documents. Your signed written request and the supporting documents constitute your appeal. You may call the Appeals Unit at 440-846-2882 or 1-888-479-5333 (440-846-2883 or 1-888-479-5371 – TTY for the hearing/speech impaired) or mail a letter to: Appeals Unit, Kaiser Foundation Health Plan of Ohio, P.O. Box 93764, Cleveland, Ohio 44101-5764.

2. We will review your appeal and send you a written decision within 60 days after we receive your appeal.

3. If we deny your appeal, our written decision will tell you why we denied your appeal, and will include further options that may be available to you.

External Appeals. After you have exhausted the internal appeal process, and the Plan continues to deny the Service, you may request a review from another source. The Appeals Unit will inform you in writing of your right to this review. The Appeals Unit will facilitate the external review process by arranging the evaluation, forwarding pertinent information, and communicating with you. You may appeal denials for any reason listed below:

- **Decisions Made Because Services Are Not Covered.** If you continue to believe that the item or Service constitutes a covered benefit, you may direct further correspondence to:

The State of Ohio Department of Insurance
2100 Stella Court, Columbus, Ohio 43215-1067
Attn: Consumer Services Division
1-800-686-1526 or 614-644-2673

If the Department determines that the Service is not a covered benefit, we do not have to pay for the Service. If the Department determines that the Service is a covered benefit, we must either pay for the Service or give you an opportunity for a review by an independent review organization (IRO). There may be occasions when the Department directs cases involving benefit interpretations back to us for referral to the IRO due to medical necessity issues.

- **Decisions Made Because Services Are Not Medically Necessary.** When the denial is based on medical necessity, the Appeals Unit will inform you of the right to request an external, independent review. Should you wish to pursue such a review, you must contact the Appeals Unit within 60 days of the notice. You will need to specify whether you are requesting a standard or expedited appeal. For standard appeals, you must also submit certification from the provider that the cost of the denied Service(s) is at least $500.00. The IRO will review your medical records and determine if the recommended Service is Medically Necessary. If the IRO determines that the Service is Medically Necessary, the Plan must pay for the Service according to the terms of this Evidence of Coverage. If the IRO determines that the Service is not Medically Necessary, the Plan does not have to pay for the Service.

- **Decisions Made Because Services Are Experimental.** Should your request involve a determination that the care represents an experimental or investigational Service, you must meet the following criteria before you may proceed to external review:

    1. You have a terminal condition for which, according to the current diagnosis made by your PCP, there is a high probability of causing death within two (2) years.
    2. You must request an external review not later than 60 days after receipt of the results of internal review.
    3. Your PCP certifies that you have the condition described in number (1) above and any of the following situations are applicable:
        - Standard therapies have not been effective in improving your condition.
        - Standard therapies are not medically appropriate for you.
        - There is no standard therapy covered by us that will benefit you more than the therapy requested by either you or your PCP.
    4. Your PCP has recommended a drug, device, procedure or therapy that he/she certifies in writing is likely to be more beneficial than standard therapies or you have requested a therapy that has been found in a preponderance of peer-reviewed published studies to be associated with effective clinical outcomes for the same condition.
    5. You have exhausted all internal appeals.
    6. The drug, device, procedure or other therapy for which coverage has been denied would be a covered benefit if it were not considered experimental or investigational.

The standard timeframe for response from the IRO is 30 days. Expedited requests must be answered within seven (7) days. We are bound by the decisions made by the IRO and, when favorable, will provide or pay for the Service. Health Plan will also pay the fees associated with this external review process.

Dispute Resolution

We want you to be satisfied with our Services, our Facilities, and our Physicians. Customer Relations receives compliments about our medical Services or administrative procedures. If you are dissatisfied for any reason, please let us know by either calling Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired) or submitting your written Complaints or Grievances to the attention of:

Customer Relations
Kaiser Foundation Health Plan of Ohio
PO Box 5309
Cleveland, Ohio 44101

You or your authorized representative must sign all Complaints/Grievances. An authorized representative may be any person you authorize in writing to act on your behalf.

All Complaints/Grievances are reviewed by an objective third party, up to and including the President of Kaiser Foundation

Health Plan of Ohio or the President and Medical Director of the Ohio Permanente Medical Group. Customer Relations will acknowledge and respond to formal written Grievances in writing within 30 days. You will be notified if additional time is required.

Termination of Membership

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

Your Group is required to inform the Subscriber of the date your coverage terminates. If your membership terminates, all rights to benefits end at 11:59 p.m. on the termination date. In addition, Dependents' memberships end at the same time the Subscriber's membership ends. You will be financially responsible for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further responsibility under this EOC after your membership terminates, except as provided for inpatient confinement in a hospital.

Members who are hospitalized on the date of termination may continue coverage until the earliest occurrence of any of the following: 1) discharge from the hospital; 2) determination by the Member's attending physician that inpatient care is no longer Medically Necessary; 3) reaching the limits of contractual benefits; 4) effective date of any new coverage.

Termination Due to Loss of Eligibility

If you meet the eligibility requirements described under "Who Is Eligible" in the "Eligibility and Enrollment" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership terminates on the last day of that month unless your Group has an agreement with us to terminate at a time other than on the last day of the month. Please check with your Group's benefits administrator to confirm your termination date.

Termination of Group Agreement

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

Termination for Cause

We may terminate the memberships of the Subscriber and all Dependents or the offending Dependent by sending written notice to the Subscriber at least 15 days before the termination if anyone in the Family Unit:

- Is disruptive, unruly, or abusive to the extent that the ability of Health Plan or a Plan Provider to provide Services to you, or to other Members, is seriously impaired.
- Knowingly (1) misrepresents membership status; (2) presents an invalid or altered prescription or physician order; (3) misuses (or lets someone else misuse) a Member ID card; or (4) commits any other type of fraud or misrepresentation in connection with membership.
- Knowingly furnishes incorrect or incomplete information to us or fails to notify us of changes in family status or Medicare coverage that may affect eligibility or benefits.

Member fraud may be reported to the appropriate authorities for prosecution.

Termination for Nonpayment

Nonpayment of Premium

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

Failure of Contribution or Participation Requirements by Employer Groups

We may terminate this Agreement upon written notice to your Group if the Group fails to adhere to our contribution or participation requirements.

Termination for Moving to Another Kaiser Foundation Health Plan or Allied Plan Service Area

You must notify us immediately if you permanently move outside the Service Area. If you move to another Kaiser Foundation Health Plan or allied plan service area, you should contact your Group's benefits administrator before you move to learn about your Group health care options. You will be terminated from this Plan, but you may be able to transfer your

Group membership if there is an arrangement with your Group in the new service area. However, eligibility requirements, benefits, Premiums, and Copayments may not be the same in the other service area.

Termination for Movement Outside the Service Area

If you move outside of the Service Area after you are a Member, you must notify us immediately and your membership will be terminated. If you are a reservist, see "Continuation of Coverage for Reservists" later in this section for more information.

We may terminate this agreement upon 30 days written notice to Group if no eligible person lives within the Service Area.

Termination for Noncompliance with Medicare Membership Requirements

For Members eligible for Medicare as primary coverage, Premiums are based on the assumption that Health Plan or its designee will receive Medicare payments for Medicare-covered Services provided to Members eligible for benefits under Medicare Part A and B (or Part B only). If you are or become eligible for Medicare as primary coverage, you must comply with all of the following requirements:

- Enroll in all parts of Medicare for which you are eligible and continue that enrollment while a Member; and
- Be enrolled through your Group in a Kaiser Permanente Medicare Plus plan; and
- Complete and submit all documents necessary for Health Plan, or any provider from whom you receive Services covered by Health Plan, to obtain Medicare payments for Medicare-covered Services provided to you.

If you do not comply with all of the above requirements for any reason, even if you are unable to enroll in a Kaiser Permanente Medicare Plus plan because you do not meet the plan's eligibility requirements or the plan is not available through your Group, we may increase your Group's Premium. If your Group fails to pay the increase in Premium for your Family Unit then we may terminate the memberships of everyone in your Family Unit.

Discontinuation of a Product or All Products

We may discontinue offering a particular product or all products in a market, as permitted by law. If we discontinue offering in a market the product described in this EOC, we will give 90 days prior written notice to your Group. If we discontinue offering all products to groups in a market, we will give 180 days prior written notice to the Group.

Continuation of Group Coverage Under Federal Law (COBRA)

You may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal COBRA law. Please contact your Group if you want to know how to elect COBRA coverage or how much you will have to pay your Group for it.

Continuation of Group Coverage Under State Law

You may be eligible to continue coverage under Ohio law. This continuation of coverage is available only if the Subscriber meets all of the following criteria:

- The Subscriber is entitled, at the time of the termination of employment, to unemployment compensation benefits.
- The Subscriber is not eligible for coverage by Medicare.
- The Subscriber is not eligible for other group medical coverage.
- The Subscriber has been a Member for at least three (3) consecutive months immediately before termination of employment.

To continue coverage, you must contact your Group for additional information. This coverage terminates on the earliest of the following occurrences:

- Six (6) months after the Subscriber's coverage would have otherwise terminated because of termination of employment.
- The date the Subscriber becomes eligible for Medicare coverage.
- The date the Subscriber becomes eligible for other group medical coverage.
- The date the Group contract with us ends.
- The date the Subscriber no longer meets eligibility requirements.
- Nonpayment of Premiums, contributions Copayments or other supplemental payments.

Continuation of Coverage for Reservists

Ohio law provides continuation of coverage for military reservists who are called to active duty and their enrolled Dependents. Coverage may be continued for 18 months after the date on which the coverage would otherwise terminate because the reservist is ordered to active duty. This can extend up to 36 months of coverage if any of the following occur within the 18-month period:

- Extension due to death of the reservist.
- Extension due to divorce or separation of the reservist from the reservist's Spouse.
- Extension for an enrolled child Dependent who loses eligibility as a Dependent under the terms of this plan.

Coverage terminates on the earliest of the following dates.

- You become covered under another group contract that does not contain preexisting conditions.
- You have exhausted the time limits for eligibility under this provision.
- The date the Group contract with us ends.

Contact your Group for additional information. All other eligibility and payment provisions apply.

USERRA (Uniformed Services Employment and Reemployment Rights Act)

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this EOC for a limited time after you would otherwise lose eligibility, if required by the federal USERRA law. You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group if you want to know how to elect USERRA coverage or how much you will have to pay your Group for it.

Conversion of Membership

You may be eligible to convert to a non-group Conversion plan or join another Kaiser Permanente plan if you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Eligibility and Enrollment" section, or if you enroll in COBRA or USERRA continuation coverage and then lose eligibility for that COBRA or USERRA coverage. However, you may not convert to a non-group plan if:

- You continue to be eligible for coverage through your Group.
- Your membership ends because our Agreement with your Group terminates.
- You do not reside in the Service Area except, that the Subscriber's or the Subscriber's Spouse's otherwise eligible children who live outside our Service Area may be eligible if (1) they are attending an accredited college or accredited vocational school, or (2) you are required to cover them pursuant to a Qualified Medical Child Support Order (QMCSO).
- We terminated your membership under "Termination for Cause" in this "Termination of Membership" section.

You must apply to convert your membership within 30 days after your Group or Health Plan notifies you that your coverage ends. During this period, no medical review is required, and your non-group coverage begins when your Group coverage ends. You will have to pay Premiums and the benefits and Copayments under the non-group coverage may differ from those under this EOC.

For information about converting your membership or about other non-group plans, call Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired).

Federally Eligible Individual

This is an individual who meets the following specified conditions:

- Has at least 18 months of "creditable coverage," the most recent of which was under a group health plan, a governmental plan, or a church plan (or health insurance coverage offered in connection with such a plan); and
- Is not eligible for coverage under another group health plan, Medicare, or Medicaid and does not have any other health insurance coverage; and
- Their most recent coverage was not terminated because of fraud or nonpayment of Premiums; and
- Either was not offered continuation coverage under the Consolidated Omnibus Budget Reconciliation Act of 1985 (COBRA) or a similar state program, or if COBRA or similar state-mandated continuation coverage was offered, elected and exhausted such continuation coverage.

The individual may be eligible for conversion to one of the following:

- Our "HIPAA Basic Plan," for federally eligible individuals, established by the Board of Directors of the Ohio Health Reinsurance Program; or,
- Our "HIPAA Standard Plan," for federally eligible individuals, also established by the Board of Directors of the Ohio Health Reinsurance Program.

Application must be made within 63 days of losing the current Group coverage. Copayments, benefits, and Premiums may differ under these plans from those currently provided under Group coverage. For more information regarding these options, please call Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired).

Miscellaneous Provisions

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

Advance Directives
You have the right to make decisions about your health care. You can put your wishes in writing as an advance directive. Ohio law recognizes Living Wills in which you write what medical care you would want to receive or refuse if you become unable to make health care decisions for yourself. You may also use a Durable Power of Attorney for Health Care, to name someone to make health care decisions for you if you are unable to do so. If you would like an informational packet about Advance Directives you may call Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired).

Agreement Binding on Members
By electing coverage or accepting benefits under this EOC, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this EOC.

Amendment of Agreement
Your Group's Agreement with us will change periodically. If these changes affect this EOC, your Group is required to make revised materials available to you.

Applications and Statements
You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this EOC.

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

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

Certificate of Creditable Coverage
Creditable coverage gives an individual credit for past health coverage. The certificate of creditable coverage is intended to establish an individual's prior creditable coverage for purposes of reducing the extent to which a plan or issuer offering health coverage in the group market can apply a pre-existing condition exclusion. To be eligible for creditable coverage an individual cannot have a break in coverage of 63 days or more. We or your Group will send you a certificate to cover you and your eligible Family Dependents when your coverage ends with us, when your COBRA or other continuation of coverage begins and ends with us, and other times upon your request.

Contracts With Plan Providers

Health Plan and Plan Providers are independent contractors. If you would like further information about the way Plan Physicians are paid to provide or arrange medical and hospital care for Members, please call Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired).

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may be liable for the cost of non-covered Services or Services you obtain from non-Plan Providers. If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered care you receive from that provider, in excess of any applicable Copayments, until we make arrangements for the Services to be provided by another Plan Provider and so notify the Subscriber.

Collection Costs

Copayments (and other charges, for example, for non-covered Services) are due when you receive Services. An administrative fee may be charged if any amount you owe is not paid at the time of Service. This administrative fee does not apply to Emergency Services or Copayments that are calculated on a percentage of the cost of a Service. If we are required to enforce a lien on a settlement or judgment in order to recover costs for Medical Services you received, you must reimburse us for the reasonable costs of collection, including any attorneys' fees.

Governing Law

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

Group and Members not Health Plan's Agents

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

Named Fiduciary

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

New Technology Assessment

When a new medical technology or procedure needs review, our Inter-regional New Technology Committee examines and evaluates data from government agencies, medical experts, medical journals, and medical specialty societies. Recommendations from this Inter-regional Committee then are passed on to the local Committee. The Committee reviews the national recommendations to see how they apply to local medical practices. Once this review takes place, the Committee makes recommendations for the new technology or procedure to become a covered benefit. In addition, the Committee communicates practice guidelines to Plan Providers and related health care providers. If the Committee's recommendation is accepted, the new technology is added to the covered benefits, either immediately or when this contract renews.

No Waiver

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

Nondiscrimination

We do not discriminate in our employment practices or in the delivery of health care services on the basis of age, race, color, national origin, religion, sex, sexual orientation, or physical or mental disability. If you would like more information contact Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired).

Notices

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired) as soon as possible to give us their new address.

All notices sent to us must be sent by U.S. Mail and addressed to:

Kaiser Foundation Health Plan of Ohio
PO Box 5309
Cleveland, Ohio 44101

Overpayment Recovery

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

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting providers to protect your PHI. PHI is health information that includes your name, social security number, or other information that reveals who you are. You may generally see and receive copies of your PHI, request corrections or updates to your PHI, and ask us for an accounting of certain disclosures of your PHI.

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

This is only a brief summary of some of our key privacy practices. To request a copy of our "Notice of Privacy Practices," please call 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired).

Definitions

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

Affiliated Physician/Provider: A physician or allied professional in the community who has entered into an agreement with the Ohio Permanente Medical Group to provide covered Services to our Members.

Complaint: A verbal or written expression of dissatisfaction from a Member.

Copayment: A specified dollar amount or percentage of covered expenses (coinsurance) that you must pay when you receive a covered Service as listed in the "Copayments and Out-of-Pocket Maximum" section.

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

Eligible Charges: (1) For Services that Health Plan or Medical Group provides and for Services for which any other Plan Provider is compensated on a capitated basis, the applicable KP Rate for the particular Service which may include administrative costs; (2) for items covered under "Drugs and Supplies" and obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if the Member's benefit plan did not cover the item. This amount is based on 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; or (3) for all other Services, the payments that Kaiser Permanente made for the Services or, if Kaiser Permanente subtracts a Copayment from its payment, the amount Kaiser Permanente would have paid if it did not subtract the Copayment.

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

Grievance: A Complaint with a request for a health care service and/or payment, prior to a denial letter being issued.

Health Plan: Kaiser Foundation Health Plan of Ohio.

Kaiser Permanente: Kaiser Foundation Health Plan of Ohio; Ohio Permanente Medical Group, Inc.

KP Rate: The amount from our schedule of charges that is used to calculate your Eligible Charges for Services including Services that Health Plan or Medical Group provides and for which any other Plan Provider is compensated on a capitated basis.

Medical Group: Ohio Permanente Medical Group, Inc.

Medically Necessary: Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; are not mainly for the convenience of you or your doctor; and, their omission would adversely affect your health.

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

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

Plan: Kaiser Foundation Health Plan of Ohio.

Plan Facility: A Plan Medical Office, Plan Hospital, or a medical office of an Affiliate Physician. Please refer to the Provider Directory for the types of covered Services available from each Plan Facility.

Plan Hospital: Any hospital with which we contract to provide specific Services for Members in our Service Area when provided or authorized by a Plan Physician. For a listing of hospitals we contract with to provide Service for you, please see the Provider Directory.

Plan Medical Office: Any outpatient treatment facility staffed by Ohio Permanente Medical Group Physicians.

Plan Pharmacy: Any pharmacy located at a Plan Facility or another pharmacy that we designate.

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

Plan Provider: A Plan Hospital, Plan Physician, or other health care provider that contracts to provide Services to Members (but not including providers who contract only to provide referral Services).

Premiums: Periodic membership charges paid by your Group.
Service Area: Our Service Area includes the following counties in the state of Ohio: Cuyahoga, Geauga, Lake, Lorain, Medina, Portage, Stark, Summit and Wayne. This may include contiguous counties if purchased by the Group. Refer to the "Additional Information or Other Benefits Requested by Your Group" section to find out.

Services: Health care services or items.

Skilled Nursing Facility: A facility that is an institution that provides primarily 24 hour a day licensed inpatient skilled nursing care or skilled rehabilitation Services, has in effect a transfer agreement with one or more hospitals, is licensed under the State of Ohio, certified by Medicare, and approved by Health Plan. The term "Skilled Nursing Facility" does not include a facility that furnishes primarily custodial care, including training in routines of daily living.

Spouse: Your legal husband or wife.

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

Appendix

Member Rights and Responsibilities

You are our partner in your health care. Your participation in decisions about your health care and your willingness to communicate with your physician (practitioner) and other health care professionals help us to provide you appropriate and effective health care. As an adult Member, you can exercise these rights yourself. If you are a minor or if you become incapable of making decisions about your health care, these rights will be exercised by the person having legal responsibility for participating in decisions concerning your medical care.

You have the right to...

- **Receive information about Kaiser Permanente, its services**, the practitioners and providers who provide your health care and your rights and responsibilities as a Kaiser Permanente Member.
- **Be assured of privacy and confidentiality.** You have the right to be treated with respect and recognition of your dignity and need for privacy. Kaiser Permanente will not release your medical information without your authorization, except as required or permitted by law. You have the right to review and receive copies of your medical records, unless the law restricts our ability to make them available.
- **Participate with practitioners in your health care** and receive the medical information you need to make health care decisions. We will try to make this information as understandable as possible. You have the right to have ethical issues that arise in connection with your health care reviewed. You have the right to accept or refuse a recommended treatment. Emergencies or other circumstances occasionally may limit your participation in a treatment decision. In general, however, you will not receive any medical treatment before you or your legal representative gives consent. You are entitled to an interpreter if you need one.
- **Have a candid discussion of appropriate or Medically Necessary treatment options for your condition,** regardless of cost or benefit coverage.
- **Use customer satisfaction resources.** We welcome your questions and comments about Kaiser Permanente, our services, the practitioners and other health care professionals providing your care, and your rights and responsibilities. You have the right to voice Complaints, or file appeals, without concern that your care will be affected. You have the right to know about the Complaints, Grievances and appeals procedures. In order to assist you, the Customer Relations staff is available to answer your questions and resolve problems.
- **Make recommendations** regarding Kaiser Permanente's Members' rights and responsibilities policies.
- **Express your wishes concerning future care in an advance directive.** You have the right to choose a person to make medical decisions for you if you are unable to do so. Your choices regarding your future care may be expressed in such documents as a durable power of attorney for health care or a living will. You should inform your family and practitioner of your wishes, and give them any documents that describe your choices regarding future care.
- **Have impartial access to medically indicated treatment that is a covered benefit,** regardless of your race, religion, gender, sexual orientation, national origin, cultural background, disability, or financial status. You have the right to access emergency health care services for conditions of sufficient severity that a prudent layperson could expect the absence of immediate medical attention to result in serious jeopardy to your health, or serious impairment or dysfunction of bodily functions.
- **Have a safe, secure, clean, and accessible health care environment.**
- **Participate in physician selection.** You have the right to select a physician with an open practice as your primary care practitioner and to change your primary care practitioner at a future date. You have the right to a second opinion by a Kaiser Permanente practitioner. You have the right to consult with a non-Kaiser Permanente practitioner at your own expense.
- **Receive relevant information and education that helps ensure your safety in the course of treatment.**
- **Receive information about the outcomes of care** you have received, including unanticipated outcomes.
- **Make Complaints** and receive a summary of information on the appeals and Grievances other Members have filed in the past.

- **Have prescriptions fulfilled timely** or within a reasonable period of time.
- **Receive information** about drug coverage and costs.

You have the responsibility to...

- **Provide accurate and complete information** about your present and past medical conditions (to the extent possible) that the organization, its practitioners, and providers need in order to provide care. You should report unexpected changes in your condition to your practitioner.
- **Follow the treatment plan to which you and your health care practitioner agree.** You should inform your practitioner if you do not clearly understand your treatment plan and what is expected of you. If you believe you cannot follow through with your treatment, you are responsible for telling your practitioner.
- **Understand your health problems** and participate in developing mutually agreed-upon treatment goals to the degree possible.
- **Know the extent and limitations of your health care benefits**. An explanation of these is contained in your Evidence of Coverage.
- **Identify yourself with your Member ID card.** You are responsible for your membership card, for using it only as appropriate, and for ensuring that other people do not use your card.
- **Keep scheduled appointments or cancel**, in a timely manner, any appointments you are unable to keep. You are responsible for promptly canceling any appointment that you don't need or cannot keep.
- **Provide accurate and complete information** regarding your current address, your eligibility status, the eligibility status of your Dependents and coverage or payments for health services available to you from other sources.
- **Recognize the effect of your lifestyle on your health.** Your health depends not just on care provided by Kaiser Permanente, but also on the decisions you make in your daily life.
- **Be considerate of others.** You should respect other people and their property as well as the people and property of Kaiser Permanente.
- **Fulfill financial obligations.** You should pay on time any money you owe Kaiser Permanente.

Utilization Review

Utilization review, which is performed by our Medical Management Department, is a process used to monitor the use of, or evaluate the clinical necessity, appropriateness, efficacy or efficiency of health care services, procedures or settings. Utilization review exists to assist you in receiving appropriate covered medical care. Utilization review takes place whether you receive your covered medical care from Plan Providers, Affiliated Providers or as the result of a Referral or a covered Emergency Service. As part of our utilization review, we use review criteria that are based on sound clinical evidence. These criteria are evaluated periodically to assure ongoing efficacy. Qualified registered nurses and Plan Physicians perform utilization review. The review team insures that clinical review criteria are consistently applied. The team also measures and evaluates the clinical appropriateness of adverse determinations that are subject to the appeal process. Individuals responsible for utilization management decisions do not receive any financial incentive or additional compensation for such decisions.

Pre-Service Review
Pre-service review is utilization review conducted before health care services are provided to a Member.

Concurrent Review
Concurrent review is utilization review conducted during a patient's hospital stay, Skilled Nursing Facility or any other ongoing course of treatment.

Post-Service Review
Post-service review is utilization review conducted after health care services have been provided to a Member.

Note: If we deny a pre-service request for covered, Medically Necessary medical care, or if during the course of a concurrent review we deny further inpatient or outpatient treatment, the provider, with the Member's consent, may request a reconsideration of the denied Services. We will reconsider the denied Services within three (3) working days (or less depending on the seriousness of your medical condition) after our receipt of the request for reconsideration. If our decision is to uphold the initial denial, you or the provider, on your behalf, with your signed authorization or representation, may appeal the denial of requested Services in writing. See the "Getting Assistance, Claims and Appeals Procedure and Dispute Resolution" section for ways to appeal.

Note: You or your authorized representative may submit an appeal if we fail to make and communicate a determination within the timeframes for pre-service, concurrent or post-service review. Failure by us to make a determination and notification within the timeframes stated in the Claims and Appeals Procedure will be considered to be a denial for the purpose of initiating an appeal.

If you have questions about our utilization review procedures please contact Customer Relations at 216-621-7100 or 1-800-686-7100 (1-877-676-6677 – TTY for the hearing/speech impaired).

Small Group Waiting Periods

We do not impose a waiting period. Your Small Group may have a waiting period. This waiting period may not exceed 90 days.

When Medicare Is Primary and Secondary

Persons for Whom Medicare Is Primary
The monthly membership charge for our coverage is based on the assumption that we will receive payment from Medicare for services provided to Members entitled to Medicare benefits. Persons eligible for Medicare benefits must submit to us all consents, releases, authorizations, and other documents necessary for us to obtain Medicare reimbursement. Any Member who fails to do so must pay for services, or, at our discretion, a surcharge will be applied to his or her membership charges.

There are a number of categories of Members for whom Medicare coverage is primary, meaning that Medicare pays for covered Services before we do, and that our benefits are secondary to any benefits to which the Member is entitled under Medicare. Therefore, references to Medicare in this EOC apply to the following categories of Members for whom Medicare is primary over us.

1. Medicare is primary for Subscribers who work for employers of 19 or fewer employees and who, or whose Spouses, qualify for Medicare due to reaching age 65.
2. Medicare is primary for Members who qualify for Medicare solely due to end stage renal disease. Medicare becomes primary over us only after the first 30 consecutive months of a regular course of renal dialysis after Medicare entitlement; or after 36 consecutive months after a kidney transplant.
3. Medicare is primary for Subscribers who work for employers of 99 or fewer employees and who, or whose Dependents, qualify for Medicare because of disability.
4. Medicare is primary for retirees who qualify for Medicare. Check with your Group to see if retiree coverage is available to you.

Persons for Whom Medicare Is Secondary
Medicare is secondary for Subscribers who work for employers of 20 or more employees, and who, or whose Spouses, qualify for Medicare due to reaching age 65. Federal law applicable to employers of 20 or more employees requires that their Medicare-eligible employees age 65 and over decide (for both self and Medicare-eligible Spouse) either (a) to continue the employer-sponsored group health benefits coverage or (b) to select Medicare as primary coverage. (When the employee is under 65 and the Spouse is age 65 or over, this decision must be made for the Spouse alone.) If the employee decides to continue the employer-sponsored group health coverage, then our coverage is provided on the same basis as for Group Members under 65. Such Health Plan coverage would be "primary," meaning that we pay for covered Services before Medicare does. In such cases, Medicare benefits are secondary to any benefits to which the Member is entitled to as a Health Plan Member. If the employee selects Medicare as primary, the employee and Spouse cease to be covered by the employer-sponsored health benefits coverage, including Health Plan. Federal law applicable to employers of 100 or more employees requires that the employer-sponsored group health benefits coverage is primary over Medicare for employees or their Dependents that qualify for Medicare due to disability. This means that we pay for covered Services before Medicare does,

and that Medicare benefits are secondary to any benefits to which the Member is entitled as a Health Plan Member. Therefore, references to Medicare in this EOC do not apply to any such Member who selects Health Plan coverage to be primary over Medicare or a disabled Member for whom we are primary over Medicare.

Copayments and Out-of-Pocket Maximum

This section discusses:

- The Copayments you are responsible for paying.
- Benefit maximums including dollar, visit or time period maximums.
- Dependent age limit.
- Dependent student age limit.
- Out-of-Pocket Maximum limit.

This section does not describe benefits. To learn what is covered for each benefit (including exclusions and limitations), please refer to the identical heading in the "Benefits" section. Be sure to check the next section, "Additional Information or Other Benefits Requested by Your Group," for additional benefits not described in the "Benefits" or "Copayments and Out-of-Pocket Maximum" sections.

Note: There are no lifetime limits on Basic Health Care Services.

Note: We reserve the right to reschedule non-urgent care if you do not pay the Copayment at the time of your visit.

Copayments

Copayments are due at the time of your visit. Copayments calculated on a percentage are based on the Eligible Charges for the covered Services. Refer to the definition of Eligible Charges shown in the "Definitions" section of this EOC.

A Copayment for Basic Health Care Service will not exceed 40% of the average cost of the Service. The average cost of a Service is calculated by dividing the Eligible Charges by the total number of the Services paid by Kaiser Permanente.

Annual Out-of-Pocket Maximum

There are limits to the total amount of Copayments you must pay in a contract year for certain Services covered under this EOC. Copayments for Basic Health Care Services cannot exceed 200% of the average annual Premium rate to the Subscriber or enrollees. The single Out-of-Pocket Maximum applies separately to each Member in your Family Unit. If the family Out-of-Pocket Maximum shown in the Copayment chart is satisfied by Members in your Family Unit, then the Out-of-Pocket Maximum will be considered to have been reached for all Members in your Family Unit and no further Copayments will be due during the contract year for Services for which Copayments are applied toward the Out-of-Pocket Maximum. We recommend that you also keep your receipts for Services received for tracking your Out-of-Pocket Maximum limits. The limits are listed in the chart that follows. Copayments for Basic Health Care Services apply toward these limits. The Copayment chart identifies Basic Health Care Services with an asterisk (*). Copayments for other covered Services that apply toward the Out-of-Pocket Maximum include:

- Inpatient and Outpatient Chemical Dependency Services.
- Home Health.
- Other Mental Health Illnesses (limited to 20 outpatient visits).
- Outpatient Physical, Occupational, and Speech Therapy, and Multidisciplinary Rehabilitation.
- Prosthetic Devices (Internally Implanted).

KAISER PERMANENTE®

2008 MEDICARE PLUS

GROUP

Evidence of Coverage

D

KAISER PERMANENTE MEDICARE PLUS

EVIDENCE OF COVERAGE (EOC):

Your Medicare Health Benefits and Services/Prescription Drug Coverage as a Member of Kaiser Foundation Health Plan of Ohio's Medicare Plus Group Plan

This booklet gives the details about your Medicare health and prescription drug coverage and explains how to get the care you need. This booklet is an important legal document. Please keep it in a safe place.

Kaiser Foundation Health Plan of Ohio Customer Relations:

For help or information, please call Customer Relations at either of the following numbers:

Call: 1-800-493-6004. TTY/TDD for the hearing/speech impaired: 1-866-513-9966. Customer Relations hours are seven (7) days a week, 8:00 a.m. to 8:00 p.m.

Notice: If you or your family members are covered by more than one health care plan, you may not be able to collect benefits from both plans. Each plan may require you to follow its rules or use specific doctors and Hospitals, and it may be impossible to comply with both plans at the same time. Read all of the rules very carefully, including the "Using all of your insurance coverage" sub-section of Section 6, and compare them with the rules of any other plan that covers you or your family.

