

EOC regardless of whether the services are within the scope of a provider's license or certificate. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in this *EOC*. These exclusions or limitations do not apply to Services that are Medically Necessary to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness.

Certain exams and Services

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

Chiropractic Services

Chiropractic Services and the Services of a chiropractor, except for manual manipulation of the spine as described under "Outpatient Care" in the "Benefits and Your Cost Share" section or if you have coverage for supplemental chiropractic Services as described in an amendment to this *EOC*.

Cosmetic Services

Services that are intended primarily to change or maintain your appearance (including Cosmetic Surgery, which is defined as surgery that is performed to alter or reshape normal structures of the body in order to improve appearance), except that this exclusion does not apply to any of the following:

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

Custodial care

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

This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice for Members who do not have Part A, Skilled Nursing Facility, or inpatient hospital care.

Dental care

Dental care and dental X-rays, such as dental Services following accidental injury to teeth, dental appliances, dental implants, orthodontia, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment, except for Services covered in accord with Medicare guidelines or under "Dental Services for Radiation Treatment and Dental Anesthesia" in the "Benefits and Your Cost Share" section.

Disposable supplies

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

This exclusion does not apply to disposable supplies covered in accord with Medicare guidelines or under "Durable Medical Equipment ("DME") for Home Use," "Home Health Care," "Hospice Care," "Ostomy, Urological, and Wound Care Supplies," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Prosthetic and Orthotic Devices" in the "Benefits and Your Cost Share" section.

Experimental or investigational Services

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

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

Hair loss or growth treatment

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

Intermediate care

Care in a licensed intermediate care facility. This exclusion does not apply to Services covered under "Durable Medical Equipment ("DME") for Home Use," "Home Health Care," and "Hospice Care" in the "Benefits and Your Cost Share" section.

Items and services that are not health care items and services

For example, we do not cover:

- Teaching manners and etiquette

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

Items and services to correct refractive defects of the eye

Items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism.

Massage therapy

Massage therapy, except when ordered as part of a physical therapy program in accord with Medicare guidelines.

Oral nutrition

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

This exclusion does not apply to any of the following:

- Amino acid–modified products and elemental dietary enteral formula covered under “Outpatient Prescription Drugs, Supplies, and Supplements” in the “Benefits and Your Cost Share” section
- Enteral formula covered under “Prosthetic and Orthotic Devices” in the “Benefits and Your Cost Share” section

Residential care

Care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is

part of covered care in a hospital, a Skilled Nursing Facility, inpatient respite care covered in the “Hospice Care” section for Members who do not have Part A, or residential treatment program Services covered in the “Substance Use Disorder Treatment” and “Mental Health Services” sections.

Routine foot care items and services

Routine foot care items and services, except for Medically Necessary Services covered in accord with Medicare guidelines.

Services not approved by the federal Food and Drug Administration

Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other Services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S., but are not approved by the FDA. This exclusion applies to Services provided anywhere, even outside the U.S., unless the Services are covered under the “Emergency Services and Urgent Care” section.

Services and items not covered by Medicare

Services and items that are not covered by Medicare, including services and items that aren’t reasonable and necessary, according to the standards of the Original Medicare plan, unless these Services are otherwise listed in this *EOC* as a covered Service.

Services performed by unlicensed people

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

Services related to a noncovered Service

When a Service is not covered, all Services related to the noncovered Service are excluded, except for Services we would otherwise cover to treat complications of the noncovered Service or if covered in accord with Medicare guidelines. For example, if you have a noncovered cosmetic surgery, we would not cover Services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and we would cover any Services that we would otherwise cover to treat that complication.

Surrogacy

Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. Please refer to “Surrogacy arrangements” under “Reductions” in this

“Exclusions, Limitations, Coordination of Benefits, and Reductions” section for information about your obligations to us in connection with a Surrogacy Arrangement, including your obligations to reimburse us for any Services we cover and to provide information about anyone who may be financially responsible for Services the baby (or babies) receive.

Travel and lodging expenses

Travel and lodging expenses, except as described in our Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at kp.org/specialty-care/travel-reimbursements or by calling our Member Service Contact Center.

Limitations

We will make a good faith effort to provide or arrange for covered Services within the remaining availability of facilities or personnel in the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC*, such as a 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 dispute. Under these circumstances, if you have an Emergency Medical Condition, call 911 or go to the nearest hospital as described under “Emergency Services” in the “Emergency Services and Urgent Care” section, and we will provide coverage and reimbursement as described in that section.

Additional limitations that apply only to a particular benefit are listed in the description of that benefit in this *EOC*.