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Section 1 Introduction

Contact Information

Telephone numbers and other information for reference

How to contact Kaiser Permanente Customer Relations.

If you have any questions or concerns, please call or write to Kaiser Permanente Customer Relations. We will be happy to help you. You may call 8:00 a.m. to 8:00 p.m., seven (7) days a week.

CALL 1-800-493-6004. (Calls to this number are free.)

TTY/TDD 1-866-513-9966. This number requires special telephone equipment. (Calls to this number are free.)

FAX (216) 635-4453. Attention: Kaiser Permanente Customer Relations.

WRITE Customer Relations
Kaiser Permanente
P.O. Box 5309
Cleveland, OH 44101-0309

Contact Information for Grievances, Organization Determinations, Coverage Determinations and Appeals.

For Organization Determinations and Grievances for Medical Service Benefits

CALL 1-800-493-6004. (Calls to this number are free.)

TTY/TDD 1-866-513-9966. This number requires special telephone equipment. (Calls to this number are free.)

FAX (216) 635-4453. Attention: Kaiser Permanente Customer Relations.

WRITE Kaiser Permanente
7th Floor
14600 Detroit Road
Lakewood, OH 44107

For information about Organization Determinations for Medical Service Benefits, see Section 10.
For information about Grievances for Medical Service Benefits, see Section 9.

For Medicare Part D Coverage Determinations and Grievances

CALL (216) 265-4408 or 1-877-265-4408. (Calls to this number are free.)

TTY/TDD 1-866-513-9966. This number requires special telephone equipment. (Calls to this number are free.)

FAX (216) 265-4415 or 1-877-265-4415 Attention: Pharmacy Utilization Management Department.

WRITE Pharmacy Utilization Management Department
Kaiser Permanente
12301 Snow Road
Parma, OH 44130

For information about Medicare Part D Grievances, see Section 9.
For information about Medicare Part D Coverage Determinations, see Section 11.

For Medical Service Benefits and Medicare Part D Appeals

CALL (440) 846-2882 or 1-888-479-5333.

TTY/TDD (440) 846-2883 or 1-888-479-5371. This number requires special telephone equipment.

FAX (440) 846-2884 (Attention: Kaiser Permanente Appeals Unit).

WRITE Appeals Unit
Kaiser Permanente
P.O. Box 93764
Cleveland, OH 44101-5764

For information about Appeals for Medical Service Benefits, see Section 10.
For information about Medicare Part D Appeals, see Section 11.

Ohio Senior Health Insurance Information Program OSHIP or SHIP – A state program that provides free local health insurance counseling to people with Medicare.

SHIP stands for State Health Insurance Assistance Program. The Ohio Senior Health Insurance Information Program (OSHIP) is a state organization paid by the federal government to give free health insurance counseling to people with Medicare. OSHIP can explain your Medicare rights and protections, help you make complaints about care or treatment, and help straighten out problems with Medicare bills. OSHIP has information about Medicare Advantage Plans, Medicare Prescription Drugs Plans, Medicare Cost Plans, and about Medigap (Medicare supplement insurance) policies. This includes information about whether to drop your Medigap policy while enrolled in a Medicare Advantage Plan. This also includes special Medigap rights for people who

disenroll from a Medigap plan when they enroll in a Medicare Cost Plan (like Kaiser Permanente Medicare Plus) for the first time, but then leave the Medicare Cost Plan within 12 months and then wish to buy another Medigap policy. (Section 3 has more information about Medigap related to prescription drug coverage.)

You can contact OSHIP at 1-800-686-1578 (or, for the hearing/speech impaired, the TTY/TDD is (614) 752-0740; this number requires special telephone equipment). You can also find the Web site for OSHIP at www.medicare.gov on the web. Under "Search Tools," select "Helpful Phone Numbers and Web sites."

KEPRO/Quality Improvement Organization (Called a QIO) – A group of doctors and health professionals in your state who review medical care and handle certain types of complaints from patients with Medicare.

QIO stands for Quality Improvement Organization. There is a QIO in each state. QIOs have different names, depending on which state they are in. In Ohio, the QIO is called KEPRO. KEPRO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. The doctors and other health experts in KEPRO review certain types of complaints made by Medicare patients. These include complaints about quality of care and Appeals or complaints from Medicare patients who think the coverage for their Hospital, Skilled Nursing Facility, Home Health Agency, or Comprehensive Outpatient Rehabilitation Facility stay is ending too soon. See Sections 9 and 10 for more information about complaints, Appeals and Grievances.

You can contact KEPRO at:

KEPRO
Rock Run Center
Suite 100
5700 Lombardo Center Drive
Seven Hills, OH 44131
Phone: 1-800-589-7337
FAX: (216) 447-7925
Hours of Operation: Monday through Friday, 8:00 a.m. to 3:00 p.m.

How to contact the Medicare program and the 1-800-MEDICARE (TTY/TDD 1-877-486-2048) helpline.

Medicare is the federal health insurance program for people age 65 or older, under age 65 with certain disabilities, and any age with permanent kidney failure (called End Stage Renal Disease or ESRD). The Centers for Medicare & Medicaid Services (CMS) is the federal agency in charge of the Medicare program. CMS contracts with and regulates Medicare health plans (including Kaiser Foundation Health Plan of Ohio).

Here are ways to get help and information about Medicare from CMS:

- Call Medicare at 1-800-MEDICARE (1-800-633-4227) to ask questions or get free information booklets from Medicare. TTY/TDD users should call 1-877-486-2048. Customer services representatives are available 24 hours a day, including weekends. Calls to these numbers are free.

- Use a computer to look at www.medicare.gov, the official government Web site for Medicare information. This Web site gives you a lot of up-to-date information about Medicare and nursing homes. It includes booklets you can print directly from your computer. It has tools to help you compare Medicare Managed Care Plans and Medicare Prescription Drug Plans in your area. You can also search under "Search Tools" for Medicare contacts in your state. Select "Helpful Phone Numbers and Web sites." If you do not have a computer, your local library or senior center may be able to help you visit this Web site using its computer.

Other organizations (including Medicaid, Social Security Administration, and the Railroad Retirement Board).

Medicaid agency – A state government agency that handles health care programs for people with limited resources.
Medicaid helps with medical costs for some people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid also has programs that can help pay for your Medicare premiums and other costs, if you qualify. To find out more about Medicaid and its programs, call: 1-800-324-8680 (or 1-800-292-3572 - TTY/TDD for the hearing/speech impaired; this number requires special telephone equipment).

Social Security.
Social Security programs include retirement benefits, disability benefits, family benefits, survivors' benefits, and benefits for the aged and blind. You can call the Social Security Administration at 1-800-772-1213. TTY/TDD users should call 1-800-325-0778. You can also visit **www.ssa.gov** on the Web.

Railroad Retirement Board.
If you get benefits from the Railroad Retirement Board, you can call your local Railroad Retirement Board office or 1-800-808-0772 (calls to this number are free). TTY/TDD users should call (312)-751-4701. You can also visit **www.rrb.gov** on the Web.

Employer (or "Group") Coverage
If you or your Spouse get your benefits from your current or former employer or union, or from your Spouse's current or former employer or union, call your employer's or union's benefits administrator or Customer Relations if you have any questions about your employer/union benefits, Plan Premiums, or the open enrollment season. Important Note: You (or your Spouse's) employer/union benefits may change, or you or your Spouse may lose the benefits, if you or your Spouse enrolls in Medicare Part D. Call your employer's or union's benefits administrator or Customer Relations to find out whether the benefits will change or be terminated if you or your Spouse enrolls in Medicare Part D.

Welcome to Kaiser Permanente Medicare Plus!

We are pleased that you've chosen Medicare Plus.

Medicare Plus is a Medicare Cost Plan for people with Medicare.

Now that you are enrolled in Medicare Plus, you are getting your health care, including prescription drugs through Kaiser Foundation Health Plan of Ohio. Medicare Plus, a Medicare Cost Plan, is offered by Kaiser Foundation Health Plan of Ohio (Kaiser Permanente). Medicare Plus is not a Medigap or Medicare supplement insurance policy.

This Evidence of Coverage (EOC), together with your enrollment form and any amendments that we may send to you, is our contract with you. It explains your rights, benefits, and responsibilities as a Member of Medicare Plus. It also explains our responsibilities to you. The information in this EOC is in effect for the time period from January 1, 2008, through December 31, 2008. If you are enrolled in Kaiser Permanente Medicare Plus through your employer, your contract effective date may be different. Kaiser Permanente contracts on a Calendar Year basis with the Centers for Medicare and Medicaid Services (CMS) to offer Kaiser Permanente Medicare Plus. CMS may change benefits, cost sharing, Part D coverage levels, or other aspects of the Medicare program that impact this Evidence of Coverage (EOC). When CMS makes such changes, they are usually effective on January 1st. Therefore you will receive an EOC in January and again when your Group renews during the Calendar Year.

You are still covered by Original Medicare, but you are getting your Medicare services as a Member of Medicare Plus. This EOC gives you the details, including:

- What is covered by Medicare Plus and what is not covered.
- How to get the care you need or prescriptions filled, including some rules you must follow.
- What you will have to pay when you get care or prescriptions.
- What to do if you are unhappy about something related to getting your Covered Services or prescriptions filled.
- How to leave Medicare Plus, and other Medicare options that are available.

Throughout the remainder of this Evidence of Coverage, we refer to Kaiser Permanente as "Plan" or "our Plan." Other capitalized terms also have special meaning in the Evidence of Coverage. Please see Section 14 for terms you should know. If you need this EOC in a different format (such as in large print), please call us so we can send you a copy.

To be a Member of our Plan, you must live in our Service Area and either be entitled to Medicare Part A and enrolled in Medicare Part B or be enrolled in Medicare Part B only. If you currently pay a premium for Medicare Part A and/or Medicare Part B, you must continue paying your premium in order to keep your Medicare Part A and/or Medicare Part B and to remain a Member of this plan.

In most cases, use your Plan identification card instead of your red, white, and blue Medicare card.

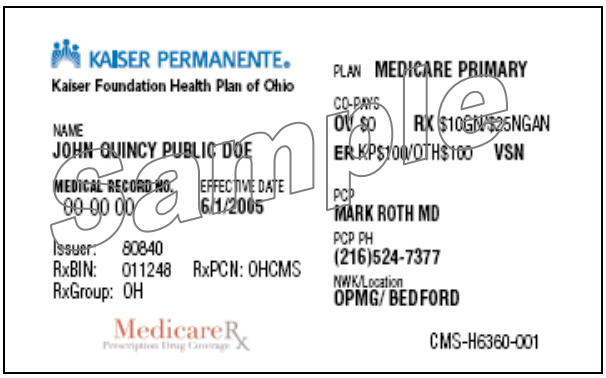
Now that you are a Member of Medicare Plus, you have a Kaiser Permanente identification card.

While you are a Plan Member and using Plan services, you must use your Plan identification card instead of your red, white, and blue Medicare card to get Covered Services and prescription drugs. (See Section 4 for information on Covered Services and Section 5 for information on prescription drug coverage.) Keep your red, white, and blue Medicare card in a safe place in case you are asked to show it, but you will not use it to get Covered Services while you are a Member. If you get Covered Services using your red, white, and blue Medicare card instead of your Kaiser Permanente identification card while you are a Plan Member, you may have to pay Original Medicare cost sharing amounts for your care.

Please carry your Kaiser Permanente identification card with you at all times. You will need to show this card when you get Covered Services. You will also need it to get your prescriptions at the pharmacy. If your identification card is ever damaged, lost, or stolen, call Customer Relations right away, and we will send you a new card. Contact information is located at the beginning of this section.

Here is a sample card to show you what it looks like:

Front



Back

Use your red, white and blue Medicare card when you want to receive services not covered by Medicare Plus from non-Plan Providers (except for Emergency or out-of-area Urgently Needed Services). Some Plan Providers may also ask to see your red, white and blue Medicare card.

The Provider Directory gives you a list of Plan Providers.
Every year as long as you are a Member of Medicare Plus, we will send you a Provider Directory, which gives you a list of Plan Providers. Medical services are provided to Medicare Plus Members through the Ohio Permanente Medical Group and other Affiliated Providers, Plan Facilities and Affiliated Pharmacies. You can ask Customer Relations for more information about Plan Providers, including their professional qualifications such as medical school attended, residency completed and board certification status and experience.

If you need a copy of the Provider Directory, you can access the information by doing one of the following:

1. You can call Customer Relations to have the most recent printed copy of the Provider Directory sent to you or to verify availability of various Plan Providers. Contact Customer Relations and a Provider Directory will be mailed to your home. See the beginning of this section for contact information, or

2. You can access our Web site at www.kp.org to obtain the most updated list of our Plan Providers. You can also view, print or download a PDF of the most recent printed copy of the Provider Directory.

The Pharmacy Directory gives you a list of Plan Pharmacies.
As a Member of Medicare Plus we will send you a complete Pharmacy Directory, which gives you a list of our Plan Pharmacies, every year. You can use it to find the Plan Pharmacy closest to you. If you don't have the Pharmacy Directory, you can get a copy from Customer Relations. They can also give you the most up-to-date information about changes in Plan Pharmacies. In addition, you can find this information on our Web site. Contact information is located at the beginning of this section.

Explanation of Benefits

What is the Explanation of Benefits?
The Explanation of Benefits is a document you will get each month you use your prescription drug coverage. It will tell you the total amount you have spent on your prescription drugs and the total amount we have paid for your drugs. You will get your Explanation of Benefits in the mail each month that you use the benefits that we provide. You will not get an Explanation of Benefits if you don't use any benefits that month.

What information is included in the Explanation of Benefits?
Your Explanation of Benefits will contain the following information:

- A list of prescriptions you filled during the month, as well as the amount paid for each prescription.
- Information about how to request an Exception and Appeal our coverage decisions.
- A description of changes to the Formulary affecting the prescriptions you filled that will occur at least 60 days in the future.
- A summary of your coverage for the current year, including information about the total out-of-pocket costs that count towards Catastrophic Coverage. This is the total amount you and/or others have spent on prescription drugs that count towards you qualifying for Catastrophic Coverage. This total includes the amounts spent for your Copayments and payments made on covered Medicare Part D Drugs after you reach the initial coverage limit. (This amount does not include payments made by your current or former employer/union, another insurance plan or policy, a government-funded health program or other excluded parties.)

What should you do if you did not get an Explanation of Benefits or if you wish to request one?
An Explanation of Benefits is also available upon request. To get a copy, please contact Customer Relations.

Help us keep your membership record up to date.

Kaiser Permanente has a file of information about you as a Plan Member. Doctors, Hospitals, and other Plan Providers use this membership record to know what services are covered for you. The membership record has information from your enrollment form, including your address and telephone number. It shows your specific Medicare Plus plan coverage and the Primary Care Physician you chose. Section 7 tells how we protect the privacy of your personal health information.

Please help us keep your membership record up to date by letting Customer Relations know right away if there are any changes in your name, address, or phone number, or if you go into a nursing home. Also, tell Customer Relations about any changes in health insurance coverage you have from other sources, such as from your employer, your Spouse's employer, workers' compensation, Medicaid, or liability claims such as claims against another driver in an automobile accident. See Section 1 for how to contact Customer Relations.

The geographic Service Area for Kaiser Permanente Medicare Plus.

The counties in our Service Area are listed below. You are generally eligible for coverage as long as you reside in one of these counties.

- Cuyahoga
- Geauga
- Lake
- Lorain
- Medina
- Portage
- Summit

Section 2 Eligibility, Enrollment, and Effective Date

Who is Eligible to Enroll in Medicare Plus?

Medicare Eligibility.
As a Medicare beneficiary you are generally eligible to enroll in Medicare Plus if:

- You are enrolled in Medicare Part B (see definition in Section 14) as of the effective date of enrollment in Medicare Plus; or,
- You are enrolled in Medicare Part B and entitled to Medicare Part A, or you purchase Medicare Part A from Social Security or the Railroad Retirement System, or you purchase an Equivalent Medicare Part A Benefit from us; and,
- You are enrolled in Medicare Part D as of the effective date of enrollment in Medicare Plus; and,
- You permanently reside in our Service Area, which consists of Cuyahoga, Geauga, Lake, Lorain, Medina, Summit, and Portage counties; or,
- You are a current Member who resides outside our Service Area; are newly entitled to Medicare Part A and/or newly enrolled in Medicare Part B and Medicare Part D.

You are not normally eligible to enroll in Medicare Plus if you have end-stage renal disease (ESRD) - that is, permanent kidney failure, which requires regular kidney dialysis or a transplant to maintain life. However, if you were already a Kaiser Permanente non-Medicare Member when you developed ESRD, and continue to live within the Kaiser Permanente Medicare-approved Service Area, you can enroll in a Medicare Plus Plan offered by Kaiser Permanente. If you are a Medicare Plus Member when you develop ESRD, you cannot be Disenrolled from Medicare Plus for that reason.

Group Eligibility.
Medicare must be primary for enrollment as a Subscriber or Dependent in this Medicare Plus Group Plan.

When entitlement is due to age, Medicare is primary for:

- Active employees, who are employed by Groups with less than 20 employees, and their Spouses.

When entitlement is due to disability, Medicare is primary for:

- Active employees, who are employed by Groups with less than 100 employees, and their Spouses and Dependents.

When entitlement is solely due to end stage renal disease, Medicare is primary for:

- Employees and retirees and their Spouses and Dependents 30 months after Medicare entitlement or eligibility begins.

In addition, you must meet the following Subscriber or Dependent eligibility requirements. However, your Group may have additional requirements that we have approved. Please check with your Group to confirm who is eligible to enroll.

You may be eligible to enroll as a Subscriber if you are:

- an employee of a Group who works at least the number of hours specified by your Group; or,
- a retiree of Group; or,
- entitled to coverage under a trust agreement or employment contract.

If you are a Subscriber, the following persons may be eligible to enroll in Medicare Plus as your Dependents by meeting the criteria outlined above:

- Your Spouse.
- You or your Spouse's unmarried children (including adopted children) who are under age 19 (unless changed by the Group) or if a student as defined by your Group and as approved by us.
- Other unmarried dependent persons (but not including foster children) who meet all of the following requirements:
    - they are under age 19 (unless changed by the Group), or if a student as defined by your Group and as approved by us, and
    - they receive from you or your Spouse substantially all of their support and maintenance (as defined by the IRS), and
    - they legally reside with you (the Subscriber), and
    - you or your Spouse is the court-appointed guardian (or was before the person reached age 18).

Continuation of Coverage

Dependents who meet the Dependent eligibility requirements except for the age limit may be eligible for continuation of coverage if they meet all the following requirements:

- they are incapable of self-sustaining employment because of mental retardation or physical handicap that occurred prior to reaching the age limit of Group, and
- they receive from you or your Spouse substantially all of their support and maintenance (as defined by IRS), and
- you give us proof of their incapacity and dependency within 31 days after we request it, and annually thereafter, if requested by us. This proof of incapacity may be requested after a two-year period from the date of the first proof furnished to us. Coverage terminates when the Dependent child no longer meets all of the criteria specified in this section.

Note: The limiting age for Dependents and student Dependents set by your Group can be found in the "2008 Medicare Plus Benefit Chart" in Section 15.

Any of your Dependents who are not entitled to Medicare, as described above, may enroll in another Kaiser Permanente plan offered by your Group. Please contact your Group for details.

Beneficiaries who meet the above eligibility requirements cannot be denied membership in Medicare Plus on the basis of health status.

Enrollment

Eligible individuals may enroll in Medicare Plus through the Group by completing the necessary applications within 31 days of becoming eligible. A completed Group Enrollment application and a Medicare Plus application form must be submitted in order to be processed. Individuals who are interested in joining the Medicare Plus Plan may contact their Group or to obtain information on enrollment and an enrollment kit.

If for any reason your application is rejected, we will contact you for additional information or provide instructions to follow regarding resubmission of the enrollment application.

You may not be enrolled in more than one Medicare Managed Care Plan at any given time. If you are already a member of a Medicare Managed Care Plan when you elect enrollment with a different Medicare Managed Care Plan, membership in the old plan will automatically be terminated on the effective date of your enrollment in the new Medicare Managed Care Plan. Also, check with your Group before enrolling in a Medicare prescription drug (Medicare Part D) Plan.

You may not be enrolled in more than one Medicare Part D plan at any given time. If you enroll in another Medicare Part D plan while enrolled in Medicare Plus, your Medicare Plus membership may be terminated. Check with your Group before enrolling in another Medicare Part D plan.

Open Enrollment.
You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting an enrollment application approved by us to your Group during the open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the membership effective date.

Special Enrollment Due to Newly Acquired Dependents.
You may enroll as a Subscriber (along with any eligible Dependents) and existing Subscribers may add newly eligible Dependents, by submitting an enrollment application approved by us to your Group within 31 days after a Dependent becomes newly eligible.

Note: Children born to an eligible Dependent other than the Subscriber's Spouse are not eligible for coverage unless the Subscriber or the Subscriber's Spouse adopts them or becomes their court appointed guardian.

Special Enrollment Due to Loss of Other Coverage.
You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting an enrollment application approved by us to your Group within 31 days after the enrolling persons lose other coverage, if:

- The enrolling persons had other coverage when you previously declined our coverage for them (some groups require you to have stated in writing when declining our coverage that other coverage was the reason).
- The loss of the other coverage is due to (i) exhaustion of COBRA (Consolidated Omnibus Budget Reconciliation Act of 1985) coverage, or (ii) in the case of non-COBRA coverage,

loss of eligibility or termination of employer contributions, and the loss is not due to individual nonpayment or cause.

Exception: If you are enrolling yourself as a Subscriber along with at least one eligible Dependent, it is necessary for only one of you to lose other coverage and only one of you to have had other coverage when you previously declined our coverage.

Your Group will let you know the membership effective date, which will be no later than the first day of the month following the date we receive the enrollment application.

Note: Despite the eligibility and enrollment provisions in this EOC, we may decline to accept new enrollments if a capacity limit approved by CMS is in place and we have reached that capacity limit.

When Medicare Plus Coverage Begins.

Membership begins at 12:00 a.m. on the membership effective date. If you or any eligible Dependent is confined to a hospital, skilled nursing facility, or other institution on your effective date, you must notify us immediately if you want the services covered under Medicare Plus, so that we can transfer your covered Medically Necessary care to a Plan Facility and Plan Physician at the appropriate time.

The effective date of enrollment in Medicare Plus will depend on the circumstances under which you enroll, for example: your Group's open enrollment period, or when you first become entitled to both Medicare Part A and Medicare Part B, or Medicare Part B only. Kaiser Permanente will send you a letter that tells you when your coverage begins. If for any reason CMS rejects your enrollment in Medicare Plus, you will be notified and your effective date of coverage will be void. You will remain enrolled in your previous Medicare Managed Care Plan or Original Medicare. From the effective date forward, all Covered Services must be received from Medicare Plus Affiliated Medical Providers.

If a Medicare Plus enrollee receives services from non-Affiliated Medical Providers without Pre-Authorization, except for Emergency Services or out-of-area Urgently Needed Services, we will not pay for those services. You will pay for those services under the terms and conditions of Original Medicare.

Section 3 How You Get Care and Prescription Drugs

Providers you can use to get services covered by Medicare Plus.

You must get services offered by Medicare Plus from Plan Providers. If you get Original Medicare benefits from a non-Plan Provider then you must pay the Original Medicare cost sharing amounts - except in an emergency or if the services were urgently needed. However, if you get Original Medicare services from non-Plan Providers for care that is not Emergency Care or Urgently Needed Care, you will have to pay Original Medicare Plan cost sharing amounts for the care you get.

What are Plan Providers?
"Providers" is the general term we use for doctors, other health care professionals, Hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them Plan Providers or Affiliated Providers when they participate in Kaiser Permanente Medicare Plus, that is, when we have arranged with them to coordinate or provide Covered Services to Members of Medicare Plus.

What are Covered Services?
"Covered Services" is the general term we use in this EOC to mean all of the health care services, supplies, and equipment that are covered by Medicare Plus. Covered Services are listed in Section 4.

Rules about using non-Plan Providers to get your Covered Services.

If you get Original Medicare benefits from a non-Plan Provider then you must pay the Original Medicare cost sharing amounts. We call them non-Plan Providers or non-Affiliated Providers when they are not part of Kaiser Permanente Medicare Plus.

Choosing your PCP (PCP means Primary Care Physician).

What is a PCP?
When you become a Member of Medicare Plus, you must choose a Plan Provider to be your PCP. Your PCP is a physician who meets state requirements and is trained to give you basic medical care. As we explain below, you will get your routine or basic care from your PCP. Your PCP will also coordinate the rest of the Covered Services you get as a Plan Member. For example, in order to see a Specialist, you usually need to get your PCP's approval first (this is called getting a Referral to a Specialist). Your PCP has an established relationship with a specific group of specialty care physicians with whom he or she works. By referring only to a select group of Specialists, your PCP is better able to coordinate and oversee your medical care.

"Coordinating" your services includes checking or consulting with other Plan Providers about your care and how it is going. If you need certain types of Covered Services or supplies, you must get approval in advance from your PCP (such as giving you a Referral to see a Specialist). In some cases, your PCP will need to get prior authorization (prior approval) from us. Since your PCP will provide and coordinate your medical care, you should have all of your past medical records sent to your PCP's office. Section 7 tells you how we will protect the privacy of your medical records and personal health information.

Medicare will still cover your care if you use non-Plan Providers without Pre-Authorization from us and if the care is a covered benefit under Original Medicare. However, with the exception of Emergency Care or Urgently Needed Care, you will have to pay the deductibles and other Original Medicare cost sharing amounts, rather than Medicare Plus out-of-pocket amounts.

How do you choose a PCP?
Your relationship with your PCP is an important one. When choosing your PCP, please keep in mind that your choice will determine where you will receive specialty care. Your PCP has an established relationship with a specific group of specialty care physicians with whom he or she works. By referring only to a select group of Specialists, your Primary Care Physician is better able to coordinate and oversee your medical care. If there is a particular Kaiser Permanente Specialist or Hospital that you want to use, check first to be sure your PCP makes Referrals to that Specialist, or uses that Hospital.

As part of the Medicare Plus enrollment process, you chose a PCP, using either our Provider Directory or through the kp.org Web site. If you did not choose a PCP, one was assigned to you. Your PCP's name and phone number are indicated on your Kaiser Permanente identification card. You may change your PCP at any time (see below for those instructions). If you do change your PCP, a new identification card will be mailed to you.

We contract with the Ohio Permanente Medical Group (OPMG) to provide care to our Members in the Service Area. In addition, the Ohio Permanente Medical Group has contracted with selected physicians in the community to provide Covered Services in their private offices directly to Members. Together, these Providers provide or arrange all of your non-Emergency Care. A most recent listing of these Plan and Affiliated physicians can be found in the Provider Directory. You can obtain additional copies by contacting Customer Relations. Please see Section 1 for ways to contact Customer Relations.

If you decide to see a non-Plan Provider for your primary care, you will pay for those services under the terms and conditions of Original Medicare. This means that you would be responsible for paying the Original Medicare cost sharing for those services. For example, you would pay 20% of the cost of the visit, plus any amount due toward the annual deductible, which Medicare requires.

How do you get care from your PCP?

You will usually see your PCP first for most of your routine health care needs. Call your PCP's office and request an appointment. Appointments are scheduled according to the type of medical care you are requesting. Medical conditions requiring more immediate attention are scheduled sooner. The telephone number for your PCP, as stated above, is listed on your Kaiser Permanente identification card. (If at all possible, please call your PCP at least 24 hours in advance if you are unable to keep a scheduled appointment.)

As we explain below and in Section 6, if you do not want to pay Original Medicare cost sharing amounts, there are only a few types of Covered Services you can get on your own, without contacting your PCP first.

How do you get care from doctors, Specialists and Hospitals?

When your PCP thinks that you need specialized treatment, he or she will give you a list of preferred Providers that may be contacted for an appointment and a copy of your Referral (approval in advance) to see a Plan Specialist. A Specialist is a doctor who provides health care services for a specific disease or part of the body. Examples include oncologists (who care for patients with cancer), cardiologists (who care for patients with heart conditions), and orthopedists (who care for patients with certain bone, joint, or muscle conditions). If you receive a bill from a Specialist you were referred to, simply forward it to us for payment. See pages 64 - 65 for where to send your claim.

Your PCP will order any necessary tests or treatment, and will arrange for hospitalization at a Plan Facility. If you require Covered Services not available from Affiliated Providers or Plan Facilities, your PCP will refer you to non-Affiliated Providers and/or non-Affiliated facilities for this Covered Service. Coverage for these services will be the same as if they were received from Affiliated Providers.

For some types of Referrals to Plan Specialists, your PCP may need to get approval in advance from our Medical Management Department (this is called getting Pre-Authorization). Covered Services that require Pre-Authorization are: Skilled Nursing Facility care, Durable Medical Equipment, external prosthetics & orthotics, home health services, transplant services, bariatric surgery and any services received from a non-Plan Provider.

If you do not want to pay Original Medicare cost sharing amounts, it is very important to get a Referral from your PCP before you see a Plan Specialist (there are a few exceptions that we explain later in this section). If you don't have a Referral before you receive services from a Specialist, or decide to seek services from a non-Plan Provider, you will have to pay the Original Medicare cost sharing amounts. If the Specialist wants you to come back for more care, check first to be sure that the Referral you got from your PCP for the first visit covers more visits to the Specialist.

Pre-Authorization is one tool used in resource management. Good resource management is important to ensure that we are providing you with appropriate care. Kaiser Permanente uses a process called Utilization Review. Our goal is to determine what your medical needs are, and then provide necessary and appropriate services in a suitable setting and in a timely and cost effective manner. Utilization Review takes place whether you receive your covered medical care from Plan Providers, Affiliated Providers, or as the result of a Referral or a covered Emergency Service. Qualified registered nurses and Plan Physicians perform Utilization Review. Decisions about providing these services are based on the Member's condition, medical evidence, and professional judgment. Kaiser Permanente uses nationally developed clinical criteria, Medicare guidelines, and internally developed criteria when making decisions about your care.

Kaiser Permanente performs Utilization Review in three different ways:

- Pre-service review is Utilization Review conducted before health care services are provided to a Member.
- Concurrent review is Utilization Review conducted during a Member's Hospital stay or course of treatment.

- Post-service review is Utilization Review conducted after health care services have been provided to a Member.

When providing and arranging medical care, each physician uses his or her clinical expertise to evaluate the needs of the Member. Kaiser Permanente does not offer incentives or additional compensation to physicians or others who make decisions about your care in return for denial of services. If you have questions about our utilization management procedures please contact Customer Relations. See Section 1 for ways to contact Customer Relations. See Section 10 for information on how to Appeal a decision that you do not agree with.

If there are specific Specialists you want to use, find out whether your PCP sends patients to these Specialists. Each Plan PCP has certain Plan Specialists they use for Referrals. This means that the Kaiser Permanente Specialists you can use may depend on which person you chose to be your PCP. You can change your PCP at any time if you want to see a Plan Specialist that your current PCP cannot refer you to. Later in this section, we tell you how to change your PCP. If there are specific Hospitals you want to use, find out whether your PCP or the doctors you will be seeing use these Hospitals.

Remember, you can get care from non-Plan Providers without a Referral. However, if you use non-Plan Providers for care that is not Emergency Care or Urgently Needed Care, you will have to pay Original Medicare cost sharing amounts for your care.

How can you switch to another PCP?

You may change your PCP for any reason, at any time. To change your PCP, call Member Support Services at (216) 524-5001 or 1-877-524-5001 or TTY/TDD at (216) 398-3187 or 1-877-398-3187 for the hearing and speech impaired. Special equipment is required to use these numbers. When you call, be sure to tell Member Support Services if you are seeing Specialists or getting other Covered Services that needed your PCP's approval (such as home health services and Durable Medical Equipment). Member Support Services will help make sure that you can continue with the specialty care and other services you have been getting when you change to a new PCP. They will also check to be sure the PCP you want to switch to is accepting new patients. Member Support Services will change your membership record to show the name of your new PCP, and tell you when the change to your new PCP will take effect. Generally, the transfer will become effective the first day of the month following your request.

What if your doctor leaves Kaiser Permanente?

Sometimes a PCP, Specialist, or other Plan Provider you are using might leave the Plan. If this happens, you will have to switch to another Provider who is part of Kaiser Permanente. If your PCP leaves Kaiser Permanente, we will let you know and help you switch to another PCP so that you can keep getting Covered Services.

What services can you get on your own, without a Referral (approval in advance) from your PCP?

As explained above, you will get most of your routine or basic care from your PCP, and your PCP will coordinate the rest of the Covered Services you get as a Plan Member. In most situations, if you get services from any doctor, Hospital, or other health care Provider without getting a Referral in advance from your PCP, you will have to pay the Original Medicare cost sharing amounts. But there are a few exceptions: you can get the following services on your own, without a Referral or approval in advance from your PCP. This is called "self-refer" when you get these services on your own.

You can self-refer (and use non-Plan Providers) for the following services. If you use non-Plan Providers, you will have to pay the Original Medicare cost sharing amounts. If you use Plan Providers, you will only have to pay the plan Copayments.

- Mammograms (x-rays of the breast). Mammograms are covered without a Referral from your PCP only if you get it from a Plan Provider.
- Flu shots such as influenza and pneumonia vaccinations (as long as you get them from a Plan Provider).
- Covered obstetrical or gynecological services from a Plan Provider affiliated with your PCP. If you're not sure which physicians are affiliated with your PCP, contact Customer Relations. Please see Section 1 for ways to contact Customer Relations.
- Covered mental health or chemical dependency services from a Plan Provider.
- Routine eye exams from a Plan optometrist designated by us to determine the need for vision correction and to provide a prescription for eyeglasses or contact lenses. Please note, services performed by a Plan ophthalmologist require a Referral, including routine eye exams.

You may self-refer for the following services, and will only have to pay the Plan Copayments:

- Emergency Services, whether you get these services from Plan Providers or non-Plan Providers.
- Urgently Needed Care that you get from non-Plan Providers when you are temporarily outside the Medicare Plus Service Area. (The Medicare Plus Service Area is defined in Section 1.)

Getting care when you travel or are away from the Medicare Plus Service Area.

You may get care when you are outside the Service Area. You will usually pay higher costs for the care because you will get care from non-Plan Providers and pay Original Medicare cost sharing amounts. Except for our Visiting Member Program described below, the only services that you may receive outside our Service Area without paying Original Medicare cost sharing amounts are care for a Medical Emergency, Urgently Needed Care, and care that Kaiser Permanente or a Plan Provider has approved in advance. If you have questions about what medical care is covered when you travel, please call Customer Relations at the telephone number in Section 1.

If you visit a different Kaiser Foundation Health Plan or allied plan service area temporarily (not more than 90 days), you can receive Visiting Member services from designated Providers in that area. The Covered Services and Copayments may differ from those in this Service Area and are governed by the Kaiser Permanente Program for Visiting Members. This Program does not cover certain services, such as transplants, out of area Renal Dialysis (ESRD) or infertility services. Except for out-of-Plan Emergency Services, your right to receive Covered Services in the visited service area ends after 90 days unless you receive written Pre-Authorization from us to continue receiving Covered Services in the visited service area.

See Section 1 for ways to contact Customer Relations to receive more information about our Visiting Member Program, including facility locations across the United States. You may also access our Visiting Member brochure online at www.members.kp.org. Service areas and facilities where you may obtain Visiting Member services may change at any time.

If you plan to permanently move or to be away from our Service Area for more than 90 days, we will have to Disenroll you. For more information, see Section 12.

Getting care if you have a Medical Emergency or an urgent need for care.

What is a Medical Emergency?
A Medical Emergency is when you reasonably believe that your health is in serious danger - when every second counts.

A Medical Emergency/Emergency Medical Condition is a medical condition brought on by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that not getting immediate medical attention could result in:

- serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child;
- serious impairment to bodily functions;
- serious dysfunction of any bodily organ or part.

Examples include severe pain, a bad injury, a serious illness, or a medical condition that is quickly getting much worse.

What should you do if you have a Medical Emergency?

If you have a Medical Emergency:

- Get medical help as quickly as possible. Call 911 for help or go to the nearest emergency room. You do not need to get permission first from your PCP (Primary Care Physician) or other Plan Provider.
- Make sure that Kaiser Permanente or your PCP knows about your emergency, because we will need to be involved in following up on your Emergency Care and transfer can be arranged when your medical condition is stable (depending on the distance involved). We

will decide whether to make arrangements for necessary continued hospitalization or transfer you to a designated Hospital. If you refuse to be transferred, we will not cover any services you receive after transfer would have been possible. If you request transfer to a Plan Facility when we have determined the treating facility is capable of meeting your health care needs, you may be responsible for transportation costs to the Plan Facility. You or someone else should call 1-877-676-6270 to tell Kaiser Permanente or your PCP about your Emergency Care as soon as possible, preferably within 48 hours, or as soon as reasonably possible.

Kaiser Permanente or your PCP will help manage and follow up on your Emergency Care.

When the doctors who are giving you Emergency Care say that your condition is stable and the Medical Emergency is over, to be covered under Medicare Plus, your follow up care must be provided or arranged by Kaiser Permanente or your PCP. If your Medical Emergency happens outside the Service Area, we prefer that you return to the Service Area to receive follow-up care through your PCP. Your follow-up care outside the Service Area will be covered according to Medicare guidelines.

What is covered if you have a Medical Emergency?
You can get covered Emergency Medical Care whenever you need it, anywhere in the world. See Section 3 for filling a prescription when you cannot access a Plan Pharmacy. See Section 4 for more information on receiving care outside of the country.

Ambulance services are covered in situations where other means of transportation would endanger your health.

What if it wasn't a Medical Emergency?
Sometimes it can be hard to know if you have a real 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 was not a Medical Emergency after all. If this happens to you, you are still covered for the care you got to determine what was wrong (as long as you thought your health was in serious danger, as explained in "What is a Medical Emergency?" above). However, please note that if you get additional care after the doctor says it was not a Medical Emergency, we will pay our portion of the covered additional care if you get it from a Plan Provider.

- If you get any extra care after the doctor says it wasn't a Medical Emergency, Medicare Plus will pay its portion of the covered extra care only if you get it from a Plan Provider.
- If you get any extra care from a non-Plan Provider after the doctor says it wasn't a Medical Emergency, you will normally have to pay Original Medicare cost sharing.
- Medicare Plus will pay its portion of the covered extra care from a non-Plan Provider if you are out of our Service Area, as long as the extra care you get meets the definition of Urgently Needed Care that is given below.

What is Urgently Needed Care? (This is different from a Medical Emergency.)

Urgently Needed Care (also referred to as Urgently Needed Services) is when you are temporarily out of the Service Area and you need medical attention right away for an unforeseen illness or injury, and it is not reasonable, given the situation, for you to get medical care from your PCP or other Plan Providers. In these cases, your health is not in serious danger.

What is the difference between a Medical Emergency and Urgently Needed Care?
The two main differences between Urgently Needed Care and a Medical Emergency are in the danger to your health and your location. A Medical Emergency occurs when you reasonably believe that your health is in serious danger, whether you are in or outside of the Service Area. Urgently Needed Care is when you need medical help for an unforeseen illness, injury, or condition, but your health is not in serious danger and you are generally outside of the Service Area.

How to get Urgently Needed Care?
Medicare Plus covers Urgently Needed Care that you get from non-Plan Providers when you are outside the Plan's Service Area. We will cover all Urgently Needed Care at the same cost share that applies to care received from in area Plan Providers. If you need Urgently Needed Care while you are outside the Service Area, we prefer that you call your PCP first, whenever possible. You must contact Kaiser Permanente within 48 hours, or as soon as reasonably possible, so that we can be involved in the management of your care and for services to be covered by Kaiser. If you are treated for an urgent care condition while out of the Service Area, we prefer that you return to the Service Area to get follow-up care through your PCP. However, we will cover follow-up care that you get from non-Plan Providers outside the Service Area as long as the care you are getting still meets the definition of Urgently Needed Care and the non-Plan Provider accepts Kaiser Permanente's terms and conditions of payment. See below for more information on filling your prescription drugs when you are getting Urgently Needed Care and when you are outside the Service Area.

Inside the Service Area/Urgent Care.
Urgent care services are Services for unexpected illness or injury that require prompt medical attention that do not meet the definition of Emergency Services.

Urgent care services are covered and may be provided in your doctor's office or a Plan urgent care facility. Contact your PCP's office 24 hours a day if you need urgent care. You may be directed to obtain urgent care at a Plan urgent care facility. A list of Plan urgent care facilities can be found in the Provider Directory or on our Web site kp.org. If Plan urgent care services are received in your doctor's office, you will pay the office visit Copayment, however, if urgent care services are received at a Plan urgent care facility, you will pay the Plan urgent care facility Copayment, which may be different. See the "2008 Medicare Plus Benefit Chart" in Section 15 for the Copayment that applies to Services provided in a doctor's office or Plan urgent care facility.

If you decide to see a non-Plan Provider for urgent care inside the Service Area, you will pay for those services under the terms and conditions of Original Medicare. This means that you would be responsible for paying the Original Medicare cost sharing amounts for those services. For example, you would pay 20% of the cost of the visit, plus any amount due toward the annual deductible, which Original Medicare requires.

Remember that routine or elective medical services not arranged by us are not covered under Medicare Plus. If you receive services from non-Affiliated Providers without Pre-Authorization, except for Emergency Care or out-of-area urgent care, Kaiser Permanente will not pay for those services. You will pay for those services under the terms and conditions of Original Medicare. Section 6 tells what you should do if you have bills from non-Plan Providers that you think we should pay.

Hospital care, Skilled Nursing Facility care, and other services.

How do you get Hospital care?
If you need Hospital care, we will arrange Covered Services for you. Covered Services are listed in Section 4 under the heading "Inpatient Hospital Services." We use Hospital to mean a facility that is certified by the Medicare program and licensed by the state to provide inpatient, outpatient, diagnostic, and therapeutic services. The term Hospital does not include facilities that mainly provide Custodial Care (such as convalescent nursing homes or rest homes). By Custodial Care, we mean help with bathing, dressing, using the bathroom, eating, and other activities of daily living.

What is a Benefit Period for Hospital care?
Our Plan uses Benefit Periods to determine your coverage for inpatient services during a hospital stay (generally, you are an inpatient of a hospital if you are admitted to the hospital and are receiving inpatient services in the Hospital). A Benefit Period begins on the first day you are admitted as an inpatient at a Medicare-covered inpatient Hospital or a Skilled Nursing Facility (SNF). The Benefit Period ends when you haven't been an inpatient at any Hospital or SNF for 60 days in a row. If you are admitted to the Hospital after one Benefit Period has ended, then a new Benefit Period begins. There is no limit to the number of Benefit Periods you may have. As shown in the "2008 Medicare Plus Benefits Chart" in Section 15, you must pay the inpatient Hospital Copayment for each Benefit Period.

Generally, your PCP or Referral Specialist has chosen a Hospital to refer his or her patients to. As mentioned earlier in this section, under "How do you choose a PCP?" your choice of PCP will determine where you will receive specialty care and this includes inpatient Hospital services. If there is a particular Hospital that you want to use, check first to be sure your PCP or Referral Specialist uses that Hospital.

What happens if you join or leave our Plan during a Hospital stay?
If you either join or leave Medicare Plus during an inpatient Hospital stay, special rules may apply to your coverage for the stay and to what you owe for this stay. If this situation applies to you, please call Customer Relations. They can explain how your services are covered for this stay, and what you owe to Kaiser Permanente, if anything, for the periods of your stay when you were and were not a Plan Member. See Section 1 for ways to contact Customer Relations.

What is Skilled Nursing Facility care?
Skilled Nursing Facility care means a level of care ordered by a physician that must be given or supervised by licensed health care professionals. It can be Skilled Nursing Care, or skilled Rehabilitation Services, or both. Skilled Nursing Care includes services that require the skills of a licensed nurse to perform or supervise. Skilled Rehabilitation Services include physical therapy,

speech therapy, and occupational therapy. Physical therapy includes exercise to improve the movement and strength of an area of the body, and training on how to use special equipment such as how to use a walker or get in and out of a wheel chair. Speech therapy includes exercise to regain and strengthen speech and/or swallowing skills. Occupational therapy helps you learn how to do usual daily activities such as eating and dressing by yourself.

How do you get Skilled Nursing Facility care (SNF care)?
If you need Skilled Nursing Facility care, we will arrange these services for you at a Plan Facility. Covered Services are listed in Section 4 under the heading "Inpatient Care in a Skilled Nursing Facility." The purpose of this subsection is to tell you more about some rules that apply to your Covered Services.

A Skilled Nursing Facility is a place that provides skilled nursing or skilled Rehabilitation Services. It can be a separate facility, or part of a Hospital or other health care facility. A Skilled Nursing Facility is called a SNF for short. The term Skilled Nursing Facility does not include places that mainly provide Custodial Care, such as convalescent nursing homes or rest homes.

Are Nursing Home stays that provide Custodial Care covered?
Custodial Care is care for personal needs rather than Medically Necessary needs. Custodial Care is care that can be provided by people who do not have professional skills or training. This care includes help with walking, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial Care is not covered by Medicare Plus unless it is provided as other care you are getting in addition to daily Skilled Nursing Care and/or skilled Rehabilitation Services.

What are the Benefit Period limitations on coverage of Skilled Nursing Facility care?
Inpatient Skilled Nursing Facility coverage is limited to 100 days each Benefit Period. A Benefit Period begins on the first day you go to a Medicare-covered inpatient Hospital or a Skilled Nursing Facility (SNF). The Benefit Period ends when you have not been an inpatient at any Hospital or SNF for 60 days in a row. If you go to the Hospital (or SNF) after one Benefit Period has ended, a new Benefit Period begins. There is no limit to the number of Benefit Periods you can have.

Please also note that if you are receiving Hospital or SNF services out of plan, and paying Original Medicare cost sharing amounts for the Hospital or SNF services, you will have to pay Original Medicare cost sharing amounts for other services you get while you are in the Hospital or SNF.

What are the situations when you may be able to get care in a Skilled Nursing Facility (SNF) that isn't a Plan Provider?
You may obtain SNF services from either Plan Providers or non-Plan Providers. However if you obtain SNF services from non-Plan Providers you must pay the Original Medicare cost sharing amounts.

What happens if you join or leave Medicare Plus during a Skilled Nursing Facility (SNF) stay?
If you either join or leave Medicare Plus during an inpatient Hospital or SNF stay, please call Customer Relations at the telephone number listed in Section 1. Customer Relations can explain how your services are covered for this stay, and what you owe to Kaiser Permanente, if anything, for the periods of your stay when you were and were not a Plan Member.

How do you get home health care?
Home health care is 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 Section 4 under the heading "Home Health Services." If you need home health care services, we will cover these services for you if Medicare coverage requirements are met.

When can home health care include services from a home health aide?
As long as some qualifying skilled-nursing services are also included, the home health care you get can include services from a home health aide. A home health aide doesn't have a nursing license or provide therapy. The home health aide provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises). The services from a home health aide must be part of the home care of plan for your illness or injury, and they aren't covered unless you are also getting a covered skilled nursing service. "Home Health Services" don't include the services of housekeepers, food service arrangements, or full time nursing care at home. (Home health care is also discussed in Section 4.)

What are "part-time" and "intermittent" home health care services?
If you meet the requirements given above for getting covered home health services, you may be eligible for part-time or intermittent skilled nursing services and home health aide services:

- Part-time or intermittent means your skilled nursing and home health aide services combined total less than eight hours per day and 35 or fewer hours each week.

What is Hospice care?
"Hospice" is a special way of caring for people who are terminally ill and providing counseling for their families. Hospice care is physical care and counseling that is given by a team of people who are part of a Medicare-certified public agency or private company. Depending on the situation, this care may be given in the home, a Hospice facility, a Hospital, or a nursing home. Care from a Hospice is meant to help patients who qualify for Hospice care in the last months of life by giving comfort and relief from pain. The focus is on care, not cure.

How do you get Hospice care if you are terminally ill?
As a Member of Medicare Plus, you may receive care from any Medicare-certified Hospice program. Your doctor can help you arrange for your care in a Hospice. If you are interested in using Hospice services, you can call Customer Relations at the number in Section 1 to get a list of the Medicare-certified Hospice Providers in your area. If you are enrolled in Medicare Part B only and not entitled to Medicare Part A, see Section 4 "Hospice Services" for more information. Call Customer Relations to get more information on your Hospice coverage.

How is your Hospice care paid for?
If you enroll in a Medicare-certified Hospice program, Original Medicare (rather than Medicare Plus) pays the Hospice for the Hospice services you receive. Your Hospice doctor can be a Plan Provider or a non-Plan Provider. Even if you choose to enroll in a Medicare-certified Hospice, you are still a Plan Member and will continue to get the rest of your care that is unrelated to your terminal condition through Medicare Plus. If you use non-Plan Providers for your routine care, Original

Medicare (rather than Medicare Plus) will cover your care and you will have to pay Original Medicare cost sharing amounts.

How do you get more information on Hospice care?
The Medicare program has written a booklet about "Medicare Hospice Benefits." To get a free copy, call Medicare at 1-800-MEDICARE (1-800-633-4227; 1-877-486-2048 TTY/TDD for the hearing and speech impaired). This is the national Medicare help line available 24 hours a day, 7 days a week, or visit the Medicare Web site at www.medicare.gov. Under "Search Tools," select "Find a Medicare Publication" to view or download the publication, "Medicare Hospice Benefits." Section 1 tells more about how to contact the Medicare program and about the Web site.

How to get an organ transplant if you need it?
If you need an organ transplant, we will arrange to have your case reviewed by one of the transplant centers that is approved by Medicare (some Hospitals that perform transplants are approved by Medicare, and others are not). The Kaiser Permanente and the Medicare-approved transplant center will decide whether you are a candidate for a transplant. Kaiser Permanente has designated Centers of Excellence, which are also Medicare-certified. The specific Center of Excellence is selected on a case-by-case basis, depending on the type of transplant and may be located outside the Kaiser Permanente Medicare Plus Service Area. See Section 4, "Transplant Services," for what is covered.

How can you participate in a clinical trial?
A clinical trial is a way of testing new types of medical care, like how well a new cancer drug works. Clinical trials are one of the final stages of a research that helps doctors and researchers see if a new approach works and if it is safe.

Medicare pays for routine costs if you take part in a clinical trial that meets Medicare requirements. Routine costs include costs like room and board for a Hospital stay that Medicare would pay for even if you weren't in a trial, an operation to implant an item that is being tested, and items and services to treat side effects and complications arising from the new care. Generally, Medicare will not cover the costs of experimental care, such as the drugs or devices being tested in a clinical trial.

There are certain requirements for Medicare coverage of clinical trials. If you participate as a patient in a clinical trial that meets Medicare requirements, Original Medicare pays the clinical trial doctors and other Providers for the Covered Services you receive that are related to the clinical trial. This is not a Medicare Plus benefit. When you are in a clinical trial, you may stay enrolled in Medicare Plus and continue to get the rest of your care that is unrelated to the clinical trial through Medicare Plus. You will have to pay the Original Medicare cost sharing for the clinical trial services. For instance, you will be responsible for the Medicare Part B Coinsurance, generally 20% of the Medicare-approved amount for most doctor services and most other outpatient services. However, there is no Coinsurance for Medicare-covered clinical laboratory services related to the clinical trial. The Medicare program has written a booklet that includes information on Original Medicare Coinsurance rules, called "Medicare & You." To get a free copy, call Medicare at 1-800-MEDICARE (1-800-633-4227) or visit www.medicare.gov on the Web.

You do not need to get a Referral from a Plan Provider to join a clinical trial, and the clinical trial Providers do not need to be Plan Providers. However, please be sure to tell us before you start participation in a clinical trial so that we can keep track of your health care services. When you tell

us about starting participation in a clinical trial, we can let you know what services you will get from clinical trial providers and the cost for those services. You may view or download the publication "Medicare and Clinical Trials" at www.medicare.gov on the Web. Under "Search Tools," select "Find a Medicare Publication." Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048.

How to access care in Religious Non-medical Health Care Institutions.
Care in a Medicare-certified Religious Non-medical Health Care Institution (RNHCI) is covered by Medicare Plus under certain conditions. Covered Services in a RNHCI are limited to non-religious aspects of care. To be eligible for Covered Services in a RNHCI, you must have a medical condition that would allow you to receive inpatient Hospital care, SNF or home health services and you would be an inpatient in a Hospital or SNF or receiving care through a Home Health Agency were it not for your religious beliefs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of nonexcepted medical treatment. (Excepted medical treatment is medical care or treatment that you receive involuntarily or that is required under federal, state or local law. Nonexcepted medical treatment is any other medical care or treatment.) You must also get authorization (approval) in advance from Medicare Plus or your stay in the RNHCI may not be covered.

If you have Medicare and Medicaid.
Medicare, not Medicaid, will pay for most of your prescription drugs. You will continue to get your health coverage under both Medicare and Medicaid as long as you qualify for Medicaid benefits.

If you have a Medigap (Medicare Supplement Insurance) policy with Prescription Drug Coverage

If you currently have a Medigap policy that includes coverage for prescription drugs, you must contact your Medigap issuer and tell them you have enrolled in our Plan. If you decide to keep your current Medigap policy, your Medigap issuer will remove the prescription drug coverage portion of your Medigap policy and adjust your premium.

Each year (prior to November 15), your Medigap insurance company must send you a letter explaining your options and how the removal of drug coverage from your Medigap policy will affect your premiums. If you didn't get this letter or can't find it, you have the right to get a copy from your Medigap insurance company.

If you are a member of another employer or retiree group.
If you currently have prescription drug coverage through another employer or retiree group, please contact your benefits administrator to determine how your current prescription drug coverage will work with this Plan.

Using Plan Pharmacies to get your prescription drugs covered by us.

What are Plan Pharmacies?
With few exceptions, you must use Plan Pharmacies to get your prescription drugs covered.

- **What is a Plan Pharmacy?** A Plan Pharmacy is a pharmacy where you can get your prescription drug through your prescription drug coverage (Medicare Part D). Medicare Part B drugs must also follow these rules for coverage under the Medicare Plus plan. We call them Plan Pharmacies because they contract with Kaiser Permanente. In most cases, your prescriptions are covered only if they are filled at one of our Plan Pharmacies. Once you go to one, you are not required to continue going to the same Plan Pharmacy to fill your prescription; you can go to any of our Plan Pharmacies. However, if you switch to a different Plan Pharmacy, you must either have a new prescription written by a physician or have the previous Plan Pharmacy transfer the existing prescription to the new Plan Pharmacy if any refills remain.
- **What are Covered Drugs?** Covered Drugs is the general term we use to mean all of the outpatient prescription drugs that are covered by Medicare Plus. Covered Drugs are listed in the Formulary.

How do I fill a prescription at a Plan Pharmacy?
To fill your prescription, you must show your Kaiser Permanente identification card at one of our Plan Pharmacies. If you do not have your identification card with you when you fill your prescription, you may have to pay the full cost of the prescription (rather than paying just your Copayment). If this happens, you can ask us to reimburse you for our share of the cost by submitting a claim to us. To learn how to submit a paper claim, please refer to the paper claims process described later in this section.

What if a pharmacy is no longer a Plan Pharmacy?
Sometimes a pharmacy might leave Medicare Plus. If this happens, you will have to get your prescriptions filled at another Plan Pharmacy. Please refer to your Pharmacy Directory or call Customer Relations to find another Plan Pharmacy in your area.

How do I fill a prescription through the Direct Mail Pharmacy service?
You can use the Kaiser Permanente Direct Mail Pharmacy service to fill prescriptions for any drug on the Formulary list with the exception of control II substances and all refrigerated items except insulin.

When you order prescription drugs through our Direct Mail Pharmacy service, you must order at least a 60-90 day supply depending on your Group's prescription drug benefit. Generally, it takes us 2 weeks to process your order and ship it to you. However, sometimes your Direct Mail order may be delayed. If your Direct Mail order is delayed, please contact the Kaiser Permanente Direct Mail Pharmacy service at (216) 749-8409 (877-676-6677 TTY/TDD for hearing/speech impaired) Monday through Friday between 9 a.m. and 5 p.m.

In order to receive a 60-90 day supply for the Direct Mail Copayment, you must use our Direct Mail Pharmacy. In addition, your Plan Physician must write the prescription for the appropriate quantity of medication. You can also get an extended supply through Plan Pharmacies in Kaiser Permanente medical offices or in the community, but you will pay a Copayment for each 31-day supply. Direct Mail order forms are available from any Plan Pharmacy located within a Kaiser Permanente medical office.

Filling prescriptions outside Plan Pharmacies.
Generally, we only cover drugs filled at a non-Plan Pharmacy in limited circumstances when a Plan Pharmacy is not available. Below are some circumstances when we would cover prescriptions filled at a non-Plan Pharmacy. Before you fill a prescription at a non-Plan Pharmacy, please call Customer Relations to see if there is a Plan Pharmacy available.

If you do go to a non-Plan Pharmacy for the reasons listed below, you may have to pay the full cost (rather than paying just your Copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim. You should submit a claim to us if you fill a prescription at a non-Plan Pharmacy, as any amount you pay will help you qualify for Catastrophic Coverage (see Catastrophic Coverage in Section 6).

Note: If we do pay for the drugs you get at a non-Plan Pharmacy, you may still pay more for your drugs than what you would have paid if you went to a Plan Pharmacy.

If you need a prescription because of a Medical Emergency.
We will cover prescriptions that are filled at a non-Plan Pharmacy if the prescriptions are related to care for a Medical Emergency or Urgently Needed Care. In this situation, you will have to pay the full cost (rather than paying just your Copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a paper claim. To learn how to submit a paper claim, please refer to the paper claims process described below.

Getting coverage when you travel or are away from the Medicare Plus Service Area.
If you take a prescription drug on a regular basis and you are going on a trip, be sure to check your supply of the drug before you leave. When possible, take along all the medication you will need. You may be able to order your prescription drugs ahead of time through the Direct Mail Pharmacy or through a Plan Pharmacy for the applicable Copayment.

If you are traveling outside of the Medicare Plus Service Area, and you become ill or run out of your prescription drugs, we will cover prescriptions that are filled at a non-Plan Pharmacy if you follow all other coverage rules identified within this document and a Plan Pharmacy is not available. In this situation, you will have to pay the full cost (rather than paying just your Copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim. To learn how to submit a paper claim, please refer to the paper claims process described below. Note: Prescriptions drugs prescribed and provided outside of the United States and its territories as part of covered emergency or urgent care are covered up to a 30-day supply. These drugs are not covered under Medicare Part D; therefore, payments for these drugs do not count toward reaching the catastrophic coverage level.

Prior to filling your prescription at a non-Plan Pharmacy, call Customer Relations to find out if there is a Plan Pharmacy in the area where you are traveling. If there are no Plan Pharmacies in that area, Customer Relations may be able to make arrangements for you to get your prescriptions from a non-Plan Pharmacy.

Other times you can get your prescription covered if you go to a non-Plan Pharmacy.
We will cover your prescription at a non-Plan Pharmacy if at least one of the following applies:

- If you are unable to get a Covered Drug in a timely manner within our Service Area because there are no Plan Pharmacies within a reasonable driving distance that provide 24-hour service.
- If you are trying to fill a covered prescription drug that is not regularly stocked at a Plan Pharmacy or the Direct Mail Pharmacy. (These drugs include orphan drugs or other specialty pharmaceuticals.)

Before you fill your prescription in either of these situations, call Customer Relations to see if there is a Plan Pharmacy in your area where you can fill your prescription. If you do go to a non-Plan Pharmacy for the reasons listed above, you will have to pay the full cost (rather than paying just your Copayment) when you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a claim. To learn how to submit a paper claim, please refer to the paper claims process described next.

How do I submit a paper claim?

When you go to a Plan Pharmacy, your claim is automatically submitted to us by the pharmacy. However, if you go to a non-Plan Pharmacy for one of the reasons listed above, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription.

You should submit your paper claim for prescription drugs that includes the following information as soon as possible:

- Member name, address, and phone number.
- Medical record number (on your ID card).
- The prescription number.
- The name, strength, and quantity of the drug prescribed.
- The date you received the drug.
- The reason for taking the drug (your diagnosis).
- NDC code (a national drug code which can be obtained from the pharmacist).
- Name, address, and telephone number of the pharmacy where the drug was purchased.
- Receipt showing you paid for the drug.
- Any other documents that may help us make a decision about your claim. For example a letter explaining why you filled a prescription at a non-Plan Pharmacy.

Kaiser Permanente
P.O. Box 5316
Cleveland, Ohio 44101-9774.

If you submit a paper claims to us, the claim is treated as a request for a Coverage Determination. If you are asking us to reimburse you for a prescription drug that is not on our Formulary or is subject to coverage requirements or limits, your doctor may need to submit additional documentation supporting your request. See Section 11 to learn more about requesting Coverage Determinations. Please call Customer Relations for more information.

How does your Prescription Drug Coverage work if you go to a Hospital or Skilled Nursing Facility?

If you are admitted to a Hospital for a Medicare-covered stay, Medicare Plus will cover the costs of your prescription drugs while you are in the Hospital. Once you are released from the Hospital, we will cover your prescription drugs as long as all coverage requirements are met (such as the drugs being on our Formulary, filled at a Plan Pharmacy, etc.) under your outpatient drug benefit. We will also cover your prescription drugs if they are approved under the Coverage Determination, Exceptions, or Appeals process.

If you are admitted to a Skilled Nursing Facility for a Medicare-covered stay, we will arrange for any Medically Necessary Medicare Part A prescription drugs for the first 100 days that you are in the facility. After the first 100 days, we will cover your prescriptions as long as the Skilled Nursing Facility's pharmacy is a Plan Pharmacy. When you enter, live in, or leave a Skilled Nursing Facility you are entitled to a special enrollment period, during which time you will be able to leave Medicare Plus and select another Medicare Managed Care Plan or Original Medicare. Please contact your benefit administrator or see Section 12 of this document for more information about leaving Medicare Plus and joining a new Medicare Prescription Drug Plan.

Long-term care pharmacies.

Residents of a long-term care facility may get their prescription drugs through a Medicare Plus long-term care pharmacy for the Copayment specified in the "Outpatient Prescription Drug Benefit" following the "2008 Medicare Plus Benefit Chart" in Section 15. In some cases, this will be the long-term care pharmacy that contracts directly with the long-term care facility. If it is not, or for more information, please contact Customer Relations.

Home infusion pharmacies

Medicare Plus will cover home infusion therapy at no charge if:

- Your prescription drug is on our Formulary, or a Formulary Exception has been granted for your prescription drug,
- Your prescription drug is not otherwise covered under Medicare Plus's medical benefits. For example, infusion drugs used in Durable Medical Equipment are covered under DME and subject to the applicable DME Coinsurance,
- You have followed all required coverage rules and we have approved your prescription for home infusion therapy,
- Your prescription is written by a doctor, and
- You get your home infusion services from a Plan Pharmacy.

Home infusion drugs are covered under your medical benefit; they are not covered under Medicare Part D. Please refer to your Pharmacy Directory to find a home infusion pharmacy in your area. For more information, please contact Customer Relations.

Some vaccines and drugs may be administered in your doctor's office.

We may cover vaccines that are preventive in nature and aren't already covered by the Medicare Plus Immunization benefit. This coverage includes the cost of vaccine administration. (Please see Section 5, "How does your enrollment in Medicare Plus affect coverage for the drugs covered under Medicare Part A or Medicare Part B?" for more information.)

Section 4 Covered Benefits

What are Covered Services?

This section describes the medical benefits and coverage you get as a Member of Medicare Plus. Covered Services means the medical care, services, supplies, and equipment that are covered by Medicare Plus. Section 8 tells about services that are not covered (these are called Exclusions). Section 15 gives a list of your Covered Services and tells what you must pay for each Covered Service.

There are some conditions that apply in order to get Covered Services.

Some general requirements apply to all Covered Services.

The Covered Services in this section are covered only when all requirements listed below are met:

- Services must be provided at a minimum according to the Medicare coverage guidelines established by the Medicare program.
- The medical care, services, supplies, and equipment that are listed as Covered Services must be Medically Necessary. Certain preventive care and screening tests are also covered. (See Section 14 for a definition of Medically Necessary.)
- With few exceptions, Covered Services must either be provided by Plan Providers, be approved in advance by Plan Providers, or be authorized by Kaiser Permanente. The exceptions are (1) Urgently Needed Care when you are temporarily traveling outside of the Service Area, (2) Emergency Care anywhere in the world, or (3) services received from non-Plan Providers when directed and arranged in advance by Kaiser Permanente. If you get care from non-Plan Providers without authorization by Kaiser Permanente, you will have to pay Original Medicare out-of-pocket amounts for that care.
- Pre-Authorization is received when required. **Pre-Authorization is required for Skilled Nursing Facility care, Durable Medical Equipment, external prosthetics & orthotics, home health services, transplant services, bariatric surgery and any services received from a non-Plan Provider.**

KAISER PERMANENTE WILL NOT PAY FOR SERVICES THAT DO NOT MEET THE REQUIREMENTS ABOVE. YOU WILL PAY FOR THOSE SERVICES UNDER THE TERMS AND CONDITIONS OF ORIGINAL MEDICARE.

Medicare Plus-Covered Benefits

1. Ambulance Services

Services and supplies of a licensed ambulance are covered only if your condition requires the use of the medical services and supplies that only a licensed ambulance can provide and the use of other means of transportation would endanger your health. This includes ambulance services to an institution (like a Hospital or SNF), from an institution to another institution, from an institution to your home, and services dispatched through 911. Medically Necessary ambulance service is covered within the Service Area or outside the Service Area in conjunction with covered Emergency Care.

We will not cover ambulance services in any other circumstances, even if no other transportation is available.

Transportation by car, taxi, bus, gurney, van, wheelchair, mini-van, or any other type of transportation (other than a licensed ambulance) is NOT COVERED even if it is the only way to travel to your PCP or Affiliated Provider.

2. Blood and Blood Components
Blood (whole blood, packed red blood cells, cryoprecipitates, platelets, plasma and fresh frozen plasma), blood products, and the collection, transportation, storage and processing of autologous or donor directed blood are covered.

3. Blood Transfusions
Blood processing and administration of blood transfusions are covered. The collection, transportation, storage and processing of autologous or donor directed blood are covered. Please refer to Item 2, Blood and Blood Components.

4. Chiropractic Services (manual manipulation of the spine)
Chiropractic services are covered; however, these services are limited to manual manipulation of the spine to correct subluxation. We do not cover any other chiropractic services.

5. Comprehensive Outpatient Rehabilitation Facility (CORF)
Acute intensive physical Rehabilitation Services such as physical, occupational, speech, and cardiac rehabilitation therapy immediately following an illness or injury for the restoration of previously existing physical functions are covered. We cover coordinated interdisciplinary Rehabilitative Services, when in the judgment of your PCP or Affiliated Provider, significant improvement is achievable within a reasonable and generally predictable period of time. Your PCP or Affiliated Provider will determine what constitutes significant improvement for such therapies. Services must be provided in a CORF designated by Kaiser Permanente. Cognitive therapy is limited according to Medicare guidelines. We do not cover long-term rehabilitative therapy.

6. Dental Services (Medically Necessary)
Services by a dentist or oral surgeon 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 treatment of neoplastic disease, dental exams prior to kidney transplantation or services that would be covered when provided by a doctor.

Generally, services in connection with the care, treatment, filling or removal, or replacement of teeth or structures directly supporting the teeth are not covered. (Structures supporting the teeth mean the periodontium, which includes the gingivae, dentogingival junction, periodontal membrane, cementum of the teeth and alveolar process.) However, in certain circumstances, services in connection with the care, treatment, filling or removal, or replacement of teeth or structures directly supporting the teeth are covered according to Medicare guidelines.

7. Diagnostic Laboratory Testing
Outpatient laboratory tests, services and materials are covered.

8. Durable Medical Equipment, Diabetic Equipment & Supplies, Prosthetics & Orthotics

Durable Medical Equipment

Rental or purchase of Durable Medical Equipment to be used in your home is covered. Durable Medical Equipment is equipment that:

- is appropriate for use in the home; and
- is intended for repeated use; and
- is primarily and customarily used to serve a medical purpose; and
- is generally not useful to a person in the absence of illness or injury; and
- is approved under Original Medicare.

This includes: a) replacement in cases of loss, irreparable damage, wear, or replacement required because of a change in the Member's condition; b) repairs; c) maintenance; d) delivery of the equipment; and e) supplies and drugs and biologicals necessary to use the equipment. Items considered Durable Medical Equipment include hospital beds, wheelchairs, respirators, intermittent positive pressure breathing machines, medical regulators, oxygen tents, crutches, canes, trapeze bars, walkers, inhalators, nebulizers, commodes, suction machines, and traction equipment, when Medicare guidelines are met and the equipment is obtained from specified Affiliated Providers.

Equipment generally used for comfort or convenience or equipment that is not primarily medical in nature is NOT COVERED.

Diabetic Equipment and Supplies

Medically Necessary diabetic equipment and supplies are covered, when prescribed by your PCP or Affiliated Provider who specializes in the treatment of diabetes and who certifies that such services are necessary for the treatment of:

- insulin-using diabetes; or
- non-insulin-using diabetes

Prosthetics and Supplies

Prosthetic devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue) or that replace all or part of the function of a permanently inoperative or malfunctioning external body part are covered. Examples of covered prosthetic devices are cardiac pacemakers, prosthetic lenses, breast prostheses, artificial legs, arms, and colostomy bags and supplies. All necessary supplies, adjustments, repairs and replacements are covered.

Accessories and/or supplies that are used directly with an enteral or parenteral device in order to achieve the therapeutic benefit of a prosthesis, or to assure the proper functioning of the device are also covered under this prosthetic benefit. These include, but are not limited to catheters, filters, extension tubing, infusion bottles, pumps, I.V. pole, needles, syringes, dressings, tape, heparin sodium, volumetric monitors, parenteral and enteral nutrient solutions. Repair required due to misuse is NOT COVERED.

Orthotics
Orthopedic shoes when the shoe is an integral part of a leg brace and its expense is included in the cost of the brace are covered. The shoe and brace must be purchased through specified Affiliated Providers. Other orthotics include rigid and semi-rigid external devices that are used for the purpose of supporting a weak or deformed body member or for restricting or eliminating motion in a diseased or injured part of the body. Leg, arm, back and neck braces are covered. This benefit provides coverage of therapeutic shoes and inserts for individuals with severe diabetic foot disease.

9. Emergency Care and Urgently Needed Care Out-of-Area (see Section 3)

Emergency Care (see Section 3)
Emergency Medical Care is covered whenever you need it, anywhere in the world. Your Copayment for Emergency Care, if any, is waived when you are admitted as an inpatient to the Hospital directly from the Emergency Department or observation unit. An overnight stay in an observation unit or observation bed of a Hospital is NOT an inpatient admission.

Urgently Needed Care (see Section 3)
Remember, if you receive services from non-Affiliated medical Providers without prior direction or arrangement by us, except for Emergency Care or out-of-area Urgently Needed Care, Kaiser Permanente will not pay for those services. You will pay for those services under the terms and conditions of Original Medicare.

10. Glasses and Contact Lenses following Cataract Surgery
Prosthetic lenses/frames (and replacements) needed after a cataract removal, without the insertion of an intraocular lens, are covered. One pair of eyeglasses or contact lenses after each cataract surgery that includes the insertion of an intraocular lens is covered. Eye surgery to correct refractive defects of the eye is not covered. In addition, tinted lenses are not covered.

11. Hearing Evaluations
We cover medical services necessary for the diagnosis and treatment of illness or injury to the ear. This includes hearing evaluations, including tests to determine the need for hearing correction, when performed by Affiliated Providers.

12. Home Health Services
Home health services are covered, when in the judgment of your PCP or Affiliated Provider, it is feasible to maintain effective supervision and control of your care.

Covered Services include:

- Part time or intermittent Skilled Nursing Care and home health aide services.
- Physical, occupational and speech therapy.
- Medical social services.
- Medical supplies.
- Durable Medical Equipment (such as wheelchairs, Hospital beds, oxygen, walkers). This benefit is described under a separate heading in this section.

You are eligible for the home health services benefit when all of the following apply:

- the care you require includes intermittent Skilled Nursing Care, physical therapy, occupational therapy, or speech therapy;
- you are homebound and reside within the Service Area;
- your PCP determines home health care is needed;
- your PCP sets up a home health plan for you and periodically reviews the home health plan for you; and
- the Home Health Agency is certified to participate in Medicare and is designated by Kaiser Permanente.

You do not have to be bedridden in order to be considered confined to the home. However, your condition should be such that there exists a normal inability to leave the home and, consequently, leaving the home would require a considerable and taxing effort. If you leave the home, you may be considered homebound if the absences from the home are infrequent or for periods of relatively short duration, or to receive medical treatment.

Home health services as an alternative to otherwise Covered Services in a Hospital or related institution are also covered.

13. Hospice Services

Original Medicare, not Medicare Plus, covers Hospice services for Members who are entitled to Medicare Part A or purchase Medicare Part A benefits from the Social Security Administration, and are diagnosed as having a terminal illness with a life-expectancy of six months or less. Covered Services include home care, drugs for symptom control and pain relief and short term respite care.

Medicare Plus covers Hospice services for Members who purchase Medicare Part A equivalent benefits from us, and are diagnosed as having a terminal illness with a life-expectancy of six months or less.

- Members must receive Hospice services from Plan Providers.
- When a Member enrolls in a Plan Hospice, the Hospice is reimbursed directly by Kaiser Permanente for all Hospice services received.
- Kaiser Permanente will provide a list of area Medicare-certified Hospice Providers.
- A contracting medical Provider may be used as a Hospice attending physician if the Member and physician so arrange.
- A Member may remain enrolled in Medicare Plus even if Hospice coverage is elected for the terminal condition.

14. Immunizations

Hepatitis B Immunizations

Hepatitis B vaccine and its administration are covered for Members who are at high or intermediate risk of contracting hepatitis B. A special hepatitis B vaccine, Engerix-B, has been approved for adults undergoing hemodialysis.

Pneumococcal and Influenza
Pneumococcal pneumonia vaccine, the influenza virus vaccine, and their administration are covered. You may receive vaccines from Affiliated Providers upon request and without a Referral from your PCP or Affiliated Provider.

Other Immunizations
Vaccines and immunizations approved for use by the Food and Drug Administration (FDA), and which are Medically Necessary to treat an injury or direct exposure to a disease or condition and consistent with accepted medical practice, are covered. In the absence of an injury or direct exposure other preventive immunizations and their administration are covered at no charge under the prescription drug benefit.

15. Inpatient Care In A Skilled Nursing Facility
Up to 100 inpatient care days in a Skilled Nursing Facility, per Benefit Period, are covered. Covered Services include:

- Semiprivate room or private room if Medically Necessary.
- Meals, including special diets.
- General nursing services.
- Physician services.
- Laboratory, X-ray, and other radiology services.
- Blood. (See Blood and Blood Components and Blood Transfusions described earlier in this section).
- Rehabilitation Services, such as physical, occupational and speech therapy.
- Medications. This includes substances that are naturally present in the body such as blood clotting factors.
- Medical and surgical supplies.
- Use of medical devices, such as a wheelchair.

A Skilled Nursing Facility admission will be covered by us when all of the following conditions apply:

- an Affiliated Provider certifies that you need and you actually receive skilled nursing or skilled rehabilitation on a daily basis;
- these services, as a practical manner, can only be provided in a Skilled Nursing Facility;
- the Skilled Nursing Facility is Medicare-certified or a distinct part of a medical facility and the distinct part is Medicare-certified as a Skilled Nursing Facility;
- the care given meets the skilled criteria as defined by Medicare; and
- you have not exhausted your 100-day skilled nursing benefit.

After you have exhausted your Inpatient Care in a Skilled Nursing Facility benefit of 100 days per Benefit Period, Medicare Part B medical services, such as the following, will be covered as described under their respective benefit headings:

- Physician visits.

- Surgical dressings, splints, casts, and other devices used for reduction of fractures and dislocations.
- Prosthetic devices.
- Total parenteral nutrition.
- Outpatient physical, occupational, and speech therapy.
- Diagnostic services.

If you either join or leave Medicare Plus during an inpatient Skilled Nursing Facility stay, please call Customer Relations. They can explain how your services are covered for this stay, and what you owe to Kaiser Permanente, if any, for the periods of your stay when you were and were not a Plan Member. Please see Section 1 for ways to contact Customer Relations. (Skilled Nursing Facility care is also discussed in Section 3.)

16. Inpatient Chemical Dependency Detoxification & Rehabilitation Services
Inpatient chemical dependency detoxification services, including inpatient physician services, provided in an acute care Hospital are covered for an unlimited number of days. Inpatient chemical dependency detoxification or rehabilitation services and inpatient physician services provided in a Medicare-approved psychiatric facility are covered for up to 190 days per lifetime.

You are eligible for inpatient chemical dependency detoxification and rehabilitation when the services are Medically Necessary Covered Services and both of the following apply:

- your PCP or Affiliated Provider determines that your condition would be responsive to therapeutic management; and
- you have not exhausted your 190-day lifetime maximum benefit amount for inpatient mental health services and inpatient chemical dependency rehabilitation.

We do not provide coverage for treatment in a specialized chemical dependency addiction treatment facility or program for a Member who, in the judgment of the Kaiser Permanente or Affiliated Provider, has not been or would not be responsive to therapeutic management, or has not been, or is not, motivated.

Limitation: The same 190-day inpatient lifetime maximum applies to both inpatient mental health and inpatient chemical dependency rehabilitation admissions when Services are rendered in a Medicare-approved psychiatric facility.

If Medically Necessary hospitalization continues after exhaustion of the 190-day inpatient lifetime maximum, Medicare Part B medical services will be covered.

17. Inpatient Hospital Services
An unlimited number of Hospital days for inpatient acute care are covered. Covered Services include:

- Semiprivate room, meals (including special diets), and general nursing services (private room, when deemed Medically Necessary or when semiprivate room accommodations are not available).

- Inpatient physician services.
- Costs of special care units such as intensive care or coronary care units.
- Use of operating room.
- Obstetrical care.
- Medications.
- Anesthesia.
- Diagnostic tests and procedures.
- X-rays and radiation therapy.
- Services and supplies furnished by the Hospital for inpatient medical and surgical treatment.
- Inhalation/respiratory therapy.
- Rehabilitation Services, such as physical therapy, occupational and speech therapy.
- Blood transfusions.
- Use of medical devices or appliances.

You are eligible for the benefits listed here if they are Medically Necessary Covered Services and both of the following apply:

- your PCP prescribes inpatient care for treatment of your illness or injury (Emergency Care inside or outside the Service Area or Urgently-Needed Care outside the Service Area do not require prior approval; however, we do encourage you to contact us as soon as possible after your admission), and
- the care required for treatment of your illness or injury can only be provided in a Hospital.

18. Inpatient Hospital Mental Health Services

Inpatient Hospital mental health services and inpatient physician services provided in an acute care Hospital are covered for an unlimited number of days when deemed Medically Necessary and clinically appropriate by your PCP or Affiliated Provider. Inpatient mental health services and inpatient physician services provided in a Medicare-approved psychiatric facility are covered for up to 190 days per lifetime when deemed Medically Necessary and clinically appropriate by your PCP or Affiliated Provider.

Limitation: The same 190-day inpatient lifetime maximum applies to both inpatient mental health and inpatient chemical dependency rehabilitation admissions when services are rendered in a Medicare-approved psychiatric facility.

If Medically Necessary Hospitalization continues after exhaustion of the 190-day inpatient lifetime maximum, Medicare Part B medical services will be covered.

We do not provide inpatient coverage for:

- mental health services, when in the judgment of your physician, your condition would not be responsive to therapeutic management. Such conditions include chronic psychosis, chronic organic brain syndrome, intractable personality disorders, and mental retardation; or
- mental health services, when in the judgment of your physician, you are seeking services for other than therapeutic purposes, or are not responsive to therapeutic management.

19. Medicare-Covered Drugs and Biologicals
You are covered for certain drugs under Original Medicare. Coverage of these Medicare Part B drugs is separate from your outpatient prescription drug benefit, which is described in Section 5.

The following Medicare-Covered Drugs are covered, subject to Medicare guidelines, when obtained at Plan Pharmacies:

- Immunosuppressive drugs following approved covered transplants.
- Certain drugs for home dialysis, including heparin, the antidote for heparin when Medically Necessary, topical anesthetics and Erythropoietin for patients with anemia associated with chronic renal failure.
- Injectable drugs for the treatment of osteoporosis if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug.
- Certain oral anti-cancer agent drugs.
- Anti-nausea drugs when used with covered anti-cancer drugs.
- Blood clotting factors for hemophilia patients.
- Intravenous Immune Globulin for the treatment of primary immune deficiency diseases in your home.
- Antigens.
- Medicare-Covered Drugs and biologicals provided in an outpatient setting (such as an Office Visit) are provided at no charge if the drug or biological is administered by a physician or by an allied health professional under physician supervision. Typically, these medications are not considered self-administered and are provided as part of your Office Visit. Office Visit Copayments may apply.
- Medicare Plus also covers some drugs according to Medicare guidelines that are usually not self-administered even if you inject them at home.

For drugs used in DME, please see Item 8 in this section.

Medicare-Covered Drugs and biologicals shall be dispensed for up to a 60-90-day supply (depending on your Group's benefit) through direct mail when they are maintenance drugs.

In addition to the drugs listed here that are covered under Original Medicare, Kaiser Permanente offers an outpatient prescription drug benefit. The prescription drug benefit is explained in Section 5 and includes rules you must follow to have prescriptions covered. The "Outpatient Prescription Drug Benefit" following the "2008 Medicare Plus Benefit Chart" in Section 15 tells you what you must pay for drugs covered by this benefit.

20. Out-of-Country Services
When you are traveling, Emergency Care and Urgently Needed Care is covered anywhere in the world. For additional information, please refer to the benefits described in Section 3 of this Evidence of Coverage.

21. Outpatient Chemical Dependency Services
Medically Necessary outpatient treatment of chemical dependency is covered and does not require a Referral. Services include diagnostic evaluation and treatment, individual therapy, and group therapy. Outpatient treatment of chemical dependency may be performed by Affiliated Providers and other medical professionals.

22. Outpatient Hospital and Surgical Services
Outpatient Hospital and surgical services are covered. Covered Services include:

Outpatient Hospital services:

- Outpatient clinic services.
- Radiation therapy.
- Chemotherapy.
- Services and supplies for outpatient care.
- Inhalation therapy and short-term occupational, physical, and speech therapy.
- Administration of drugs and biologicals furnished for therapeutic purposes.

Outpatient surgical services (includes ambulatory surgery center services):

- Operating room for outpatient services.
- Reconstructive surgery (inpatient and outpatient) that will result in significant improvement in physical function of the reconstructed body part is covered when your PCP or Affiliated Provider determines the surgery to be medically feasible and likely to result in significant improvement in physical function.
- Reconstructive surgery to correct a significant disfigurement resulting from an injury or covered surgery is provided when your PCP or Affiliated Provider determines the surgery to be medically feasible and likely to correct the disfigurement. Coverage is also provided for reconstructive surgery on a non-diseased breast, following a mastectomy, to achieve symmetry between the breasts.

23. Outpatient Mental Health Services
Medically Necessary outpatient treatment of mental illnesses and emotional disorders, including diagnostic evaluation and treatment, individual therapy, group therapy, and family therapy, are covered. Outpatient treatment of mental illness and emotional disorders may be performed by Affiliated Providers, psychologists, clinical social workers, or other mental health care professionals as allowed under applicable state laws. A Referral is not required for outpatient mental health services. Partial Hospitalization will be provided in accordance with the "Partial Hospitalization" benefit in this Section.

24. Outpatient Physician or Medical Services
Outpatient physician or medical services are covered. Covered Services include:

- Medical and surgical services including anesthesia.
- Primary care or specialty office visits.
- Medical supplies used by the Affiliated Provider in the office.

- Second opinions for any proposed Covered Service, such as surgery or other treatment, from an Affiliated Provider. If the first two physicians disagree, a third opinion may be requested from an Affiliated Provider.
- Counseling and education visits.
- Radiation therapy.
- Chemotherapy.
- Respiratory therapy.
- Reconstructive surgery, when deemed Medically Necessary to correct a functional impairment. This benefit includes coverage for reconstructive breast surgery following a mastectomy on the non-diseased breast. Kaiser Permanente shall cover all stages of reconstructive breast surgery performed on a non-diseased breast to establish symmetry with the diseased breast when reconstructive surgery on the diseased breast is performed.
- Medical nutrition therapy and self-management training. Medical nutrition therapy services will be covered for individuals with diabetes or renal disease (but not on dialysis) and after a transplant.
- Outpatient self-management training and educational services are covered when deemed Medically Necessary for the treatment of diabetes. Training is provided by your PCP or Affiliated Provider who specializes in the treatment of diabetes, and is provided through a program supervised by appropriately licensed, registered, or certified health care Providers whose scope of practice includes diabetes education or management. You may also request training through an American Diabetes Association approved, Medicare-certified non-Plan community program.

25. Outpatient Therapy: Occupational, Physical, Speech Therapy and Cardiac Rehabilitation

Medically Necessary outpatient occupational, physical, speech therapy and cardiac Rehabilitation Services for the restoration of previously existing physical functions are covered, when, in the judgment of your PCP or Affiliated Provider, significant improvement is achievable within a reasonable and generally predictable period of time. Your PCP or Affiliated Provider will determine what constitutes significant improvement for such therapies.

26. Partial Hospitalization

Partial Hospitalization services are services covered only if the individual otherwise would require inpatient mental health care services. Services must be: (1) reasonable and necessary for the diagnosis or active treatment of the Member's condition; (2) reasonably expected to improve or maintain the Member's condition and functional level, and to prevent relapse or Hospitalization; and (3) include any of the following:

- Individual and group therapy with physicians, psychologists or other mental health professionals.
- Occupational therapy.
- Services of social workers, trained psychiatric nurses and other staff trained to work with psychiatric patients.
- Administration of drugs and biologicals furnished for therapeutic purposes.
- Individualized activity therapies that are not primarily recreational or diversionary.
- Family counseling, (for treatment of the Member's condition).

- Patient training and education.
- Diagnostic services.

27. Podiatry Services (Medically Necessary)
Foot care services that are reasonable and necessary for the diagnosis or treatment of an illness or injury, or to improve the functioning of a malformed body member, are covered. Covered Services include, but are not limited to:

- Treatment and debridement of ulcerations, either ischemic, infectious and/or neurotropic.
- Treatment and debridement of symptomatic or painful mycotic toenails.
- Removal of foreign body.
- Treatment of warts, including plantar warts.

Certain routine foot care services (such as cutting or removing corns and calluses, or trimming, cutting, clipping or debriding nails) for Members with systemic conditions such as (a) metabolic diseases; (b) peripheral vascular diseases; or (c) neurologic diseases may be covered when prescribed by your PCP or Affiliated Provider.

28. Preventive Physical Exams (routine physical exams)
Preventive exams are covered. Covered Services include: measurement of height, weight and blood pressure; an electrocardiogram; and education, counseling and guidance with respect to covered screening and preventive services.

29. Preventive Services
Preventive services are provided according to Medicare guidelines.

Annual Glaucoma Screening
Annual glaucoma screening will be covered for individuals at high risk for glaucoma, such as individuals with family history of glaucoma, people with diabetes, and African-Americans who are age 50 and older.

Bone Mass Measurement
For qualified individuals (generally, this means people at risk for losing bone mass or risk of osteoporosis), the following services are covered every 2 years if Medically Necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.

Cardiovascular screening blood tests
Cholesterol and other lipid or triglyceride level blood tests for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) at a frequency determined by a Plan Physician.

Colorectal Cancer Screening
Colorectal cancer screenings for people 50 and older which include: (1) fecal-occult blood test every 12 months; (2) flexible sigmoidoscopy every 48 months (or screening barium enema as an alternative); (3) screening colonoscopy for high-risk individuals every 24 months (or screening barium enema as an alternative); and (4) screening colonoscopy for average risk individuals every 10

years but not within 48 months of a screening sigmoidoscopy are covered when performed by your PCP or Affiliated Provider. You should consult with your physician to determine what is appropriate for you.

Diabetes screening tests
For persons at risk of diabetes: fasting plasma glucose tests as recommended by your Plan Provider.

Mammography
Screening mammographies are covered which include the radiological procedure as well as the physician's interpretation of the results. A Physician's order or Referral is not required for screening mammograms; however, as explained in Section 3, they must be performed by Affiliated Providers

Pap Smears and Pelvic Examinations, and Clinical Breast Exams
Screening pap smears, which include routine exfoliative cytology tests and physician's interpretation of the results, are covered. Screening pelvic examinations that include testing for early detection of cervical or vaginal cancer are provided in addition to clinical breast examinations. A Physician's order or Referral is not required for these services as explained in Section 3, however these services must be received from a Plan Provider affiliated with your PCP.

Prostate Cancer Screening
Prostate cancer screenings, which include digital rectal exams and prostate-specific antigen blood test, are covered. Prostate cancer screenings must be performed by your PCP or an Affiliated Provider. These screenings are covered for men over 50.

30. Radiological Testing and X-rays
Outpatient x-rays, services, and materials, including diagnostic, isotopes, electro-cardiograms, electro-encephalograms, and sonograms are covered.

31. Renal Dialysis

Renal Dialysis
Renal Dialysis is covered. We cover the following services inside our Service Area:

- Outpatient maintenance dialysis treatments in an affiliated dialysis facility.
- Inpatient maintenance dialysis if you are admitted to an affiliated Hospital because your medical condition requires specialized Hospital services on an inpatient basis.
- Affiliated physician services related to inpatient or outpatient dialysis.

Self-Dialysis Training
Coverage is provided for the following:

- Training for self-dialysis at home including the instructions for a person who will assist you with self-dialysis at home.
- Services of the Affiliated Provider who is conducting your self-dialysis training.
- Retraining for use of new equipment for self-dialysis.

Home Dialysis
Home dialysis is covered and includes the following types: hemodialysis, home intermittent peritoneal dialysis (IPD), home continuous cycling peritoneal dialysis (CCPD), and home continuous ambulatory peritoneal dialysis (CAPD). The following are also covered:

- Home dialysis equipment and equipment-related services including rental or purchase (whichever is determined by us to be more appropriate under the circumstances), delivery and installation charges. Home dialysis equipment must be prescribed by your PCP or Affiliated Provider and obtained from Affiliated Providers.
- Supplies necessary to perform home dialysis including disposable items.
- Periodic support services by an Affiliated Provider, which are necessary to help you remain on home dialysis. Support services include periodic visits by trained personnel to monitor your home dialysis and to assist in emergencies when necessary.

Dialysis services received outside our Service Area are covered under Original Medicare. You must pay Original Medicare cost sharing amounts for these services.

32. Transplant Services
Coverage is provided for the following organ, tissue or bone marrow transplants according to Medicare guidelines:

- Bone Marrow.
- Stem Cell.
- Cornea.
- Heart.
- Heart/lung.
- Lung.
- Liver.
- Kidney.
- Intestine.
- Pancreas.

Transplants are covered when the transplant is performed in a facility that has been approved by both Medicare and Kaiser Permanente. We may refer you to a transplant facility outside the Service Area, even if another facility within the Service Area could perform the transplant. Covered Services include:

- Hospital services in preparation for your transplant including laboratory services and other tests to evaluate your medical condition and the medical condition of potential donors. (We do not assume responsibility for providing or assuring the availability of donor or donor tissue organs.)
- Inpatient Hospital services when you are admitted for a transplant.
- When applicable for living donors, and according to Medicare guidelines, medical care for the person who donates the organ, tissue or bone marrow for your transplant, including reasonable preparation, procedure and recovery expenses connected with the donation. Coverage also includes any additional Hospital care your donor requires if complications result directly from the donation.
- Physicians' services for performing the transplant including pre-operative care, surgical procedure and follow-up care.

We do not cover:

- Organ, tissue or bone marrow transplants which are Experimental or investigational.
- Non-human and artificial organs and their implantation.

33. Vision Services
We cover refraction exams by a Plan optometrist to determine the need for vision correction and to provide a prescription for eyeglasses or contact lenses. A Physician's order or Referral is not required for routine eye exams; however, they must be performed by a Plan optometrist. Services performed by a Plan ophthalmologist require a Referral, including a routine eye exam.

34. Other Benefits
See Section 5 for information on "Prescription Drugs Benefits." Also, see Section 15, under "Additional Information and Other Benefits Requested by Your Group" for a description of any additional benefits purchased by the Group including prescription drugs.

What if you have problems getting services you believe are covered for you?

If you have any concerns or problems getting the services that you believe are covered for you as a Member, we want to help. Please call us at Customer Relations at the telephone number in Section 1. You have the right to make a complaint if you have problems related to getting services or payment for services that you believe are covered for you. See Sections 10 for information about making a complaint.

Can your benefits change during the year?

At any time during the year, the Medicare program can change its national coverage. Since we cover what Original Medicare covers, we would have to make any change that the Medicare program makes. Your Group may also request a change to increase or decrease your benefits during the year, however your benefits will never be less than what Original Medicare covers.

Can the prescription drugs that we cover change during the year?

The Medicare program allows us to make changes in our prescription drug Formulary list at any time during the Calendar Year. As we explain in Section 5, the Formulary is a list of drugs. A change in our Formulary could affect which drugs are covered for you. Note that the Formulary applies only to the Covered Drugs.

Section 5 Prescription Drug Benefits

What is a Formulary?

We have a Formulary that lists all drugs that we cover. This list includes Medicare Part D Drugs, Medicare-covered Part B drugs and other drugs. We will generally cover the drugs listed in our Formulary as long as the drug is Medically Necessary, the prescription is filled at a Plan Pharmacy or through our Direct Mail Pharmacy and other coverage rules are followed. For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits are described later in this section under Utilization Management. We reserve the right to dispense only a 31-day supply when the prescription or refill is of a quantity greater than a 31-day supply. We provide up to a 31-day supply based upon (a) the prescribed dosage, (b) the standard manufacturer's package size, and (c) specified dispensing limits.

The drugs on the Formulary are selected by Kaiser Permanente with the help of a team of doctors, pharmacists and nurses. We select the prescription therapies believed to be a necessary part of a quality treatment program. Both Brand-Name Drugs and Generic Drugs are included on the Formulary. A Generic Drug has the same active ingredient as the Brand-Name Drug. Generic Drugs usually cost less than Brand-Name Drugs and are rated by the Food and Drug Administration (FDA) to be as safe and as effective as Brand-Name Drugs. Not all drugs are included on the Formulary. In some cases, we have decided not to include a particular drug.

In certain situations, prescriptions filled at a non-Plan Pharmacy may also be covered. See Section 3 for more information about filling a prescription at non-Plan Pharmacies.

How do you find out what drugs are on the Formulary?

You may call Customer Relations to find out if your drug is on the Formulary or to request a copy of our Formulary. You may also get updated information about the drugs covered by us by visiting our Web site www.kp.org/seniormedrx.

What are drug tiers?
Drugs on our Formulary are organized into different drug tiers, or groups of different drug types. Generic and Brand-Name Drugs are examples of two different drug tiers. Depending on your Group's benefit, your Copayment may depend on which drug tier your drugs are in. See the Outpatient Prescription Drug Benefit following the "2008 Medicare Plus Benefit Chart" in Section 15 for your Copayment through your Group's benefit. Your cost sharing depends on which drug tier your drug is in.

You may ask us to make an Exception (which is a type of Coverage Determination) to your drug's tier placement. See Section 11 to learn more about how to request an Exception.

Can the Formulary change?
We may make certain changes to our Formulary during the year. Changes in the Formulary may affect which drugs are covered and how much you will pay when filling your prescription. The kinds of Formulary changes we may make include adding or removing drugs from the Formulary.

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

A form of Medicare-covered (Part B, drugs and biologicals) drugs will always be on the Formulary.

What if your drug isn't on the Formulary?

If your prescription isn't listed on the Formulary, you should first contact Customer Relations to be sure it isn't covered.

If Customer Relations confirms that we do not cover your drug, you have three options:

- You may ask your doctor if you can switch to another drug that is covered by us. If you would like to give your doctor a list of Covered Drugs that are used to treat similar medical conditions, please contact Customer Relations or visit our Web site at www.kp.org.
- You may ask us to make an Exception (which is a type of Coverage Determination) to cover your drug. See Section 11 for more information about how to request an Exception.
- You can pay out-of-pocket for the drug and request that we reimburse you by requesting an Exception request. This doesn't obligate us to reimburse you if the Exception request is not approved. If the Exception is not approved, you may Appeal the Plan's denial. See Section 11 for more information on how to request an Appeal.

Transition Policy

New members in our Plan may be taking drugs that are not in our Formulary or that are subject to certain restrictions. Current members may also be affected by changes in our Formulary from one year to the next. Members should talk to their doctors to decide if they should switch to an appropriate drug that we cover or request a Formulary Exception (which is a type of Coverage Determination) in order to get coverage for the drug. See Section 11 (under "What is an Exception?") to learn more about how to request an Exception. Please contact Customer Relations if your drug is not on our Formulary, is subject to certain restrictions or will no longer be on our Formulary next year, and you need help switching to an appropriate drug that we cover or requesting a Formulary Exception.

During the period of time Members are talking to their doctors to determine the right course of action, we may provide a temporary supply of the non-Formulary drug if those Members need a refill for the drug during the first 90 days of new membership in our Plan. If you are a current

Member affected by a Formulary change from one year to the next, we will provide a temporary supply of the non-Formulary drug if you need a refill for the drug during the first 90 days of the new plan year or we will provide you with the opportunity to request a Formulary Exception in advance of the following year.

For each of the drugs that is not on our Formulary or that has coverage restrictions or limit, we will cover up to an 8-week temporary supply (a one month supply plus one refill) (unless the prescription is written for fewer days) when a new Member goes to a Plan Pharmacy (and the drug is otherwise a "Medicare Part D Drug"). After we cover the temporary supply, we generally will not pay for these drugs as part of our Transition Policy again. We will provide you with a written notice after we cover your temporary supply. This notice will explain the steps you can take to request an Exception and how to work with your doctor to decide if you should switch to an appropriate drug that we cover.

If a new Member is a resident of a long-term-care facility (like a nursing home), we will cover a temporary 31-day transition supply (unless you have a prescription written for fewer days). If necessary, we will cover more than one refill of these drugs during the first 90 days a new Member is enrolled in our Plan, when that Member is a resident of a long-term-care facility. If a new member, who is a resident of a long-term-care facility and has been enrolled in our Plan for more than 90 days, needs a drug that isn't on our Formulary or is subject to other restrictions, such as dosage limits, we will cover a temporary 31-day emergency supply of that drug (unless the prescription is for fewer days) while the new Member pursues a Formulary Exception.

If you are a current Member of Kaiser Permanente, you are subject to the same Kaiser Permanente Medicare Plus Formulary when you transition from one treatment setting to another. Sometimes members may be treated in the Hospital, or physician's office, and then discharged to home or transferred to a nursing home. If a transitioning Member needs a drug that is not on our Formulary or subject to other restrictions, such as dosage limits, we will cover a 31-day emergency supply of that drug (unless the prescription is for fewer days) while the transitioning Member pursues a Formulary Exception.

In some cases, we will contact you if you are taking a drug that is not on our Formulary. We can give you the names of Covered Drugs that also are used to treat your condition so you can ask your doctor if any of these drugs are an option for your treatment.

You may obtain a non-Formulary drug outside of the Exception process anytime by paying full price for the drug if the Plan Physician determines the non-Formulary drug is not Medically Necessary.

Please note that our Transition Policy applies only to those drugs that are "Medicare Part D Drugs" and that are bought at a Plan Pharmacy. The Transition Policy can't be used to buy a non-Medicare Part D Drug or a drug at a non-Plan Pharmacy.

Drug Management Programs

Utilization management.
For certain prescription drugs, we have additional requirements for coverage or limits on our coverage. These requirements and limits ensure that our Members use these drugs in the most

effective way and also help us control drug plan costs. A team of doctors, nurses, and pharmacists developed these requirements and limits to help us provide quality coverage to our Members.

The requirements for coverage or limits on certain drugs are listed as follows:

- **Quantity limits**: For certain drugs, Kaiser Permanente limits the amount of the drug that Kaiser Permanente Medicare Plus will cover per prescription. For example, when there is a shortage of a drug, we may limit the quantity of the drug dispensed and charge the Medicare Part D cost share.
- **Generic Substitution**: When there is a generic version of a Brand-Name Drug available, our Plan Pharmacies will automatically give you the generic version, unless your doctor has told us that you must take the Brand-Name Drug and we have approved this request.

You can find out if the drug you take is subject to the limits by looking in the Formulary. If your drug is subject to one of these additional restrictions or limits and your physician determines that you aren't able to meet the additional restriction or limit for medical necessity reasons, you or your physician may request an Exception (which is a type of Coverage Determination). See Section 11 for more information about how to request an Exception.

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

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

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

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

We may contact members who qualify for these programs. If we contact you, we hope you will join so that we can help you manage your medications. Remember, you don't need to pay anything extra to participate.

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

How does your enrollment in Medicare Plus affect coverage for the drugs covered under Medicare Part A or Medicare Part B?

As a person with Medicare, you are entitled to coverage of those drugs that are covered under Medicare Part A and Medicare Part B, and the drugs that are covered in your Medicare drug plan.

Your enrollment in Medicare Plus includes coverage for Medicare Part A and Medicare Part B drugs. You are entitled to all Medically Necessary Medicare Part A and Medicare Part B services including drugs that are covered under Medicare Part A and Medicare Part B. Prescriptions for Medicare Part B drugs must be filled at a Plan Pharmacy and follow the rules in this section. Some drugs may be covered under Medicare Part B in some cases and through your Outpatient Prescription drug coverage in other cases, but never both at the same time. In general, your pharmacist or provider will determine whether the drug you are receiving is Medicare Part B or Medicare Part D.

The amount you pay when you fill a prescription for Medicare Part B drugs does not count towards your total drug costs (that is, the amount you pay does not help you qualify for Catastrophic Coverage). In addition, if you are receiving extra help to pay for your prescriptions, you will not get any extra help to pay for Medicare Part B drugs.

See your "Medicare & You" handbook for more information about drugs that are covered by Medicare Part A and Medicare Part B.

Section 6 Your Costs for Medicare Plus

Paying the monthly Plan Premium.

To be a Member of Medicare Plus, you must continue to pay your Medicare Part B Premium.

Most Medicare beneficiaries are automatically entitled to Medicare Hospital Insurance (Medicare Part A). If you are not entitled to Medicare Part A, and if you would like to purchase Medicare Part A from Social Security, please call your local Social Security Office or call 1-800-772-1213, toll free; 1-800-325-0778 TTY/TDD for the hearing/speech impaired.

If you are not entitled to Medicare Part A, and have not purchased Medicare Part A through Social Security, Medicare Plus includes an Equivalent Medicare Part A Benefit that your Group has purchased from us. The applicable Equivalent Medicare Part A Benefit premium must be paid to continue your coverage.

NOTE: If you are enrolled in Medicare Part B and not entitled to Medicare Part A, and you Disenroll from Medicare Plus, you will not be eligible to enroll in a Medicare Advantage Plan. You must first purchase Medicare Part A coverage from Social Security. You may be able to re-enroll in Medicare Plus if the Plan is open for enrollment.

There may be a monthly Medicare Plus Plan Premium that you must pay.

How much is your monthly Plan Premium?

Your Group may require you to pay part of the Plan Premium. Please contact your Group's benefit administrator for further information.

Can your premiums change during the year?

Please contact your Group's benefit administrator for further information.

Paying your share of the cost when you get Covered Services or drugs.

What are Copayments and Coinsurance?

- A Copayment is a payment you make for your share of the cost of certain Covered Services or drugs you receive, such as an office visit. It is a set amount per visit. You pay it when you get the service. The "2008 Medicare Plus Benefit Chart" in Section 15 gives your Copayments for Covered Services. See the Outpatient Prescription Drug Benefit following the "2008 Medicare Plus Benefit Chart" for your Copayment through your Group's drug benefit.
- Coinsurance is a payment you make for your share of the cost of certain Covered Services or drugs you receive. Coinsurance is a percentage of the cost of the service. The "2008 Medicare Plus Benefit Chart" in Section 15 gives your Coinsurance for Covered Services. See the Outpatient Prescription Drug Benefit following the "2008 Medicare Plus Benefit Chart" for your Copayment through your Group's drug benefit.

What is the maximum amount you will pay for Covered Services?
There is a limit to how much you have to pay out-of-pocket for certain basic health care services each contract year. This is called your Annual Out-of-Pocket Maximum. When you have reached the annual total, you will not have to pay Copayments for the services listed below for the remainder of the contract year. The Copayments for the following health services contribute to this limit:

- Physician services.
- Outpatient Hospital and surgical services.
- Inpatient Hospital services (except mental health inpatient services).
- Inpatient and outpatient chemical dependency rehabilitation services.
- The first 20 outpatient mental health visits per contract year.
- Emergency Services and out-of-area Urgently Needed Care.
- Home health services.
- Outpatient physical, speech and occupational therapy and cardiac rehabilitation.
- Diagnostic laboratory testing, radiological testing and X-ray services.
- Medically Necessary ambulance services.

The annual dollar limit is listed in Section 15 in the "2008 Medicare Plus Benefit Chart" at the back of this EOC.

How much do you pay for drugs covered by us?

See the Outpatient Prescription Drug Benefit following the "2008 Medicare Plus Benefit Chart" in Section 15 for your Copayment through your Group's benefit. When you fill a prescription for a Covered Drug, you may pay part of the costs for your drug. The amount you pay for your drug depends on whether you are in the catastrophic level or not, the type of drug it is, and whether you are filling your prescription at a Plan Pharmacy or non-Plan Pharmacy.

If you qualify for extra help with your Medicare prescription drug coverage, your costs for your drugs may be different than those described in the "Outpatient Prescription Drug Benefit" following the "2008 Medicare Plus Benefit Chart" in Section 15. For more information, see "Do you qualify for extra help?" later in this section and the "Evidence of Coverage Rider for those who Receive Extra Help Paying for their Prescription Drugs."

Catastrophic Coverage.
All Medicare prescription drug plans include Catastrophic Coverage for people with high drug costs. In order to qualify for Catastrophic Coverage, you must spend $4,050 out-of-pocket for the year. When the total amount you have paid toward Copayments and the cost for covered Medicare Part D Drugs after you reach the initial coverage limit reaches $4,050, you will qualify for Catastrophic Coverage. During Catastrophic Coverage you will pay: $5 for Generics and $15 for Brand-Name and Specialty Drugs or your Group's Prescription Drug Copayment, whichever is less. We will pay the rest.

Vaccines (including administration)
The Medicare Plus prescription drug benefit covers a number of vaccines (including vaccine administration). In some cases, you will be receiving the vaccine from someone who is not part of

our pharmacy network and you may have to pay for the entire cost of the vaccine and its administration in advance. You will then need to mail us the receipts, and then you will be reimbursed.

We can help you understand the costs associated with vaccines (including administration) available through Medicare Plus before you see your doctor. For more information, please contact Customer Relations.

How is your out-of-pocket cost calculated?

What type of prescription drug payments count toward your out-of-pocket costs?
The following types of payments for prescription drugs may count toward your out-of-pocket costs and help you qualify for Catastrophic Coverage so long as the drug you are paying for is a Medicare Part D Drug or transition drug, on the Formulary (or if you get a favorable decision on a Coverage-Determination request, Exception request or Appeal), obtained at a Plan Pharmacy (or you have an approved claim from an non-Plan Pharmacy); and otherwise meets our coverage requirements:

- Your Coinsurance or Copayments;
- Any payments you make for prescription drugs after the initial coverage limit that would otherwise be covered by Medicare Plus.

When you have spent a total of $4,050 for these items, you will reach the Catastrophic Coverage level.

What type of prescription drug payments will not count toward your out-of-pocket costs?
The amount you pay, if any, for your monthly Plan Premium does not count toward reaching the Catastrophic Coverage level. In addition, the following types of payments for prescription drugs will not count toward your out-of-pocket costs:

- Prescription drugs purchased outside the United States and its territories;
- Prescription drugs not covered by the Plan;
- Prescription drugs obtained at a non-Plan Pharmacy when that purchase does not meet our requirements; or
- Prescription drugs covered by Medicare Part A or Medicare Part B.
- Prescription drugs that are not Medicare Part D Drugs.

Who can pay for your prescription drugs, and how do these payments apply to your out-of-pocket costs?
Except for contributions you make, if any, toward your premium payments, any payments you make for Medicare Part D Covered Drugs count toward your out-of-pocket costs and will help you qualify for Catastrophic Coverage. In addition, when the following individuals or organizations pay your costs for such drugs, these payments will count toward your out-of-pocket costs (and will help you qualify for Catastrophic Coverage):

- Family members or other individuals;
- Medicare programs that provide extra help with prescription drug coverage; and

- Most charities or charitable organizations. Please note that if the charity is established, run or controlled by your current or former employer or union, the payments usually will not count toward your out-of-pocket costs.

Payments made by the following do not **count** toward your out-of-pocket costs:

- Group Health Plans;
- Insurance Plans and government funded health programs (e.g., TRICARE, the Veteran's Administration (VA), the Indian Health Service, AIDS Drug Assistance Programs);
- Third party arrangements with a legal obligation to pay for prescription costs (e.g., Workers' Compensation); and
- Pharmaceutical Manufacturers Patient Assistance Programs.

If you have coverage from a third party such as those listed above that pays a part of or all of your out-of-pocket costs, you must disclose this information to us.

We will be responsible for keeping track of your out-of-pocket expenses and will let you know when you have qualified for Catastrophic Coverage. In addition, every month you purchase covered prescription drugs through us, you will get an Explanation of Benefits that shows your out-of-pocket cost amount to date.

CMS may change your out-of-pocket cost amount each year. The change takes effect on January 1st of every year. You will be notified in advance of the new amounts for the next Calendar Year.

What extra help is available?
Medicare provides "extra help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you will get help paying for your Medicare drug plan's Plan Premium and prescription Copayments.

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

1 You automatically qualify for extra help and don't need to apply. If you have full coverage from a state Medicaid program, get help from Medicaid paying your Medicare premiums (belong to a Medicare Savings Program), or get Supplemental Security Income benefits, you automatically qualify for extra help and do not have to apply for it. Medicare mails letters monthly to people who automatically qualify for extra help.

2 You apply and qualify. You may qualify if your yearly income in 2007 is less than $15,315 (single with no dependents) or $20,535 (married and living with your Spouse with no dependents), and your resources are less than $11, 710 (single) or $23, 410 (married and living with your Spouse). Resources include your savings and stocks but not your home or car. If you think you may qualify, call Social Security at 1-800-772-1213, visit www.socialsecurity.gov on the Web, or apply at your State Medical Assistance (Medicaid) office. TTY/TDD users should call 1-800-325-0778. After you apply, you will get a letter in the mail letting you know if you qualify and what you need to do next.

The above income and resource amounts are for 2007 and will change in 2008. If you live in Alaska or Hawaii, or pay at least half of the living expenses of dependent family members, income limits are higher.

How do costs change when you qualify for extra help?
The extra help you get from Medicare will help you pay for your Plan Premium and prescription Copayments. The amount of extra help you get is based on your income and resources.

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

What if you believe you have qualified for extra help and you believe that you are paying an incorrect Copayment amount?
If you believe you have qualified for extra help and you believe that you are paying an incorrect Copayment amount when you get your prescription at a pharmacy, our Plan has established a process that will allow you to provide evidence of your proper Copayment level

Please contact Customer Relations about how to submit documentation (i.e., Medicaid card, Social Security letter, etc.) that supports your eligibility for extra help as soon as possible. You may also present documentation at your Kaiser Permanente Plan Pharmacy where you fill your covered Medicare Part D prescriptions. Upon receipt and verification of your documentation, we will update your membership records so that you will pay the correct extra help cost share going forward. **Note:** If you do not qualify for extra help, we will send you a bill for the prescriptions you received.

Please be assured that if you overpay your Copayment, we will generally reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future Copayments. Of course, if the pharmacy hasn't collected a Copayment from you and is carrying your Copayment as a debt owed by you, we may make the payment directly to the pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please contact Customer Relations if you have questions.

What is your cost for services that are not covered by Original Medicare or Medicare Plus?

You are personally responsible to pay for care and services that are not covered by Original Medicare or Medicare Plus. You must also pay Original Medicare cost sharing amounts if you receive Medicare-Covered Services from non-Plan Providers unless Kaiser Permanente has approved these services in advance. The exceptions are care for a Medical Emergency, Urgently Needed Care, and services that are found upon Appeal to be services that we should have paid or covered. (Sections 3 and 4 explain about using Plan Providers and the exceptions that apply.) For Covered Services that have a benefit limitation, you must pay the full cost of any services you get after you have used up your benefit for that type of Covered Service.

What is your cost if you get care from non-Plan Providers?

Your out-of-pocket costs may be higher if you use non-Plan Providers than if you use Plan Providers.

The Original Medicare Plan will pay for covered care that you get from non-Plan Providers. However, unless it was Emergency Care, you may pay more for the care you get from non-Plan Providers since you will owe Original Medicare cost sharing amounts. You will generally pay less to see our Plan Providers because these providers have an agreement with us to accept a specific negotiated amount as payment in full for services provided to you. There are a lot of doctors, hospitals, and other health care providers who are our Plan Providers. If you don't have a list of our Plan Providers (called the "Provider Directory") and would like to have one, please call Customer Relations.

Using all of your insurance coverage.

If you have other health insurance coverage besides Medicare Plus, it is important to use this other coverage in combination with your coverage as a Member to pay for the care you receive. This is called coordination of benefits because it involves coordinating all of the health benefits that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

You are required to tell our Plan if you have additional health insurance OR drug coverage.

Important Information about Medicare Prescription Drug Coverage and any other health insurance coverage.
We will send you a COB survey so that we can know what other drug coverage you have in addition to the coverage you get through Medicare Plus. Medicare requires us to collect this information from you, so when you get the survey, please fill it out and send it back. If you have additional drug coverage, you are required to provide that information to our Plan. The information you provide helps us calculate how much you and others have paid for your prescription drugs. In addition, if you lose or gain additional prescription drug coverage, please call Customer Relations to update your membership records.

You must tell us if you have any other health insurance coverage or prescription drug coverage besides our Plan, and let us know whenever there are any changes in your additional coverage. The types of additional coverage you might have include the following:

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

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

What should you do if you have bills from non-Plan Providers that you think we should pay? As explained in Section 3, we cover certain health care services that you get from non-Plan Providers. These include care for a Medical Emergency, Urgently Needed Care when you are temporarily out of the Service Area, care that has been approved in advance by Kaiser Permanente, and services that we denied but that were overturned in an Appeal. If a non-Plan Provider asks you to pay for Covered Services you get in these situations, please contact us. See Section 1 for ways to reach Customer Relations. Generally, it is best to ask a non-Plan Provider to bill the Original Medicare Plan first, and then to bill us for the remaining amount. But if you have already paid for the Covered Services we will reimburse you for our share of the cost. If you received a bill for the services, you may send the bill to us for payment. We will pay your doctor for our share of the bill and will let you know what, if anything, you must pay. You will not have to pay a non-Plan Provider any more than what he or she would have received from you if you had been covered with Original Medicare. We may require the non-Plan Provider to bill Original Medicare. We will then pay our share of the bill and will let you know what, if anything, you must pay.

To ask us to pay for services you think we should pay, write us a letter that includes as much of the following information as possible:

- Your name and medical record number found on your Kaiser Permanente identification card;
- Name and address of the physician or facility that provided the service or supply;
- Dates you received the service or supply;
- Diagnosis;
- Type of each service or supply;
- Follow up services rendered;
- A copy of the explanation of benefits, payments or denial from any other payer;
- Copies of itemized bills, receipts or proofs of payment for your services or supplies. Be sure that any bills, receipts or proofs of payments are labeled with your name and medical record number and the date of service. Remember to copy both sides of any cancelled checks; and
- Any supporting documents that may help us make a decision about your request.

Provide us with this information as soon as reasonably possible after the date the services were rendered. In no event will a request be allowed unless Kaiser Permanente has received the request for payment or reimbursement by the last day of the year following the year in which services were rendered, except that, if the services were rendered in October, November or December, then the claim must be received by us by the last day of the second year after the year in which the Emergency or Urgently Needed Services were rendered.

Letters or bills should be submitted to the following address:

Kaiser Permanente
P.O. Box 5316
Cleveland, OH 44101-9774

Once you have submitted a claim, we will process it within 30 days of receipt if we have all of the information that we need. If we need additional information, we will notify you of our decision within 60 days of receipt of the claim. If you have questions about making a claim or the status of a claim, contact Customer Relations.

NOTE: If we do not cover services furnished by a non-Plan Provider, the services will be covered by Original Medicare if they are Medicare-Covered Services. In this case you would be responsible for Original Medicare cost sharing amounts.

What is the Medicare Prescription Drug Plan late enrollment penalty?

If you don't join a Medicare drug plan when you are first eligible, and you go without Creditable Coverage (as good as Medicare's) for 63 continuous days or more, you may have to pay a late enrollment penalty to join a plan later. This penalty amount changes every year, and you will have to pay it as long as you have Medicare prescription drug coverage. However, if you qualified for extra help in 2006 and/or 2007, you may not have to pay a penalty.

If you must pay a late enrollment penalty, your penalty is calculated when you first join a Medicare drug plan. To estimate your penalty, take 1% of the national base beneficiary premium for the year you join (in 2007, the national base beneficiary premium is $27.35). Multiply it by the number of full months you were eligible to join a Medicare drug plan but didn't, and then round that amount to the nearest ten cents. This is your estimated penalty amount, which is added each month to your Medicare drug plan's premium for as long as you are in that plan.

If you disagree with your late enrollment penalty, you may be eligible to have it reconsidered (reviewed). Call Customer Relations to find out more about the reconsideration process and how to ask for such a review.

You won't have to pay a late enrollment penalty if:

- You had Creditable Coverage (as good as Medicare's).
- The period of time that you didn't have Creditable Coverage was less than 63 continuous days.
- You prove that you were not informed that your prescription drug coverage was <u>not</u> creditable.
- You lived in an area affected by Hurricane Katrina AND you signed up for a Medicare prescription drug plan by December 31, 2006, AND you stay in a Medicare prescription drug plan.
- You received or are receiving extra help AND you join a Medicare prescription drug plan by December 31, 2007, AND you stay in a Medicare prescription drug plan.

Your late enrollment penalty may be reduced or eliminated if:

- You receive extra help in 2008 or after.

Section 7 Your Rights and Responsibilities as a Member of Medicare Plus

Introduction about your rights and protections.

You are our partner in your health care. Your participation in decisions about your health care and your willingness to communicate with your physician (practitioner) and other health care professionals help us to provide you appropriate and effective health care. As an adult Member, you can exercise these rights yourself. If you are a minor or if you become incapable of making decisions about your health care, these rights will be exercised by the person having legal responsibility for participating in decisions concerning your medical care.

If you want to receive Medicare publications on your rights, you may call Medicare and request them at 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. You can also visit www.medicare.gov to view or download the Medicare publication. Go to "Your Medicare Rights & Protections." Under "Search Tools," select "Find a Medicare Publication."

Your rights as a Medicare Plus Member.
You have the right to...

- Receive information about Kaiser Permanente, its services, the practitioners and Providers who provide your health care, and your rights and responsibilities as a Kaiser Permanente Member.
- Be assured of privacy and confidentiality. You have the right to be treated with respect and recognition of your dignity and need for privacy. Kaiser Permanente will not release your medical information without your authorization, except as required or permitted by law. You have the right to review and receive copies of your medical records, unless the law restricts our ability to make them available.
- Participate with practitioners in your health care and receive the medical information you need to make health care decisions. We will try to make this information as understandable as possible. You have the right to have ethical issues that arise in connection with your health care reviewed. You have the right to accept or refuse a recommended treatment. Emergencies or other circumstances occasionally may limit your participation in a treatment decision. In general, however, you will not receive any medical treatment before you or your legal representative gives consent. You are entitled to an interpreter if you need one.
- Have a candid discussion of appropriate or Medically Necessary treatment options for your condition, regardless of cost or benefit coverage.
- Use customer satisfaction resources. We welcome your questions and comments about Kaiser Permanente, our services, the practitioners and other health care professionals providing your care, and your rights and responsibilities. You have the right to voice complaints, or file Appeals, without concern that your care will be affected. You have the right to know about the complaints, Grievances and Appeals procedures. In order to assist you, the Customer Relations staff is available to answer your questions and resolve problems.

- Make recommendations regarding Kaiser Permanente's Members' rights and responsibilities policies.
- Express your wishes concerning future care in an advance directive. You have the right to choose a person to make medical decisions for you if you are unable to do so. Your choices regarding your future care may be expressed in such documents as a durable power of attorney for health care or a living will. You should inform your family and practitioner of your wishes, and give them any documents that describe your choices regarding future care.
- Have impartial access to medically indicated treatment that is a covered benefit, regardless of your race, religion, gender, sexual orientation, national origin, cultural background, disability, or financial status. You have the right to access emergency health care services for conditions of sufficient severity that a prudent layperson could expect the absence of immediate medical attention to result in serious jeopardy to your health, or serious impairment or dysfunction of bodily functions.
- Have a safe, secure, clean, and accessible health care environment.
- Participate in physician selection. You have the right to select a physician with an open practice as your primary care practitioner and to change your primary care practitioner at a future date. You have the right to a second opinion by a Kaiser Permanente practitioner. You have the right to consult with a non-Kaiser Permanente practitioner at your own expense.
- Receive relevant information and education that helps ensure your safety in the course of treatment.
- Receive information about the outcomes of care you have received, including unanticipated outcomes.
- Receive information about your health care coverage and costs. This booklet tells you what medical services are covered for you as a Medicare Plus Member and what you have to pay. If you need more information, please call Customer Relations at the number shown in Section 1. You have the right to an explanation from us about any bills you may get for services not covered by us. We must tell you in writing why we will not pay for or allow you to get a service, and how you can file an Appeal to ask us to change this decision. See Section 10 for more information about filing an Appeal.
- Receive information about Plan Providers. You have the right to find out from us how we pay our doctors. The Medicare program does not allow us to pay our doctors in a way that would keep them from giving you the care you need. To get this information, call Customer Relations at the phone number shown in Section 1.
- Appeal. We provide you with a written notice every time a service or payment is denied. If Kaiser Permanente has denied payment for services you think should have been covered, or if we refuse to arrange for services that you believe are covered by Original Medicare, you have the right to Appeal. See Section 10 for information about the Appeals process.
- Have certain expectations regarding your Medicare Part D outpatient prescription drug coverage, including the right to get information about your outpatient prescription drug coverage and the cost of that coverage. You have the right to get your prescriptions filled at a Plan Pharmacy within a reasonable period of time. You have the right to know about different medication management treatment programs we offer and which you may participate in. You have the right to stop taking your medication. See Section 5 for information about your Medicare Part D outpatient prescription drug coverage. See

Section 11 for information about the Medicare Part D outpatient prescription drug coverage Appeals process.

Your responsibilities as Medicare Plus Member.
You have the responsibility to...

- Provide accurate and complete information about your present and past medical conditions (to the extent possible) that the organization, its practitioners, and Providers need in order to provide care. You should report unexpected changes in your condition to your practitioner.
- Follow the treatment plan to which you and your health care practitioner agree. You should inform your practitioner if you do not clearly understand your treatment plan and what is expected of you. If you believe you cannot follow through with your treatment, you are responsible for telling your practitioner.
- Understand your health problems and participate in developing mutually agreed-upon treatment goals to the degree possible.
- Know the extent and limitations of your health care benefits. An explanation of these is contained in your Evidence of Coverage.
- Identify yourself with your Member ID card. You are responsible for your identification card, for using it only as appropriate, and for ensuring that other people do not use your card.
- Keep scheduled appointments or cancel, in a timely manner, any appointments you are unable to keep. You are responsible for promptly canceling any appointment that you don't need or cannot keep.
- Provide accurate and complete information regarding your current address, your eligibility status, the eligibility status of your Dependents and coverage or payments for health services available to you from other sources.
- Recognize the effect of your lifestyle on your health. Your health depends not just on care provided by Kaiser Permanente, but also on the decisions you make in your daily life.
- Be considerate of others. You should respect other people and their property as well as the people and property of Kaiser Permanente.
- Fulfill financial obligations. You should pay on time any money you owe Kaiser Permanente.

Other rights and protections as a Medicare Plus Member.

Access to care from Plan Providers.
You have the right to get timely access to Plan Providers and to all services covered by the Plan. (Timely access means that you can get appointments and services within a reasonable period of time.)

How we protect the confidentiality and release of your medical information (privacy practices).
Kaiser Permanente will protect the privacy of your protected health information (PHI). We also require contracting Providers to protect your PHI. PHI is health information that includes your name, social security number, or other information that reveals who you are. You may generally see

and receive copies of your PHI, request corrections or updates to your PHI, and ask us for an accounting of certain disclosures of your PHI.

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

This is only a brief summary of some of our key privacy practices. To request a copy of our "Notice of Privacy Practices," contact Customer Relations. See Section 1 for ways to contact Customer Relations.

How to get more information about your rights.
If you have questions or concerns about your rights and protections, please call Customer Relations at the number in Section 1. You can also get free help and information from your State Health Insurance Assistance Program, or SHIP (Section 1 tells how to contact the SHIP in your state). In addition, the Medicare program has written a booklet called "Your Medicare Rights and Protections." To get a free copy, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, you can visit www.medicare.gov on the Web to order this booklet or print it directly from your computer.

To let us know if you have any questions, concerns, problems, or suggestions, please call Customer Relations at the phone number shown in Section 1.

How to complete advance directives.
We are required by law to inform you of your right to make health care decisions and to execute advance directives. An advance directive is a formal document, written by you in advance of an incapacitating illness or injury. As long as you can speak for yourself, affiliated medical Providers will honor your wishes. But, if you become so sick that you cannot speak for yourself, then this directive will guide your health care Providers in treating you and will save your family, friends, and physicians from having to guess what you would have wanted. There may be several types of advance directives you can choose from, depending on state law. Most states recognize:

- Durable Power of Attorney for Health Care.
- Living Wills.
- Natural Death Act Declarations.

A Durable Power of Attorney for Health Care allows you to appoint an agent (family, friend or other person) whom you trust to make treatment decisions for you, should there come a time you are unable to make them yourself. You can purchase the form from a stationery store or ask for a form from your Affiliated medical Provider, a Kaiser Permanente Customer Relations representative, or social worker.

It is necessary that you provide copies of your completed directive to your:

1. PCP.
2. Agent/attorney.
3. Family.

Be sure to keep a copy with you and take a copy to the Hospital when you are hospitalized for medical care.

You are not required to initiate an advance directive, and you will not be denied care if you do not have an advance directive. Contact us for an informational packet, which includes instructions and preprinted forms, by writing to:

Customer Relations
Kaiser Permanente
P.O. Box 5309
Cleveland, OH 44101-0309.

You may also call us at (216) 479-5077; (1-866-513-9966 – TTY/TDD for the hearing/speech impaired) seven (7) days a week, 8:00 a.m. to 8:00 p.m. Or, call Medicare at 1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week. Or, you can visit www.medicare.gov on the Web.

If you believe your Provider has not complied with your advanced directive, you may file a complaint with Kaiser Permanente by following the Kaiser Permanente Grievance procedure outlined in Section 10.

What to do if you think you have been treated unfairly or your rights have not been respected.

If you think you have been treated unfairly or your rights have not been respected, what you should do depends on the situation:

- If you think you have been treated unfairly due to your race, color, national origin, disability, age, or religion please let us know. Or, call the Office for Civil Rights in your area. The Office for Civil Rights can be contacted at: (216) 787-3150.
- For any other kind of concern or problem related to your Medicare rights and protections described in this section, you can call Kaiser Permanente Customer Relations. See Section 1 for ways to contact Customer Relations. You can also get help from the Ohio State Health Insurance Assistance Program, or OSHIP. See Section 1 for ways to contact OSHIP.

Section 8 General Exclusions

Introduction

The purpose of this section is to tell you about medical care and services that are not covered (excluded) or are limited by Medicare Plus. The list below tells about these Exclusions and limitations. The list describes services that are not covered under any condition, and some services that are covered only under specific conditions. Information in Section 4 also explains about some restrictions or limitations that apply to certain services.

If you get services that are not covered or you get services after limits are exhausted, you must pay for them yourself.

We will not pay for the Exclusions that are listed in this section (or elsewhere in this EOC), and neither will Original Medicare, unless they are found upon Appeal to be services that we should have paid or covered (Appeals are discussed in Sections 9 and 10). When a service is excluded, all services that are necessary for the excluded service and that would otherwise be covered are also excluded, except services required because of complications. The word service means any treatment, therapeutic or diagnostic procedure, drug, facility, equipment, device, or supply, or use of any of them.

What services are not covered by Medicare Plus?

In addition to any Exclusions or limitations described in Section 4 and in Section 15, or anywhere else in this booklet, the following items and services are not covered by Medicare Plus:

1. Services that are not covered under Original Medicare, unless such services are specifically listed as covered in Section 4.
2. Services that are not reasonable and necessary according to the standards of Original Medicare unless these services are otherwise listed as a Covered Service. As noted in Section 4, we provide all Covered Services according to Medicare guidelines.
3. Emergency Services for non-authorized, routine conditions that do not appear to a reasonable person to be based on a Medical Emergency/Emergency Medical Condition. (See Section 3 for more information about getting care for a Medical Emergency).
4. Experimental Procedures and Items (including investigational medical and surgical procedures, equipment and medications), unless covered by Original Medicare or for certain services covered under an approved clinical trial. Experimental Procedures and Items are those items and procedures determined by Kaiser Foundation Health Plan of Ohio and Original Medicare to not be generally accepted by the medical community. See Section 3 for information about participation in clinical trials while you are a Member of Medicare Plus.
5. Surgical treatment of morbid obesity unless Medically Necessary and covered under Original Medicare.
6. Private room in a Hospital, unless Medically Necessary.
7. Private duty nurses.
8. Personal convenience items, such as a telephone or television in your room at a Hospital or Skilled Nursing Facility.

9. Nursing care on a full-time basis in your home.
10. Custodial Care is not covered by Medicare Plus unless it is provided in conjunction with Skilled Nursing Care and/or skilled Rehabilitative Services. Custodial Care includes care that helps people with activities of daily living, like walking, getting in and out of bed, bathing, dressing, eating and using the bathroom, preparation of special diets, and supervision of medication that is usually self-administered.
11. Homemaker services.
12. Charges imposed by immediate relatives or members of your household.
13. Meals delivered to your home.
14. Unless Medically Necessary, elective or voluntary enhancement procedures, services, supplies and medications including but not limited to: weight loss, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging and mental performance.
15. Cosmetic surgery or procedures, unless it is needed because of accidental injury or to improve the function of a malformed part of the body. Breast surgery is covered for all stages of reconstruction for the breast on which a mastectomy was performed and, to produce a symmetrical appearance, surgery and reconstruction of the unaffected breast.
16. Routine dental care (such as cleanings, fillings, or dentures) or other dental services. Certain dental services that you get when you are in the Hospital will be covered.
17. Unless your Group has purchased additional coverage for chiropractic care, chiropractic care is generally not covered under the Plan, (with the exception of manual manipulation of the spine, as outlined in Section 4) and is limited according to Medicare guidelines.
18. Unless your Group has purchased additional coverage for routine foot care, routine foot care is generally not covered under Medicare Plus and is limited according to Medicare guidelines.
19. Orthopedic shoes, unless they are part of a leg brace and are included in the cost of the leg brace. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4, under "Durable Medical Equipment, Diabetic Equipment & Supplies, Prosthetics & Orthotics").
20. Supportive devices for the feet. There is an exception: orthopedic or therapeutic shoes are covered for people with diabetic foot disease (as shown in Section 4, under "Durable Medical Equipment, Diabetic Equipment & Supplies, Prosthetics & Orthotics").
21. Unless your Group has purchased additional coverage for hearing aids, hearing aids or tests to determine their effectiveness are not covered under the plan.
22. Unless your Group has purchased additional coverage for eyeglasses, eyeglasses (except after cataract surgery), all services related to eye surgery for the purpose of correcting refractive defects such as myopia, hyperopia, or astigmatism (for example, radial keratotomy, LASIK surgery, photo-refractive keratectomy, and similar procedures), vision therapy, (orthoptic therapy or eye training) and other low vision aids and services are not covered under this plan.
23. Self-administered prescription medication for the treatment of sexual dysfunction, including erectile dysfunction, impotence and anorgasmy or hyporgasmy is not covered under this plan unless your Group has purchased additional coverage for these medications.
24. Reversal of sterilization procedures (i.e., voluntary, surgically-induced fertility), sex change operations, and non-prescription contraceptive supplies and devices. (Infertility services, including a) cost of donor semen and donor eggs; b) services, other than artificial insemination, related to conception by artificial means, including, but not limited to, in-vitro fertilization, ovum transplants, gamete intrafallopian transfer, zygote intrafallopian transfer and prescription drugs related to such services. However, Medically Necessary services for

infertility are covered according to Original Medicare guidelines.) This exclusion applies to fertile and infertile individuals or couples.

25. Acupuncture.
26. Naturopaths' services.
27. Services provided to veterans in VA facilities. However, in the case of Emergency Services received at a VA Hospital, if the VA cost sharing is more than the cost sharing required under Medicare Plus, we will reimburse veterans for the difference. Members are still responsible for the Medicare Plus cost sharing amount.
28. Abortions, unless the life of the mother is endangered as the result of carrying the fetus to full term, and in case of incest and rape.
29. Massage therapy, except when part of a physical therapy treatment plan, ordered by a physician and provided by a physical therapist.
30. Blood products not specified in Section 4.
31. Disposable supplies for home use such as bandages, gauze, tape, antiseptics, dressings, ace-type bandages, and any other supplies, dressings, applicants, or devices not specifically listed as covered in Section 4.
32. Drugs or dermatological preparations, ointments, lotions, and creams prescribed for cosmetic purposes.
33. Hypnotism or hypnotic anesthesia services.
34. Services, including mental health services on court order or as a condition of parole or probation, unless determined by an Affiliated Provider to be necessary and appropriate
35. Methadone maintenance for the treatment of alcoholism or drug dependency.
36. Non-human organs and artificial organs and their implantation.
37. Non-prescription drugs that are not administered in Hospitals or Skilled Nursing Facilities.
38. Outpatient prescription drugs, unless your plan has an outpatient prescription drug benefit.
39. Procedures, services, supplies and medications until they are reviewed for safety, efficacy, and cost effectiveness and approved by Kaiser Permanente or Medicare.
40. Recreational therapy as part of either inpatient or outpatient mental health treatment.
41. Replacement prescriptions necessitated by theft or loss.
42. Testing for ability, aptitude, intelligence, or interest.
43. Treatment in a specialized alcoholism, drug abuse, or drug addiction treatment facility or program, when in the judgment of an Affiliated Provider, the services are not Medically Necessary.
44. Employer or government responsibility:
    a) Financial responsibility for services otherwise covered under this Agreement for any illness, injury or condition to the extent a payment or any other benefit, including any amount received as a settlement (collectively referred to as financial benefit), is provided under any workers' compensation or employers' liability law. We will provide services even if it is unclear whether a Member is entitled to a financial benefit. However, we may recover the value of any such services provided under this EOC, from any source providing a financial benefit, or from whom a financial benefit is due. In the alternative, we may recover such value from the Member, to the extent that a financial benefit is provided or payable, only if the Member does not receive claim under workers' compensation or employers' liability law because of the Member's failure to diligently seek to establish his or her rights thereto, or if a financial benefit is actually received by the Member.
    b) Financial responsibility for services that an employer is required by law to provide.

c) Services for any military service-connected illness, injury or condition when such services are reasonably available to the Member at a Department of Veteran Affairs Facility.
d) Financial responsibility for services for any illness, injury or condition, when the law requires such service to be provided only by, or received from, a government agency.

If there is a reasonable doubt whether any benefit is available or is required to be provided pursuant to any workers' compensation or employers' liability law, and if the Member seeks diligently to establish his or her rights to benefits, then services that otherwise would be provided under this EOC will be provided, except that the value of such services is recoverable by us or our nominee from any source providing benefits or from whom benefits are due, or from the Member, to the extent that the monetary benefits are provided or payable or would have been required to be provided if the Member had diligently sought to establish his or her rights to such benefits. This provision does not apply to Medicaid benefits.

Drug exclusions.

See the "Outpatient Prescription Drug Benefit" following the "2008 Medicare Plus Benefit Chart" in Section 15 for drug exclusions.

Section 9 How to File a Grievance

What is a Grievance?

A Grievance is any complaint, other than one that involves a request for an Organization Determination, a Coverage Determination or an Appeal, as described in Section 10 or Section 11 of this EOC because Grievances do not involve problems related to approving or paying for care or Medicare Part D benefits, problems about having to leave the Hospital too soon, and problems about coverage for Skilled Nursing Facility (SNF), Home Health Agency (HHA) or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending too soon.

For problems about coverage or payment for care, problems about being discharged from the Hospital too soon, and problems about coverage for Skilled Nursing Facility (SNF), Home Health Agency (HHA), or Comprehensive Outpatient Rehabilitation Facility (CORF) services ending too soon, you must follow the rules outlined in Section 10.

If you have a problem about our failure to cover or pay for a Medicare Part D prescription drug, you must follow the rules outlined in Section 11.

What types of problems might lead to your filing a Grievance?

- Problems with the quality of the medical care you receive, including quality of care during a Hospital stay.
- If you feel that you are being encouraged to leave (Disenroll from) Medicare Plus.
- Problems with the service you receive from Customer Relations.
- Problems with how long you have to spend waiting on the phone, in the waiting room, in a Plan Pharmacy, or in the exam room.
- Problems with getting appointments when you need them, or having to wait a long time for an appointment.
- Disrespectful or rude behavior by doctors, nurses, receptionists, Plan Pharmacists, or other staff.
- Cleanliness or condition of doctor's offices, clinics, Plan Pharmacies, or Hospitals.
- If you disagree with our decision not to expedite your request for an expedited Coverage Determination, Organization Determination, redetermination, or reconsideration.
- You believe our notices and other written materials are difficult to understand.
- Failure to give you a decision within the required timeframe.
- Failure to forward your case to the independent review organization if we do not give you a decision within the required timeframe.
- Failure by the Plan to provide required notices.

If you have one of these types of problems and want to make a complaint, it is called "Filing a Grievance." In certain cases, you have the right to ask for a "fast Grievance," meaning we will answer your Grievance within 24 hours. We discuss fast Grievances in more detail in Section 10 and/or Section 11.

Filing a Grievance with Kaiser Permanente.

If you have a complaint, please call the phone number for Organization Determinations and Grievances for Medical Service Benefits and/or Medicare Part D Coverage Determinations and Grievances in Section 1 of this EOC. We will try to resolve your complaint over the phone. If you ask for a written response, we will respond in writing to you. **If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. We call this our Member Grievance Procedure.** To use the Member Grievance Procedure, send your Grievance in writing to Customer Relations. Please see Section 1 for ways to contact Customer Relations. We must notify you of our decision about your Grievance as quickly as your case requires based on your health status, but no later than 30 days after receiving your complaint. We may extend the timeframe by up to 14 days if you request the extension, or if we justify a need for additional information and the delay is in your best interest. If additional time is needed, we will keep you informed of how your Grievance is being handled.

For quality of care problems, you may also complain to the QIO.

You may complain about the quality of care received under Medicare, including care during a Hospital stay. You may complain to us using the Grievance process, to an independent review organization called the Quality Improvement Organization QIO, or both. If you file with the QIO, we must help the QIO resolve the complaint. See Section 1 for more information about the QIO.

How to file a quality of care complaint with the QIO.

You must write to the QIO to file a quality of care complaint. You may file your complaint with the QIO at any time. See Section 1 for more information about how to file a quality of care complaint with the QIO.

Section 10 What to Do if you have Complaints about Your Medical Service Benefits

Introduction

This section gives the rules for making complaints about the medical services and payments in different types of situations. Note: please see Section 11 for complaints about prescription drugs (Medicare Part D). Federal law guarantees your right to make complaints if you have concerns or problems with your medical care as a plan member. If you make a complaint, we must be fair in how we handle it. You cannot be Disenrolled from Medicare Plus or penalized in any way if you make a complaint.

As stated in Section 3, you may use non-Plan Providers. However, if you use non-Plan Providers for care that is not emergent or Urgently Needed Care, you will usually have to pay Original Medicare cost sharing amounts for your care. If you have a complaint about a bill when you receive care from a non-Plan Provider, the Appeals process in this section will not apply (unless you were directed to go to that non-Plan Provider by the Plan or one of the Plan Providers). Instead, please refer to the notice of the service you receive from Original Medicare. It is called a **M**edicare **S**ummary **N**otice **(MSN)**. The MSN will provide information on how to Appeal a decision made by Original Medicare.

If you have a complaint regarding a service provided by a hospital or skilled nursing facility that is not part of Medicare Plus, you will follow Original Medicare rules as provided in your 2008 Medicare & You Handbook. However, if you have a complaint involving a Plan Facility, such as a Hospital or Skilled Nursing Facility (or you were directed to go to a non-Plan Facility by us or one of our Providers), you will follow the instructions contained in this section. This is true even if you received a Medicare Summary Notice (MSN) indicating that a claim was processed but not covered by Original Medicare. Furthermore, if you have a complaint regarding an Emergency Service or Urgently Needed Care, or the cost sharing for Hospital or Skilled Nursing Facility services, you will follow the instructions contained in this section. See Section 3 for guidance on what is emergency or Urgently Needed Care.

Please refer to Original Medicare of your 2008 Medicare & You Handbook for additional guidance on your Appeal rights under Original Medicare. If you do not have a "Medicare & You" Handbook, please call Medicare at 1-800-MEDICARE to get a copy.

How to make complaints in different situations.

This section tells you how to make a complaint about services or payment disputes in each of the following situations:

Part 1. Complaints about what benefit or service we will approve or what we will pay for.

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

Part 3. Complaints if you think your Skilled Nursing Facility (SNF), home health (HHA) or comprehensive outpatient rehabilitation facility (CORF) services are ending too soon.

If you want to make a complaint about any situation not listed above, you may file a Grievance. For more information about Grievances, see Section 9.

PART 1. Complaints about what benefit or service Medicare Plus will approve or what Kaiser Permanente will pay for.

What are "complaints about your services or payment for your care?"
If you are not getting the care you want, and you believe that this care is covered by the Plan.

- If we will not approve the medical treatment your doctor or other medical provider wants to give you, and you believe that this treatment is covered by the Plan.
- If you are being told that a treatment or service you have been getting will be reduced or stopped, and you believe that this could harm your health.
- If you have received care that you believe should be covered by the Plan, but we have refused to pay for this care because we say it is not Medically Necessary or is not a plan benefit.

What is an organization determination?
An organization determination is our **Initial Decision** about whether we will provide the medical care or service you request, or pay for a service you have received.

If our Initial Decision is to deny your request, you may **Appeal** the decision by going to Appeal Level 1 (see below). You may also Appeal if we fail to make a timely Initial Decision on your request.

When we make an "organization determination," we are giving our interpretation of how the benefits and services that are covered for Members of Medicare Plus apply to your specific situation. This EOC and any amendments you may receive describe the benefits and services covered by Medicare Plus, including any limits on these services. This EOC also lists services that are "not covered" by the plan.

Who may ask for an "organization determination" about your medical care or payment?

Your doctor or other medical provider may ask us whether we will authorize the treatment. You may also ask us for an Initial Decision, or you can name (appoint) someone to do it for you. This person you name would be your representative. You can name a relative, friend, advocate, doctor, or someone else to act for you. Other persons may already be authorized under state law to act for you. If you want someone to act for you, then you and the person you want to act for you must sign and date a statement that gives this person legal permission to be your representative. This statement must be sent to us at the address listed under Organization Determinations and Grievances for Medical Service Benefits in Section 1 of this booklet. Please call us at the phone

number shown under Organization Determinations and Grievances for Medical Service Benefits for more information.

You also have the right to have a lawyer act for you. You can get your own lawyer, or find 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. You may want to call the following agencies for more information:

- Medicare Rights Center 1-888-HMO-9050.
- Area Agency on Aging (telephone number varies by county, check your local phone book for the correct listing).
- Eldercare 1-800-677-1116.
- Ohio State Health Insurance Assistance Program 1-800-686-1578.

Do you have a request for medical care that needs to be decided more quickly than the standard time frame?

A decision about whether we will pay for or approve medical care can be a "standard decision" that is made within the standard time frame (typically within 14 days), or it can be a "fast decision" that is made more quickly (typically within 72 hours). A fast decision is also called an "expedited organization determination." You may ask for a fast decision **only** if you or any doctor believe that waiting for a standard decision could seriously harm your health or your ability to function.

Asking for a standard decision.

To ask for a standard Initial Decision about providing medical care or payment for care, you or your representative should mail or deliver a request in writing to the address listed under Organization Determinations and Grievances for Medical Service Benefits in Section 1 of this booklet

Asking for a fast decision.

You, any doctor, or your representative can ask us to give a fast decision (rather than a standard decision) about medical care by calling us. Or you may send or fax us a written request to the fax number or address listed under Organization Determinations and Grievances for Medical Service Benefits in Section 1 of this booklet. Be sure to ask for a "fast" or "72-hour" review.

If **any** doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will give you a fast decision.

If you ask for a fast decision without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast decision, we will send you a letter informing you that if you get a doctor's support for a fast decision, we will automatically give you a fast decision. The letter will also tell you how to file a Grievance if you disagree with our decision to deny your request for a fast review. It will also tell you about your right to ask for a fast Grievance. If we deny your request for a fast Initial Decision, we will give you a standard Initial Decision. For more information about Grievances, see Section 9.

What happens next when you request an Initial Decision?

1. For an Initial Decision about payment for care you already received.

We have 30 days to make a decision after we receive your request. However, if we need more information, we can take up to 30 more days. You will be told in writing if we extend the time frame for making a decision. If we do not approve your request for payment, we must tell you why, and tell you how you can Appeal this decision. If you have not received an answer from us within 60 days of your request, you can Appeal this decision. (An Appeal is also called a "reconsideration.")

2. For a standard Initial Decision about medical care.

We have 14 days to make a decision after we receive your request. However, we can take up to 14 more days if you ask for additional time, or if we need more time to gather information (such as medical records) that may benefit you. If we take additional days, we will notify you in writing. If you believe that we should not take additional days, you can make a specific type of complaint called a fast Grievance (see Section 9). If we do not approve your request, we must explain why in writing, and tell you of your right to Appeal our decision. If you have not received an answer from us within 14 days of your request (or by the end of any extended time period), you have the right to Appeal.

3. For a fast Initial Decision about medical care.

If you receive a fast decision, we will give you our decision about your requested medical care within 72 hours after you or your doctor ask for it – sooner if your health requires. However, we can take up to 14 more days if we find that some information is missing that may benefit you, or if you need more time to prepare for this review. If you believe that we should not take any extra days, you can file a fast Grievance.

We will call you as soon as we make the decision. If we deny any part of your request, we will send you a letter that explains the decision within 3 days of calling you. If we do not tell you about our decision within 72 hours (or by the end of any extended time period), you have the right to Appeal. If we deny your request for a fast decision, you may file a fast Grievance.

Appeal Level 1: If we deny any part of your request for a service or payment of a service, you may ask us to reconsider our decision. This is called an Appeal or a request for reconsideration.

Please call us if you need help in filing your Appeal. We give the request to different people than those who made the organization determination. This helps ensure that we will give your request a fresh look.

If your Appeal concerns a decision we made about a service you asked for, then you and/or your doctor will first need to decide whether you need a fast Appeal. The procedures for deciding on a standard or a fast Appeal are the same as those described for a standard or fast Initial Decision. While the process for deciding on a Standard or Fast Appeal is the same as the process for an Initial Decision, please note that the place where the Appeal is sent is different. To file your Appeal, you

can call or send the Appeal to us in writing. See Section 1 for contact information under Medical Service Benefits and Medicare Part D Appeals.

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

You can give us additional information to support your Appeal by calling, faxing, or writing to the numbers or address listed under Medical Service Benefits and Medicare Part D Appeals in Section 1 of this EOC. You can also deliver additional information in person to the address listed under Medical Service Benefits and Medicare Part D Appeals in Section 1 of this EOC or we may notify you in writing when and where to appear in order to present the additional information for your Appeal.

You also have the right to ask us for a copy of the information we have regarding your Appeal. You may call or write us at the numbers or address listed under Medical Service Benefits and Medicare Part D Appeals in Section 1 of this EOC.

How do you file your Appeal of the Initial Decision?
The rules about who may file an Appeal are the same as the rules about who may ask for an Initial Decision. Follow the instructions under "Who may ask for an Initial Decision about medical care or payment?" However, providers who do not have a contract with Kaiser Permanente must sign a "waiver of payment" statement that says that they will not ask you to pay for the medical service under review, regardless of the outcome of the Appeal.

How soon must you file your Appeal?
You need to file your Appeal within 60 days after we notify you of our Initial Decision. We can give you more time if you have a good reason for missing the deadline. To file your Appeal, you may call or write us at the phone number or address listed under Medical Service Benefits and Medicare Part D Appeals in Section 1 of this EOC.

What if you want a fast Appeal?
The rules about asking for a fast Appeal are the same as the rules about asking for a fast decision. While the process for deciding on a Standard or Fast Appeal is the same as the process for an Initial Decision, please note that the place where the Appeal is sent is different. As stated above, to file your Appeal, you can call or send the Appeal to us in writing. See Section 1 for contact information under Medical Service Benefits and Medicare Part D Appeals.

How soon must we decide on your Appeal?

1. **For a decision about payment for care you already received.**
   After we receive your Appeal, we have 60 days to decide. If we do not decide within 60 days, your Appeal automatically goes to Appeal Level 2.

2. **For a standard decision about medical care.**
   After we receive your Appeal, we have 30 days to decide, but will decide sooner if your health condition requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not tell you our decision within 30 days (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

3. **For a fast decision about medical care.**
   After we receive your Appeal, we have 72 hours to decide, but will decide sooner if your health requires. However, if you ask for more time, or if we find that helpful information is missing, we can take up to 14 more days to make our decision. If we do not decide within 72 hours (or by the end of the extended time period), your request will automatically go to Appeal Level 2.

What happens next if we rule completely in your favor?

1. **For a decision about payment for care you already received.**
   We must pay within 60 days of the day we received your Appeal.

2. **For a standard decision about medical care.**
   We must authorize or provide your requested care within 30 days of receiving your Appeal. If we extended the time needed to decide your Appeal, we will authorize or provide your medical care immediately.

3. **For a fast decision about medical care.**
   We must authorize or provide your requested care within 72 hours of receiving your Appeal – or sooner, if your health requires it. If we extended the time needed to decide your Appeal, we will authorize or provide your medical care immediately.

Appeal Level 2: If on your Level 1 Appeal, we do not rule completely in your favor, your Appeal will automatically be reviewed by an independent review organization.

If we do not rule completely in your favor, your Appeal is automatically sent to Appeal Level 2 where an independent review organization that has a contract with CMS (**C**enters for **M**edicare & Medicaid **S**ervices), the government agency that runs the Medicare program will review your Appeal. This organization is not affiliated with Kaiser Permanente. We will tell you in writing that your Appeal has been sent to this organization for review.

How quickly we must forward your Appeal depends on the type of Appeal.

1. **For a decision about payment for care you already received.**
   We must forward your Appeal to the independent review organization within 60 days of the date we received your Level 1 Appeal.

2. **For a standard decision about medical care.**
   We must send all of the information about your Appeal to the independent review organization as quickly as your health requires, but no later than 30 days after we received your Level 1 Appeal.

3. **For a <u>fast</u> decision about medical care.**
   We must forward your Appeal to the independent review organization within 24 hours of our decision.

We will send the independent review organization a copy of your case file. You also have the right to get a copy of your case file from us by calling or writing us at the phone number or address listed under Medical Service Benefits and Medicare Part D Appeals in Section 1 of this EOC.

How soon must the independent review organization decide?

1. For an Appeal about payment for care, the independent review organization has 60 days to make a decision.

2. For a standard Appeal about medical care, the independent review organization has 30 days to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.

3. For a fast Appeal about medical care, the independent review organization has 72 hours to make a decision. However, it can take up to 14 more days if more information is needed and the extension will benefit you.

What if the independent review organization decides completely in your favor?

The independent review organization will tell you in writing about its decision.

1. For an Appeal about payment for care, we must pay within 30 days after receiving the decision.

2. For a standard Appeal about medical care, we must authorize the care you requested within 72 hours after receiving the decision, or provide the care no later than 14 days after receiving the decision.

   We must authorize or provide the care no later than 14 days after receiving the decision. If it is not appropriate to provide the service within 14 calendar days, e.g., because of your medical condition or you are outside of the Service Area, we must authorize the services within 72 hours from the date we receive notice that the independent review organization reversed the determination.

3. For a fast Appeal about medical care, we must authorize or provide the care you requested within 72 hours after receiving the decision.

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

You must ask for a review by an Administrative Law Judge in writing within 60 days after the date you were notified of the decision made at Appeal Level 2. They may extend the deadline for good cause. You must send your written request to the ALJ Field Office that is listed in the decision you received from the independent review organization. The Administrative Law Judge will not review the Appeal if the dollar value of the medical care does not meet the minimum requirement included

in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not Appeal any further. During this review, you may present evidence, review the record, and be represented by a lawyer.

How soon will the Judge make a decision?
The Administrative Law Judge will hear your case, weigh all of the evidence up to this point, and decide as soon as possible.

What if the Judge decides in your favor?
We must pay for, authorize, or provide the service you have asked for within 60 days of the date we receive notice of the decision. However, we have the right to Appeal this decision by asking for a review by the Medicare Appeals Council (Appeal Level 4).

Appeal Level 4: If the Judge does not rule completely in your favor, you may ask for a review by the Medicare Appeals Council.

The Medicare Appeals Council does not review every case it receives. If they decide not to review your case, then either you or we may ask for a review by a Federal Court Judge (Appeal Level 5). The Medicare Appeals Council will send a notice informing you of any action it has taken on your request. The notice will tell you how to request a review by a Federal Court Judge.

How soon will the Council make a decision?
If the Medicare Appeals Council reviews your case, they will decide as soon as possible.

What if the Council decides in your favor?
We must pay for, authorize, or provide the medical care you requested within 60 days of the date we receive the decision. However, we have the right to ask a Federal Court Judge to review the case (Appeal Level 5), as long as the dollar value of the care you asked for meets the minimum requirement.

If the Council decides against you:
If the amount involved is less than the minimum requirement, the Council's decision is final and you may not take the Appeal any further.

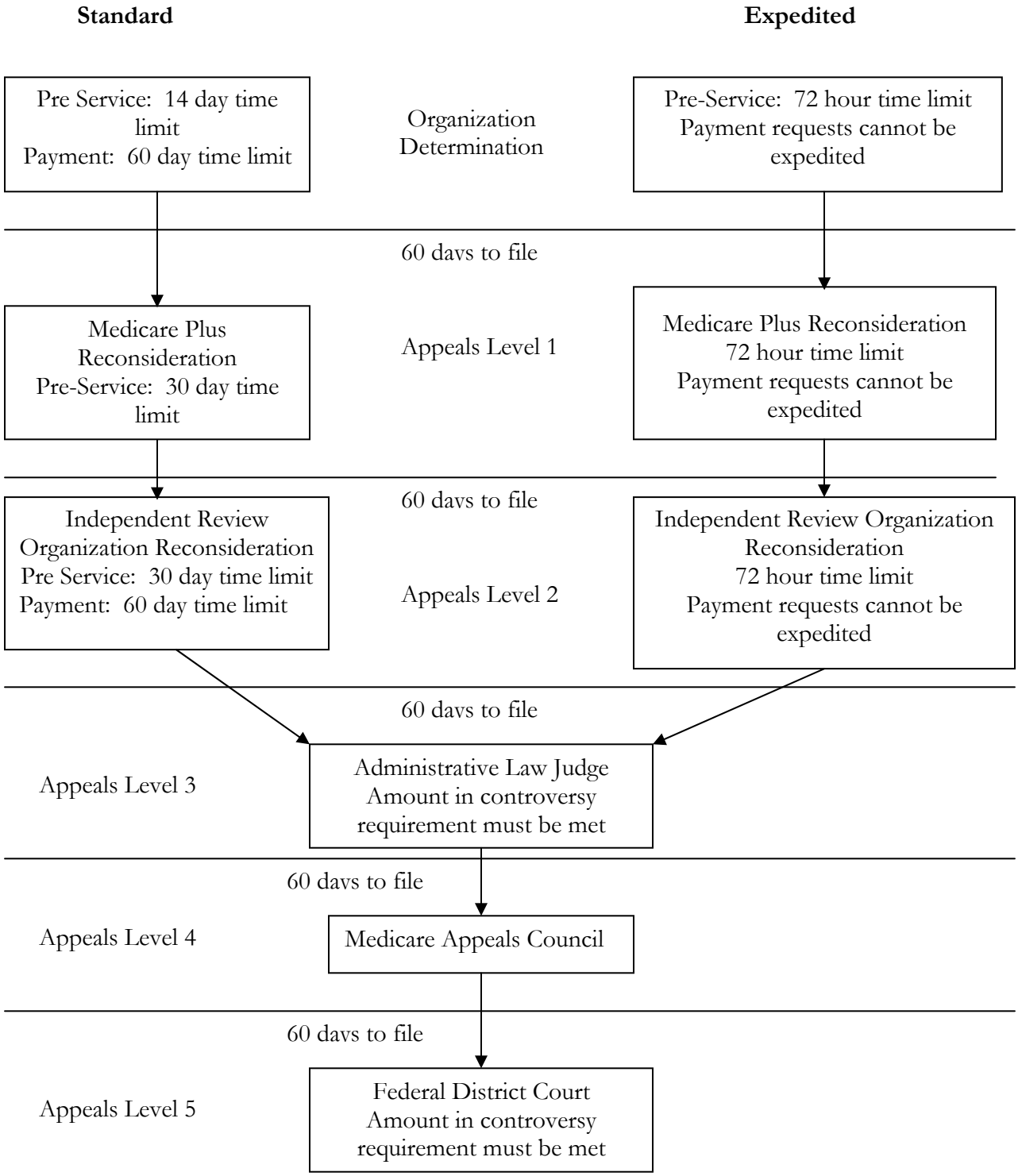
Appeal Level 5: If the Medicare Appeal Council does not rule completely in your favor, you may ask for a review by a Federal Court.

You may file an Appeal in Federal court if you receive a decision from the Medicare Appeals Council (MAC) that is not completely favorable to you or the MAC decided not to review your case. The letter you get from the MAC will tell you how to ask for this review. The Federal Court Judge will first decide whether to review your case. Your Appeal will not be reviewed by a Federal Court if the dollar value of the care you asked for does not meet the minimum requirement included in the MAC's decision.

How soon will the Judge make a decision?
The Federal judiciary controls the timing of any decision. The Judge's decision is final and you may not take the Appeal any further.

As a Plan Member, some of the Covered Services may also be covered by Medicaid. Therefore, if you believe that we improperly denied you a service or payment for a service, you may also have the right to Appeal this decision to Medicaid. We will let you know in writing if you have the right to Appeal our decision to Medicaid.

Complaint process for what benefit or service Medicare Plus will approve or what it will pay for.



PART 2. Complaints (Appeals) if you think you are being discharged from the Hospital too soon.

When you are admitted to the Hospital, you have the right to get all the Hospital care covered by Medicare Plus that is necessary to diagnose and treat your illness or injury. The day you leave the Hospital (your discharge date) is based on when your stay in the Hospital is no longer Medically Necessary. This part of Section 10 explains what to do if you believe that you are being discharged too soon.

Information you should receive during your Hospital stay
Within two days of admission as an inpatient, someone at the Hospital must give you a notice called the "Important Message from Medicare." You can call the Customer Relations phone number listed in Section 1 of this EOC or call Medicare at 1-800-MEDICARE (1-800-633-4227) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI/. This notice explains:

- Your right to get all Medically Necessary Hospital services covered by Medicare Plus (except for any applicable Copayments or deductibles).
- Your right to be involved in any decisions that the Hospital, your doctor, or anyone else makes about your Hospital services and who will pay for them.
- Your right to get services you need after you leave the Hospital.
- Your right to Appeal a discharge decision and have your Hospital services paid for by us during the Appeal (except for any applicable Copayments or deductibles).

You (or your representative) will be asked to sign the "Important Message from Medicare" to show that you received and understood this notice. **Signing the notice does not mean that you agree that the coverage for your services should end – only that you received and understand the notice.** If the Hospital gives you the "Important Message from Medicare" more than 2 days before your discharge day, it must give you a copy of your signed "Important Message from Medicare" before you are scheduled to be discharged.

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

What is the "Quality Improvement Organization"/KEPRO?
KEPRO or "QIO" stands for **Q**uality **I**mprovement **O**rganization. The QIO is a group of doctors and other health care experts paid by the federal government to check on and help improve the care given to Medicare patients. They are not part of the Plan or the Hospital. There is one QIO in each state. QIOs have different names, depending on which state they are in. In Ohio, the QIO is called KEPRO. The doctors and other health experts in the KEPRO review certain types of complaints made by Medicare patients. These include complaints from Medicare patients who think their Hospital stay is ending too soon.

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

- You must ask the QIO for a **"fast review"** of your discharge. This "fast review" is also called an "immediate review."
- You must request a review from the QIO no later than the day you are scheduled to be discharged from the Hospital. If you meet this deadline, you may stay in the Hospital after your discharge date without paying for it while you wait to get the decision from the QIO.
- The QIO will look at your medical information provided to the QIO by us and the Hospital.
- During this process, you will get a notice giving our reasons why we believe that your discharge date is medically appropriate.
- The QIO will decide, within one day after receiving the medical information it needs, whether it is medically appropriate for you to be discharged on the date that has been set for you.

What happens if the QIO decides in your favor?
We will continue to cover your Hospital stay for as long as it is Medically Necessary (except for any applicable Copayments or deductibles).

What happens if the QIO agrees with the discharge?
You will not be responsible for paying the Hospital charges until noon of the day after the QIO gives you its decision. However, you could be financially liable for any inpatient Hospital services provided after noon of the day after the QIO gives you its decision. You may leave the Hospital on or before that time and avoid any possible financial liability.

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

What happens if you Appeal the QIO decision?
The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive inpatient care. If the QIO agrees that your care should continue, we must pay for or reimburse you for any care you have received since the discharge date on the "Important Message from Medicare," and provide you with inpatient care as long as it is Medically Necessary (except for any applicable Copayments or deductibles).

If the QIO upholds its original decision, you may be able to Appeal its decision to the Administrative Law Judge. Please see Appeal Level 3 in Part 1 of this section for guidance on the Administrative Law Judge (ALJ) Appeal. If the ALJ upholds the decision, you may also be able to ask for a review by the Medicare Appeals Council (MAC) or a Federal court. If any of these decision makers (Administrative Law Judge, Medicare Appeal Council, Federal Court) agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date, and provide you with inpatient care as long as it is Medically Necessary (except for any applicable Copayments or deductibles).

What if you do not ask the QIO for a review by the deadline?
If you do not ask the QIO for a fast review of your discharge by the deadline, you may ask us for a "fast appeal" of your discharge, which is discussed in Part 1 of this section.

If you ask us for a fast Appeal of your discharge and you stay in the Hospital past your discharge date, you may have to pay for the Hospital care you receive past your discharge date. Whether you have to pay or not depends on the decision we make.

- If we decide, based on the fast appeal, that you need to stay in the Hospital, we will continue to cover your Hospital care for as long as it is Medically Necessary (except for any applicable co-payments or deductibles).
- If we decide that you should not have stayed in the Hospital beyond your discharge date, we will not cover any Hospital care you received after the discharge date.

If we uphold our original decision, we will forward our decision and case file to the independent review organization within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the Independent Review Organization (IRO) Appeal. If the IRO upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers (Independent Review Organization, Administrative Law Judge, Medicare Appeal Council, Federal Court) agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for as long as they are Medically Necessary (except for any applicable Copayments or deductibles).

PART 3. Complaints (Appeals) if you think coverage for your Skilled Nursing Facility, Home Health Agency, or Comprehensive Outpatient Rehabilitation Facility Services is ending too soon.

When you are a patient in a **S**killed **N**ursing **F**acility (SNF), **H**ome **H**ealth **A**gency (HHA), or **C**omprehensive **O**utpatient **R**ehabilitation **F**acility (CORF), you have the right to get all the SNF, HHA or CORF care covered by Medicare Plus that is necessary to diagnose and treat your illness or injury. The day we end coverage for your SNF, HHA or CORF services is based on when these services are no longer Medically Necessary. This part of Section 10 explains what to do if you believe that coverage for your services is ending too soon.

Information you will receive during your SNF, HHA or CORF stay.
Your provider will give you written notice called the "Notice of Medicare Non-Coverage" at least 2 days before coverage for your services ends. You can call the Customer Relations phone number in Section 1 of this EOC or call Medicare at 1-800-MEDICARE (1-800-633-4227) to get a sample notice or see it online at http://www.cms.hhs.gov/BNI/. You (or your representative) will be asked to sign and date this notice to show that you received it. **Signing the notice does not mean that you agree that coverage for your services should end – only that you received and understood the notice.**

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

How soon do you have to ask for QIO review?
You must quickly contact the QIO. The written notice you got from your provider gives the name and telephone number of your QIO and tells you what you must do.

- If you get the notice 2 days before your coverage ends, you must contact the QIO no later than noon of the day after you get the notice.
- If you get the notice more than 2 days before your coverage ends, you must make your request no later than noon of the day before the date that your Medicare coverage ends.

What will happen during the QIO's review?
The QIO will ask why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish. The QIO will also look at your medical information, talk to your doctor, and review information that we have given to the QIO. During this process, you will get a notice called the "Detailed Explanation of Non-Coverage" giving the reasons why we believe coverage for your services should end. You can call the Customer Relations phone number in Section 1 of the EOC or call Medicare at 1-800-MEDICARE to get a sample notice or see it online at http://www.cms.hhs.gov/BNI/.

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

What happens if the QIO decides in your favor?
We will continue to cover your SNF, HHA or CORF services for as long as they are Medically Necessary (except for any applicable co-payments or deductibles).

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

What happens if you Appeal the QIO decision?
The QIO has 14 days to decide whether to uphold its original decision or agree that you should continue to receive services. If the QIO agrees that your services should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for as long as they are Medically Necessary (except for any applicable Copayments or deductibles).

If the QIO upholds its original decision, you may be able to Appeal its decision to the Administrative Law Judge (ALJ). Please see Appeal Level 3 in Part 1 of this section for guidance on the ALJ Appeal. If the ALJ upholds our decision, you may also be able to ask for a review by the Medicare Appeals Council or a Federal Court. If either the Medicare Appeal Council or Federal Court agrees that your stay should continue, we must pay for or reimburse you for any care you have received since the termination date on the notice you got from your provider, and provide you with any services you asked for as long as they are Medically Necessary (except for any applicable Copayments or deductibles).

What if you do not ask the QIO for a review by the deadline?
If you do not ask the QIO for a review by the deadline, you may ask us for a fast appeal, which is discussed in Part 1 of this section.

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

- If we decide, based on the fast appeal, that coverage for your services should continue, we will continue to cover your SNF, HHA, or CORF services for as long as they are Medically Necessary.
- If we decide that you should not have continued getting services, we will not cover any services you received after the termination date.

If we uphold our original decision, we will forward our decision and case file to the independent review organization within 24 hours. Please see Appeal Level 2 in Part 1 of this section for guidance on the Independent Review Organization (IRO) Appeal. If the IRO upholds our decision, you may also be able to ask for a review by an ALJ, MAC, or a Federal court. If any of these decision makers (Independent Review Organization, Administrative Law Judge, Medicare Appeal Council, Federal Court) agree that your stay should continue, we must pay for or reimburse you for any care you have received since the discharge date on the notice you got from your provider, and provide you with any services you asked for as long as they are Medically Necessary (except for any applicable Copayments or deductibles).

Section 11 What to Do if You have Complaints about Your Medicare Part D Prescription Drug Benefits

What to do if you have complaints.

We encourage you to let us know right away if you have questions, concerns, or problems related to your prescription drug coverage. Please call Customer Relations at the number in Section 1 of this EOC.

Please note that this section addresses complaints about your Medicare Part D prescription drug benefits. If you have complaints about your medical service benefits, you must follow the rules outlined in Section 10.

This section gives the rules for making complaints in different types of situations. Federal law guarantees your right to make complaints if you have concerns or problems with any part of your care as a plan member. The Medicare program has helped set the rules about what you need to do to make a complaint and what we are required to do when we receive a complaint. If you make a complaint, we must be fair in how we handle it. You cannot be Disenrolled or penalized in any way if you make a complaint.

A complaint will be handled as a Grievance, Coverage Determination, or an Appeal, depending on the subject of the complaint.

A Grievance is any complaint other than one that involves a Coverage Determination. You would file a Grievance if you have any type of problem with us or one of our Plan Pharmacies that does not relate to coverage for a prescription drug. For more information about Grievances, see Section 9.

A Coverage Determination is the first decision we make about covering the drug you are requesting. If your doctor or pharmacist tells you that a certain prescription drug is not covered, you may contact us if you want to request a Coverage Determination. For more information about Coverage Determinations and Exceptions, refer to "How to request a Coverage Determination?" described later in this section.

An Appeal is any of the procedures that deal with the review of an unfavorable Coverage Determination. You cannot request an Appeal if we have not issued a Coverage Determination**.** If we issue an unfavorable Coverage Determination, you may file an Appeal called a "redetermination" if you want us to reconsider and change our decision. If our redetermination decision is unfavorable, you have additional Appeal rights. For more information about Appeals, refer to "The Appeal Process" described later in this section.

How to request a Coverage Determination?

What is the purpose of this section?
This part of Section 11 explains what you can do if you have problems getting the prescription drugs you believe we should provide and you want to request a Coverage Determination. We use the word "provide" in a general way to include such things as authorizing prescription drugs, paying for prescription drugs, or continuing to provide a Medicare Part D prescription drug that you have been getting.

What is a Coverage Determination?
The Coverage Determination made by Kaiser Permanente is the starting point for dealing with requests you may have about covering or paying for a Medicare Part D prescription drug. If your doctor or pharmacist tells you that a certain prescription drug is not covered, you should contact us and ask us for a Coverage Determination. With this decision, we explain whether we will provide the prescription drug you are requesting or pay for a prescription drug you have already received. If we deny your request (this is sometimes called an "adverse Coverage Determination"), you may "Appeal" the decision by going on to Appeal Level 1 described later in this section. If we fail to make a timely Coverage Determination on your request, it will be automatically forwarded to the independent review organization for review (see Appeal Level 2 described later in the section).

The following are examples of Coverage Determination requests:

- You ask us to pay for a prescription drug you have received. This is a request for a Coverage Determination about payment. You may call us at the phone number shown under Medicare Part D Coverage Determinations and Grievances in Section 1 of this EOC to ask for this type of decision.
- You ask for a Medicare Part D Drug that is not on the Plan's list of Covered Drugs (called a "Formulary"). This is a request for a "Formulary Exception." You may call us at the phone number shown under Medicare Part D Coverage Determinations and Grievances in Section 1 of this EOC to ask for this type of decision. See "What is an Exception?" below for more information about the Exceptions process.
- You ask for an Exception to our utilization management tools - such as quantity limits. Requesting an Exception to a utilization management tool is a type of Formulary Exception. You may call us at the phone number shown under Medicare Part D Coverage Determinations and Grievances in Section 1 of this EOC to ask for this type of decision. See "What is an Exception?" below for more information about the Exceptions process.
- You ask us to reimburse you for the cost of a drug you bought at a non-Plan Pharmacy. In certain circumstances, non-Plan Pharmacy purchases, including drugs provided to you in a physician's office, will be covered by the Plan. See "Filling Prescriptions Outside Plan Pharmacies" in Section 3 for a description of these circumstances. You may call us at the phone number shown under Medicare Part D Coverage Determinations and Grievances in Section 1 of this EOC to make a request for payment or coverage for drugs provided by a non-Plan Pharmacy or in a physician's office.

What is an Exception?
An Exception is a type of Coverage Determination. You may ask us to make an Exception to our coverage rules in a number of situations.

- You may ask us to cover your drug even if it is not on our Formulary. Excluded drugs cannot be covered by a Medicare Part D plan unless coverage is through an enhanced plan that covers those excluded drugs.
- You may ask us to waive coverage restrictions or limits on your drug. For example, for certain drugs, we limit the amount of the drug that we will cover. If your drug has a quantity limit, you may ask us to waive the limit and cover more. See Section 5 ("Utilization management") to learn more about our additional coverage restrictions or limits on certain drugs."

Generally, we will only approve your request for an Exception if the alternative drugs included on the Plan Formulary would not be as effective in treating your condition and/or would cause you to have adverse medical effects.

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

If we approve your Exception request, our approval is valid for the remainder of the Plan year, so long as your doctor continues to prescribe the drug for you and it continues to be safe and effective for treating your condition. If we deny your Exception request, you may Appeal our decision.

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

Who may ask for a Coverage Determination?
You, your prescribing physician, or someone you name may ask us for a Coverage Determination. The person you name would be your appointed representative. You may name a relative, friend, advocate, doctor, or anyone else to act for you. Other persons may already be authorized under State law to act for you. If you want someone to act for you, then you and that person must sign and date a statement that gives the person legal permission to be your appointed representative. This statement must be sent to us at the address listed under Medicare Part D Coverage Determinations and Grievances in Section 1 of this EOC. To learn how to name your appointed representative, you may call Customer Relations at the number also located in Section 1 of this EOC.

You also have the right to have a lawyer 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.

Asking for a "standard" or "fast" Coverage Determination.

Do you have a request for a Medicare Part D prescription drug that needs to be decided more quickly than the standard time frame?
A decision about whether we will give you or pay for a Medicare Part D prescription drug can be a "standard" Coverage Determination that is made within the standard time frame (typically within 72 hours; see below), or it can be a "fast" Coverage Determination that is made more quickly (typically within 24 hours; see below). A fast decision is also called an "expedited Coverage Determination."

You may ask for a fast decision only if you or your doctor believe that waiting for a standard decision could seriously harm your health or your ability to function. (Fast decisions apply only to requests for Medicare Part D Drugs that you have not received yet. You cannot get a fast decision if you are asking us to pay you back for a Medicare Part D Drug that you already received.)

Asking for a standard decision.
To ask for a standard decision, you, your doctor, or your appointed representative should contact us using any of the methods provided under Medicare Part D Coverage Determinations and Grievances in Section 1 of this EOC.

Asking for a fast decision.
You, your doctor, or your appointed representative may ask us to give you a fast decision by calling, faxing, or writing us at the numbers or address listed under Medicare Part D Coverage Determinations and Grievances in Section 1 of this EOC. Be sure to ask for a "fast," "expedited," or "24-hour" review.

- If your doctor asks for a fast decision for you, or supports you in asking for one, and the doctor indicates that waiting for a standard decision could seriously harm your health or your ability to function, we will automatically give you a fast decision.
- If you ask for a fast Coverage Determination without support from a doctor, we will decide if your health requires a fast decision. If we decide that your medical condition does not meet the requirements for a fast Coverage Determination, we will send you a letter informing you that if you get a doctor's support for a fast review, we will automatically give you a fast decision. The letter will also tell you how to file a "Grievance" if you disagree with our decision to deny your request for a fast review. If we deny your request for a fast Coverage Determination, we will give you our decision within the 72-hour standard time frame.

What happens when you request a Coverage Determination?
1. For a standard Coverage Determination about a Medicare Part D Drug that includes a request to pay you back for a Medicare Part D Drug that you have already received.

   Generally, we must give you our decision no later than 72 hours after we receive your request, but we will make it sooner if your health condition requires. However, if your request involves a request for an Exception (including a Formulary Exception or an Exception from utilization management rules – such as quantity limits), we must give you our decision no later than

72 hours after we receive your physician's "supporting statement" explaining why the drug you are asking for is Medically Necessary.

If you have not received an answer from us within 72 hours after we receive your request, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

2. For a fast Coverage Determination about a Medicare Part D Drug that you have not received.

   If we give you a fast review, we will give you our decision within 24 hours after you or your doctor ask for a fast review – sooner if your health requires. If your request involves a request for an Exception, we will give you our decision no later than 24 hours after we have received your physician's "supporting statement," which explains why the non-Formulary drug you are asking for is Medically Necessary.

   If we decide you are eligible for a fast review, and you have not received an answer from us within 24 hours after receiving your request, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

What happens if we decide completely in your favor?

1. For a standard decision about a Medicare Part D Drug that includes a request to pay you back for a Medicare Part D Drug that you have already received.

   We must authorize or provide you with the Medicare Part D Drug you requested as quickly as your health requires, but no later than 72 hours after we receive the request. If your request involves a request for an Exception, we must authorize or provide you with the Medicare Part D Drug you requested no later than 72 hours after we receive your physician's "supporting statement." If you are asking us to pay you back for a Medicare Part D Drug that you already paid for and received, we must send payment to you no later than 30 calendar days after we receive the request.

2. For a fast decision about a Medicare Part D Drug that you have not received.

   We must authorize or provide you with the Medicare Part D Drug you requested no later than 24 hours after we receive your request. If your request involves a request for an Exception, we must authorize or provide you with the Medicare Part D Drug you requested no later than 24 hours after we receive your physician's "supporting statement."

What happens if we decide against you?

If we decide against you, we will send you a written decision explaining why we denied your request. If a Coverage Determination does not give you all that you requested, you have the right to Appeal the decision. (See Appeal Level 1 described later in this section for more information.)

The Appeals Process

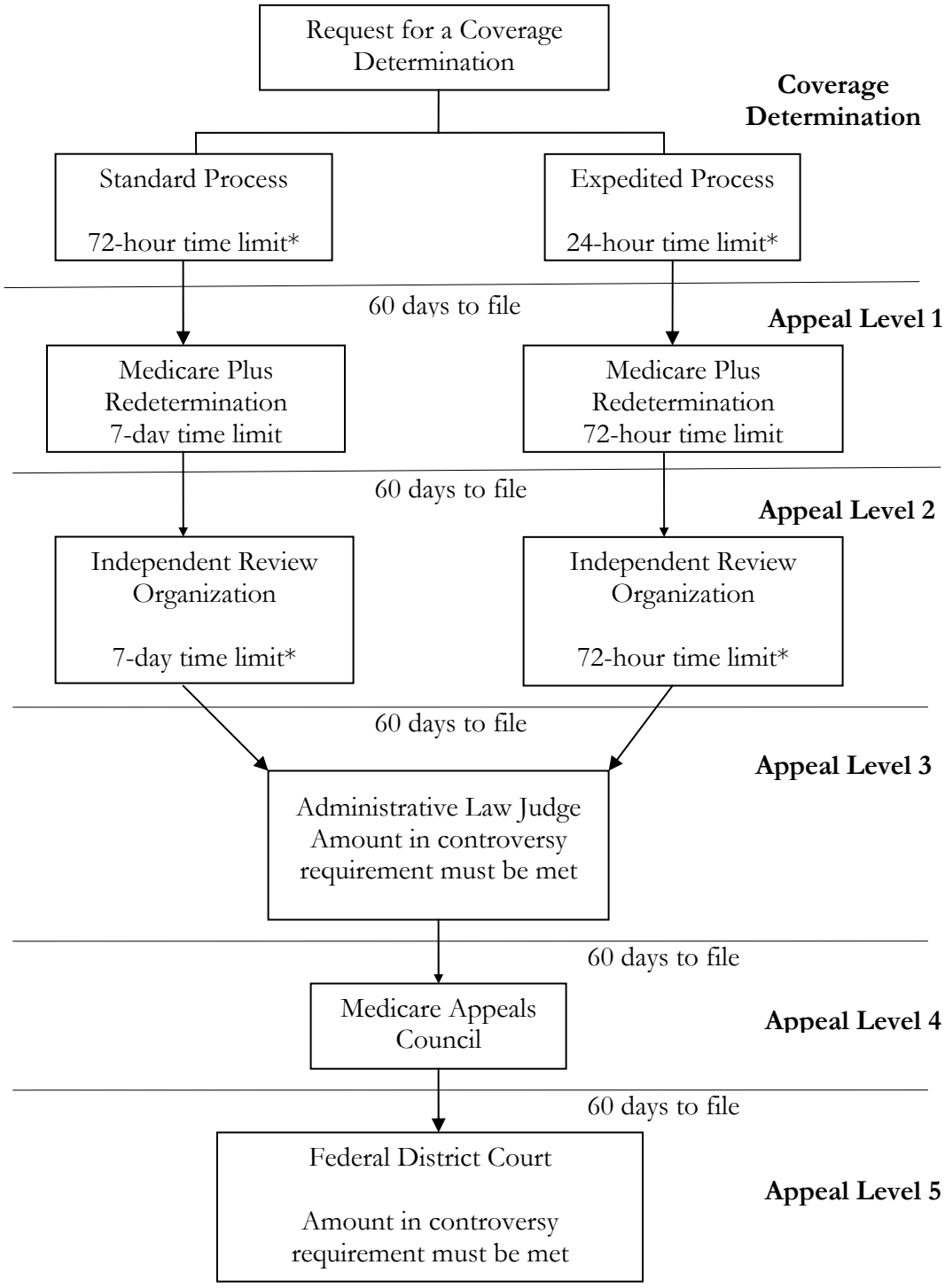
This part of Section 11 explains what you can do if you disagree with our Coverage Determination.

What kinds of decisions can be Appealed?
If you are not satisfied with our Coverage Determination decision, you may ask for an Appeal called a "redetermination." You may generally Appeal the following decisions:

- We do not cover a Medicare Part D Drug you think you are entitled to receive,
- We do not pay you back for a Medicare Part D Drug that you paid for,
- We paid you less for a Medicare Part D Drug than you think we should have paid you,
- We ask you to pay a higher Copayment amount than you think you are required to pay for a Medicare Part D Drug, or
- We deny your Exception request.

How does the Appeals process work?
There are five levels in the Appeals process. At each level, your request for Medicare Part D prescription drug benefits or payment is considered and a decision is made. The decision may give you some or all of what you have asked for, or it may not give you anything you asked for. If you are unhappy with the decision, you may be able to Appeal it and have someone else review your request.

The following chart summarizes the Appeals process. Each Appeal level is discussed in greater detail later in this section.



*The adjudication time frames generally begin when the request is received by Kaiser Permanente. However, if the request involves an Exception to the Medicare Plus Formulary, the adjudication time frame begins when Kaiser Permanente or independent review organization receives the doctor's supporting statement.

Appeal Level 1: If we deny any part of your request in our Coverage Determination, you may ask us to reconsider our decision. This is called a "request for redetermination."

You may ask us to review our Coverage Determination, even if only part of our decision is not what you requested. When we receive your request to review the Coverage Determination, we give the request to people at our organization who were not involved in making the Coverage Determination. This helps ensure that we will give your request a fresh look.

Who may file your Appeal of the Coverage Determination?
You or your appointed representative may file a standard Appeal request.

You, your appointed representative, or your doctor may file a fast Appeal request.

How soon must you file your Appeal?
You must file the Appeal request within 60 calendar days from the date included on the notice of our coverage determination. We may give you more time if you have a good reason for missing the deadline.

How to file your Appeal?

1. Asking for a standard Appeal
To ask for a standard Appeal, you or your appointed representative may send a written Appeal request to the address listed under Medical Service Benefits and Medicare Part D Appeals in Section 1 of this EOC.

2. Asking for a fast Appeal
If you are appealing a decision we made about giving you a Medicare Part D Drug that you have not received yet, you and/or your doctor will need to decide if you need a fast Appeal. The rules about asking for a fast Appeal are the same as the rules about asking for a fast Coverage Determination. You, your doctor, or your appointed representative can ask us to give a fast Appeal (rather than a standard Appeal) by calling us at (440) 846-2882 or 1-888-479-5333 ((440) 846-2883 or 1-888-479-5371, TTY/TDD for hearing/speech impaired) Monday through Friday, 8:15 a.m. to 5:00 p.m. or send the Appeal to us in writing at: Appeals Unit, Kaiser Permanente P.O. Box 93764, Cleveland, OH 44101-5764. Requests for a fast Appeal outside of regular weekday business hours can be made by calling (440) 846-2882 or 1-888-479-5333 ((440) 846-2883 or 1-888-479-5371, TTY/TDD for hearing/speech impaired) and leaving a clear message on the voice mail. The message should include the Member's name, medical record number and the nature of the Appeal. Provide as much information as possible and be sure to ask for a fast, expedited, or 72-hour review. Remember, if your doctor provides a written or oral supporting statement explaining that you need the fast Appeal, we will automatically give you a fast Appeal.

Getting information to support your Appeal.
We must gather all the information we need to make a decision about your Appeal. If we need your assistance in gathering this information, we will contact you. You have the right to obtain and include additional information as part of your Appeal. For example, you may already have

documents related to your request, or you may want to get your doctor's records or opinion to help support your request. You may need to give the doctor a written request to get information.

You may give us your additional information to support your Appeal by calling, faxing, or writing us at the numbers or address listed under Medical Service Benefits and Medicare Part D Appeals in Section 1 of this EOC. You may also deliver additional information in person to the address listed under Medical Service Benefits and Medicare Part D Appeals in Section 1. You also have the right to ask us for a copy of information regarding your Appeal. You may call or write us at the phone number or address listed under Medical Service Benefits and Medicare Part D Appeals in Section 1 of this EOC.

How soon must we decide on your Appeal?

1. For a standard decision about a Medicare Part D Drug that includes a request to pay you back for a Medicare Part D Drug you have already paid for and received.

   We will give you our decision within seven (7) calendar days of receiving the Appeal request. We will give you the decision sooner if your health condition requires us to. If we do not give you our decision within seven (7) calendar days, your request will automatically go to the second level of Appeal, where an independent review organization will review your case.

2. For a fast decision about a Medicare Part D Drug that you have not received.

   We will give you our decision within 72 hours after we receive the Appeal request. We will give you the decision sooner if your health requires us to. If we do not give you our decision within 72 hours, your request will automatically go to Appeal Level 2, where an independent review organization will review your case.

What happens if we decide completely in your favor?

1. For a standard decision to pay you back for a Medicare Part D Drug you already paid for and received.

   We must send payment to you no later than 30 calendar days after we receive your Appeal request.

2. For a standard decision about a Medicare Part D Drug you have not received.

   We must authorize or provide you with the Medicare Part D Drug you asked for within seven (7) calendar days we receive your Appeal request. We will give it to you sooner if your health requires us to.

3. For a fast decision about a Medicare Part D Drug you have not received.

   We must authorize or provide you with the Medicare Part D Drug you asked for within 72 hours after we receive your Appeal request. We will give it to you sooner if your health requires us to.

Appeal Level 2: If we deny any part of your first Appeal, you may ask for a review by a government-contracted independent review organization.

What independent review organization does this review?
At the second level of Appeal, your Appeal is reviewed by an outside, independent review organization that has a contract with the Centers for Medicare & Medicaid Services (CMS), the government agency that runs the Medicare program. The independent review organization has no connection to us. You have the right to ask us for a copy of your case file that we sent to this organization.

Who may file your Appeal?
You or your appointed representative may file a **standard** or **fast** Appeal request.

How soon must you file your Appeal?
You must file the Appeal request within 60 calendar days after the date you were notified of the decision on your first Appeal. The independent review organization may give you more time if you have a good reason for missing the deadline

How to file your Appeal?

1. Asking for a standard Appeal.

   To ask for a standard Appeal, you or your appointed representative can send a written Appeal request to the independent review organization at the address included in the redetermination notice you receive from us.

2. Asking for a fast Appeal.

   To ask for a fast Appeal, you or your appointed representative may send a written Appeal request to the independent review organization at the address included in the redetermination notice you receive from us. Remember, if your doctor provides a written or oral statement supporting your request for a fast Appeal, the independent review organization will automatically give you a fast Appeal.

How soon must the independent review organization decide?
1. For a standard decision about a Medicare Part D Drug that includes a request to pay you back for a Medicare Part D Drug that you have already paid for and received.

   The independent review organization will give you its decision within seven (7) calendar days after it receives your Appeal request. The independent review organization will make the decision sooner if your health condition requires it. If your request involves an Exception to the Plan's Formulary, the time frame begins once the independent review organization receives your doctor's supporting statement.

2. For a fast decision about a Medicare Part D Drug that you have not received.

The independent review organization will give you its decision within 72 hours after they receive your Appeal request. The independent review organization will make the decision sooner if your health condition requires it. If your request involves an Exception to the Plan's Formulary, the time frame begins once the independent review organization receives your doctor's supporting statement.

If the independent review organization decides completely in your favor:
The independent review organization will tell you in writing about its decision and the reasons for it.

1. For a decision to pay you back for a Medicare Part D Drug you already paid for and received.

   We must send payment to you within 30 calendar days from the date we receive notice reversing our coverage determination.

2. For a standard decision about a Medicare Part D Drug you have not received.

   We must authorize or provide you with the Medicare Part D Drug you asked for within 72 hours after we receive notice reversing our coverage determination.

3. For a fast decision about a Medicare Part D Drug you have not received.

   We must authorize or provide you with the Medicare Part D Drug you asked for within 24 hours after we receive notice reversing our coverage determination.

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

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

Who may file your Appeal?
You or your appointed representative may file an Appeal request with an Administrative Law Judge.

How soon must you file your Appeal?
The Appeal request must be filed within 60 calendar days of the date you were notified of the decision made by the independent review organization (Appeal Level 2). The Administrative Law Judge may give you more time if you have a good reason for missing the deadline.

How to file your Appeal?
The request must be filed with an Administrative Law Judge in writing. The written request must be sent to the Administrative Law Judge at the address listed in the decision you receive from the independent review organization (Appeal Level 2).

The Administrative Law Judge will not review your Appeal if the dollar value of the requested Medicare Part D Drug(s) does not meet the minimum requirement specified in the independent review organization's decision. If the dollar value is less than the minimum requirement, you may not Appeal any further.

How is the dollar value (the "amount remaining in controversy") calculated?
If we have refused to provide Medicare Part D prescription drug benefits, the dollar value for requesting an Administrative Law Judge hearing is based on the projected value of those benefits. The projected value includes:

- Any costs you could incur based on what you would be charged for the drug and the number of refills prescribed for the requested drug during the Plan year,
- Your Copayments,
- All drug expenses after your drug costs exceed the initial coverage limit, and
- Payments for drugs made by other entities on your behalf.

You may also combine multiple Medicare Part D claims to meet the dollar value if:
1. The claims involve the delivery of Medicare Part D prescription drugs to you;

2. All of the claims have received a determination by the independent review organization as described in Appeal Level 2;

3. Each of the combined requests for review are filed in writing within 60 calendar days after the date that each decision was made at Appeal Level 2; and

4. Your hearing request identifies all of the claims to be heard by the Administrative Law Judge.

How soon will the Judge make a decision?
The Administrative Law Judge will hear your case, weigh all of the evidence, and make a decision as soon as possible.

If the Judge decides in your favor:
The Administrative Law Judge will tell you in writing about his or her decision and the reasons for it.

1. For a decision to pay you back for a Medicare Part D Drug you already received.

   We must send payment to you no later than 30 calendar days after we receive notice reversing our coverage determination.

2. For a standard decision about a Medicare Part D Drug you have not received.

   We must authorize or provide you with the Medicare Part D Drug you have asked for within 72 hours after we receive notice reversing our coverage determination.

3. For a fast decision about a Medicare Part D Drug you have not received.

   We must authorize or provide you with the Medicare Part D Drug you have asked for within 24 hours after we receive notice reversing our coverage determination.

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

If the Administrative Law Judge does not rule completely in your favor, you or your appointed representative may ask for a review by the Medicare Appeals Council.

Who may file your Appeal?
You or your appointed representative may request an Appeal with the Medicare Appeals Council.

How soon must you file your Appeal?
The Appeal request must be filed within 60 calendar days after the date you were notified of the decision made by the Administrative Law Judge (Appeal Level 3). The Medicare Appeals Council may give you more time if you have a good reason for missing the deadline.

How to file your Appeal?
The request must be filed with the Medicare Appeals Council. The decision you receive from the Administrative Law Judge (Appeal Level 3) will tell you how to file this Appeal.

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

If the Council decides in your favor:
The Medicare Appeals Council will tell you in writing about its decision and the reasons for it.

1. For a decision to pay you back for a Medicare Part D Drug you already received.

   We must send payment to you no later than 30 calendar days after we receive notice reversing our coverage determination.

2. For a standard decision about a Medicare Part D Drug you have not received.

We must authorize or provide you with the Medicare Part D Drug you asked for within 72 hours after we receive notice reversing our coverage determination.

3. For a fast decision about a Medicare Part D Drug you have not received.

   We must authorize or provide you with the Medicare Part D Drug you asked for within 24 hours after we receive notice reversing our coverage determination.

Appeal Level 5: If the Medicare Appeals council does not rule in your favor, your case may go to a Federal Court.

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

- The decision is not completely favorable to you, or
- The decision tells you that the Medicare Appeals Council decided not to review your Appeal request.

Who may file your Appeal?
You or your appointed representative may request an Appeal with a Federal Court.

How soon must you file your Appeal?
The Appeal request must be filed within 60 calendar days after the date you were notified of the decision made by the Medicare Appeals Council (Appeal Level 4).

How to file your Appeal?
In order to request judicial review of your case, you must file a civil action in a United States district court. The letter you get from the Medicare Appeals Council in Appeal Level 4 will tell you how to request this review.

Your Appeal request will not be reviewed by a Federal Court if the dollar value of the requested Medicare Part D Drug(s) does not meet the minimum requirement specified in the Medicare Appeals Council's decision.

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

If the Judge decides in your favor:
1. For a decision to pay you back for a Medicare Part D Drug you already received.

   We must send payment to you within 30 calendar days after we receive notice reversing our coverage determination.

2. For a standard decision about a Medicare Part D Drug you have not received.

We must authorize or provide you with the Medicare Part D Drug you asked for within 72 hours after we receive notice reversing our coverage determination.

3. For a fast decision about a Medicare Part D Drug you have not received.

   We must authorize or provide you with the Medicare Part D Drug you asked for within 24 hours after we receive notice reversing our coverage determination.

If the Judge decides against you:
The Judge's decision is final and you may not take the Appeal any further.

Section 12 Ending Your Membership

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 we are required to end your membership. For example, if you move permanently out of our geographic Service Area.

Voluntarily ending your membership.

You may end your membership in our Plan at any time during the year and go to Original Medicare. If you decide to change from Medicare Plus to Original Medicare, you must tell us or Medicare that you want to leave Medicare Plus. You do not have to enroll in Original Medicare, because you will automatically be in Original Medicare when you leave Medicare Plus. Here is how it works:

1. To tell us that you want to leave Medicare Plus, you can write a letter to us. Send it to:

   Customer Relations
   Kaiser Foundation Health Plan of Ohio
   P.O. Box 921007
   Fort Worth, TX 76121-9930

   Be sure to sign and date your letter.

2. To tell Medicare that you want to leave Medicare Plus, you can call 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY users should call 1-877-486-2048. You can call 24 hours a day, 7 days a week.

Termination from the Group
If your Group coverage ends for any reason, you will not be automatically Disenrolled from Medicare Plus. You will have two choices. You may:

- Request Disenrollment from Medicare Plus by sending us a written request; or
- Request conversion to our Direct Pay Medicare Plus Plan by writing us a letter or by completing a conversion request.

Whether you tell us or Medicare that you want to leave Medicare Plus, you will receive a letter that tells you when your membership will end. This is your Disenrollment date, the day you officially leave Medicare Plus. Your Disenrollment date will be the first day of the month that comes after the month we receive your request to leave, or, at your request, a later date of up to 3 months after we receive your request. For example, if we receive your request to leave during the month of February, your Disenrollment date will be March 1st. Remember, while you are waiting for your membership to end, you are still a Member of Medicare Plus and may continue to get your medical care as usual through Kaiser Permanente.

On your Disenrollment date, your membership in Medicare Plus ends, and unless you have joined another Medicare Managed Care Plan, you should use 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, because you will automatically be in Original Medicare when you leave Medicare Plus. (Call Social Security at 1-800-772-1213 if you need a new red, white, and blue Medicare card.)

After you leave your Group, you may be able to join another Medicare Managed Care Plan. Call the national Medicare helpline at 1-800-MEDICARE (1-800-633-4227) for additional information on when these plans are open for enrollment. The TTY number is 1-877-486-2048. Please see Section 1 for additional information on how to contact the helpline.

Until your membership ends, you must keep getting your Medicare services through Medicare Plus or you will have to pay for them yourself.

If you leave Medicare Plus, it takes some time for your membership to end. While you are waiting for your membership to end, you are still a Member and should continue to get your care and prescription drugs as usual through Medicare Plus.

If you get services from doctors or other medical providers who are not Plan Providers or Plan Pharmacies before your membership in Medicare Plus ends, you will have to pay Original Medicare cost sharing amounts for the services. The exceptions are Urgently Needed Care, care for a Medical Emergency, and care that has been approved by us. There is another possible exception, if you happen to be hospitalized on the day your membership ends. If this happens to you, call Customer Relations at the number in Section 1 to find out if your Hospital care will be covered by Medicare Plus. If you have any questions about leaving Medicare Plus, please also call Customer Relations.

We cannot ask you to leave Medicare Plus because of your health.

We cannot ask you to leave Medicare Plus for any health-related reasons. If you ever feel that you are being encouraged or asked to leave Medicare Plus because of your health, you should call Medicare at 1-800-MEDICARE (1-800-633-4227), which is the national Medicare help line. TTY/TDD users should call 1-877-486-2048. You may call 24 hours a day, 7 days a week.

Involuntarily ending your Membership.

If any of the following situations occur, we will end your membership in Medicare Plus.

- If you move out of the Service Area or are away from the Service Area for more than 90 days in a row. If you plan to move or take a long trip, please call Customer Relations to find out if the place you are moving to or traveling to is in the Service Area. If you move permanently out of our Service Area, or if you are away from our Service Area for more than 90 days in a row, you will need to leave ("Disenroll" from) Medicare Plus. In these situations, if you do not leave on your own, we must end your membership ("Disenroll" you). (See Section 1 for information about the Service Area).
- If you were permitted to enroll in Medicare Plus when you lived outside the Service area because you were a current Member who was newly entitled to Medicare Part A and or

newly enrolled in Medicare Part B, you may continue your membership unless you move and are still outside our Service Area, in which case you will be Disenrolled, as stated above.

- If you do *not* stay continuously enrolled in Medicare Part B.
- If you give us information on your enrollment form that you know is false or deliberately misleading, and it affects whether or not you can enroll in Medicare Plus.
- If you behave in a way that is unruly, uncooperative, disruptive, or abusive, and this behavior seriously affects our ability to arrange or provide medical care for you or for others who are members of Kaiser Permanente. We cannot make you leave Medicare Plus for this reason unless we get permission first from the Centers for Medicare & Medicaid Services, the government agency that runs Medicare.
- If you let someone else use your plan membership card to get medical care. Before we ask you to leave Medicare Plus for this reason, we must refer your case to the Inspector General and this may result in criminal prosecution.
- If you do not pay the basic Plan Premiums, Copayments or Coinsurances, we will tell you in writing before you are required to leave Medicare Plus.

You have the right to make a complaint if we ask you to leave Medicare Plus.

If we ask you to leave Medicare Plus, we will tell you our reasons in writing and explain how you may file a complaint against us if you want to. You may also request a review by the Ohio Department of Insurance at:

The State of Ohio, Department of Insurance
Attn: Consumer Services Division
2100 Stella Court
Columbus, OH 43215-1067
Consumer Hotline Toll Free Phone:
1-800-686-1526 or (614) 644-2673

Section 13 Legal Notices

Notice about governing law

Many laws apply to this Evidence of Coverage and some additional provisions may apply to your situation 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 of Ohio may apply. In the event of any inconsistency or conflict between this Evidence of Coverage and applicable law, the applicable law shall govern.

Administration of this EOC

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

Assignment

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

Attorneys' fees and expenses

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

EOC binding on Members

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

Notice about nondiscrimination

We don't discriminate based on a person's race, disability, religion, sex, sexual orientation, health, ethnicity, creed, age, or national origin. All organizations that provide Medicare Managed Care Plan, like Kaiser Foundation Health Plan of Ohio, must obey federal laws against discrimination, including Title VI of the Civil Rights Act of 1964, the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, the Americans with Disabilities Act, all other laws that apply to organizations that get Federal funding, and any other laws and rules that apply for any other reason.

Member Non-Liability

In the event Kaiser Permanente fails to reimburse an Affiliated Medical Provider's charges for Covered Services or in the event that we fail to pay a non-Affiliated Medical Provider for Pre-Authorized services, you shall not be liable for any sums owed by Kaiser Permanente.

Kaiser Permanente will not pay for services you receive from non-Affiliated Medical Providers without Pre-Authorization (except for Emergency Services or out-of-area Urgently Needed Services). In addition, if you enter into a private contract with a non-Affiliated Medical Provider, neither Kaiser Permanente nor Original Medicare will pay for those services.

Provider-Patient Relationship

Kaiser Permanente does not prohibit or otherwise restrict a Provider, acting within the lawful scope of practice, from advising or advocating on your behalf about:

- Your health status, medical care, or treatment options.
- The risk, benefits, and consequences of treatment or non-treatment.
- The opportunity for you to refuse treatment and to express preferences about future treatment decisions.

No Waiver

If we fail to enforce any part of your coverage described in this Agreement, this does not take away our right after that to require your strict observation of its terms and conditions.

New Technology Assessments

When a new medical technology or procedure needs review, our Inter-regional New Technology Committee examines and evaluates data from government agencies, medical experts, medical journals and medical specialty societies. Recommendations from this Inter-regional Committee then are passed on to the local Committee. The Committee reviews the national recommendations to see how they apply to local medical practices. Once this review takes place, the Committee makes recommendations for the new technology or procedure to become a covered benefit. In addition, the Committee communicates practice guidelines to Plan Providers and related health care Providers. If the Committee's recommendation is accepted, the new technology is added to our list of covered benefits, either immediately or when this contract renews.

Notices

Any notice required to be given under this Evidence of Coverage shall be in writing, and either delivered personally or by United States mail at the addresses set forth below, or at such other address as the parties may designate.

If to Kaiser Permanente and personally delivered:

Customer Relations
Kaiser Foundation Health Plan of Ohio
North Point Tower - 1001 Lakeside Avenue Suite 1200
Cleveland, OH 44114-1153

If to Kaiser Permanente via U.S. mail:

Customer Relations
Kaiser Permanente
P.O. Box 5309
Cleveland, OH 44101-0309

If to you, to your last address known to Kaiser Permanente. You are responsible for notifying us of any change in your address.

Section 14 Definition of Some Words Used in This EOC

The following definitions apply to this Evidence of Coverage.

Affiliated Providers – Any professional person, organization or health care Specialist who has entered into a contractual agreement with the us or Ohio Permanente Medical Group to provide specified, Covered Services to Members as prescribed, directed or arranged by a Plan Physician.

Appeal – A type of complaint you make when you want us to reconsider and change a decision we have made about what services are covered for you or what we will pay for a service. These include reconsiderations by us, an independent review entity, hearings before Administrative Law Judges (of the Social Security Administration), review by the Medicare Appeals Council, and judicial review. Sections 10 and 11 explain about Appeals, including the process involved in making an Appeal.

Benefit Period – For both Medicare Plus and the Original Medicare Plan, a Benefit Period is used to determine coverage for inpatient stays in Hospitals and Skilled Nursing Facilities. A Benefit Period begins on the first day you go to a Medicare-covered inpatient Hospital or Skilled Nursing Facility. The Benefit Period ends when you haven't been an inpatient at any Hospital or SNF for 60 days in a row. If you go to the Hospital (or SNF) after one Benefit Period has ended, a new Benefit Period begins. There is no limit to the number of Benefit Periods you can have. The type of care you actually get during the stay determines whether you are considered an inpatient for SNF stays, but not for Hospital stays.

> You are an inpatient in a SNF only if your care in the SNF meets certain standards for skilled level of care. Specifically, in order to be an inpatient in a SNF, you must need daily skilled-nursing or skilled-rehabilitation care, or both. (Section 3 tells what is meant by skilled care.)
>
> Generally, you are an inpatient of a Hospital if you are getting inpatient services in the Hospital (the type of care you actually receive in the Hospital doesn't determine whether you are considered an inpatient in the Hospital).

Brand-Name Drug – Brand-Name Drugs are drugs that are produced and sold under the original manufacturer's brand name. The Brand-Name Drug Copayment applies to compounded products.

Calendar Year – A 12 month period that begins on January 1st and ends 12 consecutive months later on December 31st.

Catastrophic Coverage – The phase in the Outpatient Prescription Drug Benefit where you pay a low Copayment or coinsurance for your drugs after you or other qualified parties on your behalf have spent $4050.00 in Medicare Part D Covered Drugs during the covered year. Please see Section 6 of this document.

Centers for Medicare & Medicaid Services (CMS) – The Federal agency that runs the Medicare program. Section 1 explains how to contact CMS.

Coinsurance – A percentage of the cost of the service that you have to pay.

Copayment – The amount you pay for each medical service you get, such as a doctor visit. It is a set amount per visit. All Copayments are due at the time of service.

Coverage Determination – The Plan has made a Coverage Determination when it makes a decision not to provide or pay for a Medicare Part D Drug that you believe may be covered by the Plan, or a decision about a Formulary Exception request. A Plan also makes a Coverage Determination when it does not provide a Coverage Determination in a timely manner when a delay would adversely affect your health.

Covered Drugs – Is the general term we use to mean all of the outpatient prescription drugs that are covered by Medicare Plus. Covered Drugs are listed in the Formulary.

Covered Services – The general term we use in this booklet to mean all of the health care services and supplies that are covered by Kaiser Permanente Medicare Plus. Covered Services are described in Section 4 of this EOC.

Creditable Coverage – Coverage that is at least as good as the standard Medicare Prescription Drug coverage.

Custodial Care – Care furnished for the purpose of meeting non-Medically Necessary personal needs which could be provided by persons without professional skills or training, such as assistance in mobility, dressing, bathing, eating, preparation of special diets, and taking medication. Custodial Care is not covered by Medicare Plus or Original Medicare unless provided in conjunction with Skilled Nursing Care and/or skilled Rehabilitation Services.

Customer Relations – A department within Kaiser Permanente responsible for answering your questions about your membership, benefits, Grievances, and Appeals. Please see Section 1 for ways to contact Customer Relations.

Dependent – A Member whose relationship to a Subscriber is the basis for membership eligibility and who meets the eligibility requirements as a Dependent. (For Dependent eligibility requirements, see "Who Is Eligible to Enroll in Medicare Plus?" in Section 2.)

Direct Mail Pharmacy – A type of Plan Pharmacy that delivers prescription drugs to Medicare Plus Members through the mail.

Disenroll or Disenrollment – The process of ending your membership. Disenrollment can be voluntary (your own choice) or involuntary (not your own choice). Section 12 tells about Disenrollment.

Durable Medical Equipment – Equipment needed for medical reasons, which is sturdy enough to be used many times without wearing out. A person normally needs this kind of equipment only when ill or injured. It can be used in the home. Examples of durable medical equipment are wheelchairs, hospital beds, and equipment that supplies a person with oxygen, and other items that are determined Medically Necessary, in accordance with Medicare law, regulations and guidelines.

Emergency Care – Also referred to as Emergency Services. Covered Services that are: 1) rendered by a provider qualified to furnish Emergency Services; and 2) needed to evaluate or stabilize an Emergency Medical Condition. Section 3 tells about Emergency Services.

Emergency Medical Condition – Also referred to as a Medical Emergency, a medical condition brought on by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect that not getting immediate medical attention could result in (1) serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child; (2) serious impairment to bodily functions; or (3) serious dysfunction of any bodily organ or part. As defined in Section 3, a Medical Emergency is when you reasonably believe that your health is in serious danger – when every second counts.

Evidence of Coverage – This document along with your enrollment form, which explains your Covered Services, and what we must do, and explains your rights and responsibilities as a Member of Kaiser Permanente Medicare Plus.

Exception – A type of Coverage Determination that, if approved, allows you to obtain a drug that is not on our Formulary. You may also request an Exception if we require you to try another drug before receiving the drug you are requesting, or we limit the quantity or dosage of the drug you are requesting.

Exclusion – Items or services that Medicare Plus does not cover under this Evidence of Coverage. You are responsible for paying for excluded items or services.

Experimental Procedures and Items – Procedures and items determined by Kaiser Permanente and Original Medicare not to be generally accepted by the medical community. When deciding if a service or item is Experimental, Kaiser Permanente will follow CMS guidance (via the Medicare Carriers Manual and Coverage Issues Manual) if applicable or will follow decisions already made by Medicare. With the exceptions of procedures and items under clinical trials, Experimental Procedures and Items are not covered under this Evidence of Coverage.

Formulary – A list of Covered Drugs provided by Medicare Plus.

Generic Drug – A drug product that meets the approval of the FDA and is equivalent to a Brand-Name Drug in terms of quality and performance but may differ in certain other characteristics (e.g., shape, flavor, or preservatives). By law, Generic Drug products must contain the identical amounts of the same active drug ingredient as the Brand-Name Drug. Generic Drugs usually cost less than Brand-Name Drugs.

Grievance – A type of written or verbal complaint you make about us or one of our Plan Providers, including a complaint concerning the quality of your care. This type of complaint doesn't involve payment or coverage disputes. See Section 9 for more information about Grievances.

Group – Your employer or a retirement system through whom/which you receive health care benefits.

Home Health Agency – A Medicare-certified agency which provides intermittent Skilled Nursing Care and other therapeutic services in your home when Medically Necessary, when you are confined to your home and when arranged by your PCP.

Hospice – Medicare-certified organization or agency, which is primarily engaged in providing pain relief, symptom management and supportive services to terminally ill people and their families.

Hospital – A Medicare-certified institution licensed by the state, which provides inpatient, outpatient, emergency, diagnostic and therapeutic services. The term Hospital does not include a Skilled Nursing Facility, convalescent nursing home, rest facility or facility for the aged which furnishes primarily Custodial Care, including training in routines of daily living.

Initial Coverage Limit – The maximum limit of coverage under the initial coverage period.

Initial Coverage Period – This is the period before your total drug expenses, have reached $2,510 including amounts you've paid and what our Plan has paid on your behalf.

Initial Decision – In general, a decision by Kaiser Permanente or a person acting on behalf of Kaiser Permanente, to approve or deny a payment for a service or a request to provide a service made by you or on your behalf.

Kaiser Foundation Health Plan of Ohio – A Health Insuring Corporation, which has a contract with the Centers for Medicare and Medicaid Services (CMS). Kaiser Foundation Health Plan of Ohio, sometimes referred to as "Health Plan," "us," "we" or "our," contracts with the Ohio Permanente Medical Group, Inc. to provide Medicare-Covered Services and supplies.

Late Enrollment Penalty – An amount added to your monthly Plan Premium for Medicare drug coverage if you don't join a plan when you're first able. You pay this higher amount as long as you have Medicare. There are some exceptions. If you do not have Creditable prescription drug Coverage, you will have to pay a penalty in addition to your monthly Plan Premium.

Medicaid – A joint federal/state medical assistance program established by Title XIX of the Social Security Act. Some Medicare beneficiaries are also eligible for Medicaid. Medicaid, unlike Medicare, can cover long-term care, such as custodial nursing home care. Medicaid can cover all or part of your Medicare premiums and/or deductibles and Coinsurance, if your income and resources are low enough. You should inquire about Medicaid and related programs - Qualified Medicare Beneficiary, Special Low Income Medicare Beneficiary, Qualified Disabled Working Individual, Qualified Individual - at your local Department of Human Services.

Medically Necessary – Services or supplies that: are proper and needed for the diagnosis or treatment of your medical condition; are used for the diagnosis, direct care, and treatment of your medical condition; meet the standards of good medical practice in the local community; and are not mainly for your convenience or that of your doctor.

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 permanent kidney failure (who need dialysis or a kidney transplant).

Medicare Advantage Organization – Medicare Advantage Plans are run by private companies. They give you more options, and sometimes, extra benefits. These plans are still part of the Medicare Program and are also called "Medicare Part C." They provide all your Medicare Part A (Hospital) and Medicare Part B (Medical) coverage. Some may also provide Medicare Part D (prescription drug) coverage.

Medicare Advantage Plan – A benefit package offered by a Medicare Advantage Organization that offers a specific set of health benefits at the same premium and level of cost sharing to all people with Medicare who live in the Service Area covered by the Plan. Medicare Advantage Organizations can offer one or more Medicare Advantage Plans plan in the same service area.

Medicare Cost Plan – A Medicare health plan offered by an organization licensed to bear risk under state law. Members may receive coverage for services furnished by both Plan Providers and non-Plan Providers. However, if members receive services from non-Plan Providers without a Referral, unless the services are emergently or urgently needed, the Member must pay the cost sharing amounts applicable under Original Medicare. Kaiser Permanente is Medicare Cost Plan.

Medicare Managed Care Plan – Means a Medicare Advantage HMO, Medicare Cost Plan, or Medicare Advantage PPO.

Medicare Part A – Hospital insurance benefits including inpatient Hospital care, Skilled Nursing Facility care, Home Health Agency care, and Hospice care, offered through Medicare.

Medicare Part A Premium – Medicare Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers and by part of the self-employment tax paid by self-employed persons. If you are entitled to benefits under either the Social Security or Railroad Retirement systems or worked long enough in federal, state, or local government employment to be insured, you do not have to pay a monthly premium. If you do not qualify for premium free Medicare Part A benefits, you may buy the coverage from Social Security if you are at least 65 years old and meet certain other requirements.

Medicare Part B – Medical insurance that is optional and requires a monthly premium. Medicare Part B covers physician services (in both Hospital and non-Hospital settings) and services furnished by certain non-physician practitioners. Other Medicare Part B services include lab testing, Durable Medical Equipment, diagnostic tests, ambulance services, prescription drugs that cannot be self-administered, certain self-administered anti-cancer drugs, some other therapy services, certain other health services, and blood not covered under Medicare Part A.

Medicare Part B Premium – A monthly premium paid to Medicare (usually deducted from your Social Security check) to cover Medicare Part B services. You must continue to pay this premium to Medicare to receive Covered Services whether you are covered by us or by Original Medicare.

Medicare Part D – The voluntary prescription drug benefit program. (For ease of reference, we will refer to the new prescription drug benefit program as Medicare Part D.)

Medicare Part D Drugs – Any drug that can be covered under a Medicare prescription drug plan. Generally, any drug not specifically excluded under Medicare drug coverage is considered a Medicare

Part D Drug. Medicare Part D Drugs that are listed on our Formulary, and that we pay for based on an Exception or an Appeal, are called covered Medicare Part D Drugs.

Medicare Prescription Drug Coverage – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part B.

"Medigap" (Medicare supplement insurance) policy – Medicare Supplement Insurance sold by private insurance companies to fill "gaps" in the Original Medicare Plan coverage. Medigap policies only work with the Original Medicare Plan.

Member (Medicare Plus Plan Member) – A person with Medicare who is eligible to get Covered Services, who has enrolled in Medicare Plus and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Non-Affliliated (or Non-Plan) Provider or non-Plan Facility – A provider or facility with which we have not arranged to coordinate or provide Covered Services to Members of Medicare Plus. Non-Plan Providers are providers that are not employed, owned, or operated by Kaiser Permanente or are not under contract to deliver Covered Services to you. You will have to pay Original Medicare cost sharing amounts for most services you get without authorization from non-Plan Providers.

Office Visit – A visit to your PCP, Specialist, other Affiliated Provider, or Non-Affiliated Provider upon Referral.

Ohio Permanente Medical Group (OPMG) – The Ohio Permanente Medical Group, Inc. is a group of physicians organized as a legal entity to provide medical care. Ohio Permanente Medical Group has an agreement with the Kaiser Foundation Health Plan of Ohio to provide medical services to you.

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

Plan Facility – A facility operated by us, or a facility that contracts with us, Ohio Permanente Medical Group, or Kaiser Foundation Hospitals to provide certain specified, Covered Services to Members as prescribed, directed, or arranged by a Plan Physician.

Plan Pharmacy – A Plan Pharmacy is a pharmacy where members of our Plan can receive their prescription drug benefits. We call them Plan Pharmacies because they contract with our Plan. In most cases, your prescriptions are covered only if they are filled at one of our Plan Pharmacies. Plan Pharmacies include pharmacies operated by us and community pharmacies that contract with us to provide prescription drugs to our members. These community pharmacies are sometimes called Affiliated Pharmacies.

Plan Physician – Any doctor of medicine or doctor of osteopathy who is employed by or who has entered into an agreement with the Ohio Permanente Medical Group to provide Covered Services to our Members.

Plan Premium – The monthly payment to Kaiser Permanente, if applicable, along with the Medicare Part B Premiums paid to Medicare and Medicare Part A Premiums paid if applicable, that entitles you to the Covered Services outlined in this Evidence of Coverage. (To qualify for the services outlined in this EOC, you must also pay the monthly Medicare Part B Premium and, if applicable, Medicare Part A Premium).

Plan Provider – Provider is the general term we use for doctors, other health care professionals, Hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. We call them Plan Providers when they are part of Kaiser Permanente. When we say that Plan Providers are part of Kaiser Permanente, this means that we have arranged with them to coordinate or provide Covered Services to Members of Kaiser Permanente Medicare Plus. Kaiser Permanente pays Plan Providers based on the contracts it has with the Providers.

Pre-Authorization – Approval in advance to get services. Some services are covered only if your doctor or other Plan Provider gets Pre-Authorization from Kaiser Permanente.

Primary Care Physician (PCP) – The Kaiser Permanente or Affiliated Provider you choose to coordinate your health care. Your PCP is responsible for providing or arranging Covered Services while you are a Medicare Plus Member. PCPs are generally physicians of internal medicine, family practice, general practice or pediatrics. Section 3 tells more about PCPs.

Provider – Any professional person, organization, health facility, Hospital, or other person or institution licensed and/or certified by the state or Medicare to deliver or furnish health care services.

Quality Improvement Organization (QIO) – Groups of practicing doctors and other health care experts that are paid by the federal government to check and improve the care given to Medicare patients. They must review your complaints about the quality of care given by Medicare Providers. See Section 1 for information about how to contact the QIO in your state and Section 10 for information about making complaints to the QIO.

Quantity Limits – A management tool that is designed to limit the use of selected drugs for quality, safety, or utilization reasons. Limits may be on the amount of the drug that we cover per prescription or for a defined period of time.

Referral – A written recommendation by a Plan Provider for you to receive certain Covered Services from another designated Provider.

Rehabilitation Services – These services include physical therapy, cardiac rehabilitation, speech and language therapy, and occupational therapy that are provided under the direction of a Plan Provider.

Service Area – Section 1 defines the Medicare Plus Service Area. "Service Area" is the geographic area approved by the Centers for Medicare & Medicaid Services (CMS) within which an eligible individual may enroll in a Medicare Health Plan.

Skilled Nursing Care – Services that can only be performed by, or under the supervision of, licensed nursing personnel.

Skilled Nursing Facility (SNF) – A facility (or a distinct part of a facility) which provides inpatient Skilled Nursing Care, Rehabilitation Services or other related health services, and is certified by Medicare and approved by us. The term Skilled Nursing Facility does not include a Hospital, convalescent nursing home, rest facility or facility for the aged, which furnishes primarily Custodial Care, including training in routines of daily living.

Specialist – Any duly licensed physician, osteopath, psychologist, or other practitioner (as defined by Medicare) who provides health care services for a specific disease or part of the body. Your PCP/Affiliated medical Provider may refer you to a Specialist when needed. Examples include oncologists (care for cancer patients), cardiologists (care for the heart), and orthopedists (care for bones).

Specialty Drugs – Drugs that are very high cost medications approved by the Food & Drug Administration (FDA).

Spouse – Your legal husband or wife.

Subscriber – A Member who is eligible for membership on his or her own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber. (For Subscriber eligibility requirements, see "Who is Eligible to Enroll in Medicare Plus?" in Section 2.)

Supplemental Security Income (SSI) – A monthly benefit paid by the Social Security Administration to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits are not the same as Social Security benefits.

Urgently Needed Care/Services – Covered Services provided when you are temporarily absent from the Medicare Plus Service Area, when such services are Medically Necessary and immediately required (1) as a result of an unforeseen illness, injury, or condition; and (2) to prevent a serious deterioration of your health; and (3) it is not reasonable given the circumstances to obtain the services through your Plan Provider. Section 3 explains about Urgently Needed Services. These are different from Emergency Services.

Utilization Review – A process used by Kaiser Permanente or an Affiliated Provider to promote the efficient use of resources and the effectiveness of quality of health care. This includes pre-service, concurrent and post-service review of medical services.

Visiting Member – A Member who is temporarily away from the Service Area and in the service area of another Kaiser Permanente Affiliated Plan for less than 90 days.

Visiting Member Program – A program in which health care services, in addition to Emergency and Urgently Needed Care, may be obtained when traveling in the service area of another Kaiser Permanente Affiliated Plan.

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