Coordination of Benefits

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

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

- Coverage that you have from an employer’s group health care coverage for employees or retirees, either through yourself or your spouse
- Coverage that you have under workers’ compensation because of a job-related illness or injury, or under the Federal Black Lung Program
- Coverage you have for an accident where no-fault insurance or liability insurance is involved
- Coverage you have through Medicaid
- Coverage you have through the “TRICARE for Life” program (veteran’s benefits)
- Coverage you have for dental insurance or prescription drugs
- “Continuation coverage” you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions)

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

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

If you have additional health coverage, please call our Member Service Contact Center to find out which rules apply to your situation, and how payment will be handled.

Reductions

Employer responsibility

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

Government agency responsibility

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

Injuries or illnesses alleged to be caused by third parties

Third parties who cause you injury or illness (and/or their insurance companies) usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue these primary payments. If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered Services, you must ensure we receive reimbursement for those Services. Note: This “Injuries or illnesses alleged to be caused by third parties” section does not affect your obligation to pay your Cost Share for these Services.

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

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

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

Equian
Kaiser Permanente - Northern California Region
Subrogation Mailbox
P.O. Box 36380
Louisville, KY 40233
Fax: 1-502-214-1137

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

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

Surrogacy arrangements

If you enter into a Surrogacy Arrangement and you or any other payee are entitled to receive payments or other compensation under the Surrogacy Arrangement, you must reimburse us for covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement (“Surrogacy Health Services”) to the maximum extent allowed under California Civil Code Section 3040. A “Surrogacy Arrangement” is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Note: This “Surrogacy arrangements” section does not affect your obligation to pay your Cost Share for these Services. After you surrender a baby to the legal parents, you are not obligated to reimburse us for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical

expenses. To secure our rights, we will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds 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 all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receive
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

Equian
Kaiser Permanente – Northern California Region
Surrogacy Mailbox
P.O. Box 36380
Louisville, KY 40233
Fax: 1-502-214-1137

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

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

If you have questions about your obligations under this provision, please contact our Member Service Contact Center.

U.S. Department of Veterans Affairs

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

Workers’ compensation or employer’s liability benefits

Workers’ compensation usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue primary payments under workers’ compensation or employer’s liability law. You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as “Financial Benefit”), under workers’ compensation or employer’s liability law. We will provide covered Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered Services from the following sources:

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

Requests for Payment

Requests for Payment of Covered Services or Part D drugs

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

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

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

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

- **When you've received emergency, urgent, or dialysis care from a Non-Plan Provider.** You can receive emergency services from any provider, whether or not the provider is a Plan Provider. When you receive emergency, urgent, or dialysis care from a Non-Plan Provider, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill our plan for our share of the cost
 - ◆ if you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made
 - ◆ at times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made
 - ◆ if the provider is owed anything, we will pay the provider directly
 - ◆ if you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost
- **When a Plan Provider sends you a bill you think you should not pay.** Plan Providers should always bill us directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share
 - ◆ you only have to pay your Cost Share amount when you get Services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your Cost Share amount) applies even if we pay the provider less than the provider charges for a service, and even if there is a dispute and we don't pay certain provider charges
 - ◆ whenever you get a bill from a Plan Provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem
 - ◆ if you have already paid a bill to a Plan Provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan
- **If you are retroactively enrolled in our plan.** Sometimes a person's enrollment in our plan is retroactive. ("Retroactive" means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.) If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered Services or Part D drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement. Please call our Member Service Contact Center for additional information about how to ask us to pay you back and deadlines for making your request
- **When you use a Non-Plan Pharmacy to get a prescription filled.** If you go to a Non-Plan Pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. We cover prescriptions filled at Non-Plan Pharmacies only in a few special situations. Please see "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section to learn more
 - ◆ save your receipt and send a copy to us when you ask us to pay you back for our share of the cost
- **When you pay the full cost for a prescription because you don't have your plan membership card with you.** If you do not have your plan membership card with you, you can ask the pharmacy to call us or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself
 - ◆ save your receipt and send a copy to us when you ask us to pay you back for our share of the cost
- **When you pay the full cost for a prescription in other situations.** You may pay the full cost of the prescription because you find that the drug is not covered for some reason
 - ◆ for example, the drug may not be on our *2021 Comprehensive Formulary*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it

- ◆ save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost
- **When you pay copayments under a drug manufacturer patient assistance program.** If you get help from, and pay copayments under, a drug manufacturer patient assistance program outside our plan's benefit, you may submit a paper claim to have your out-of-pocket expense count toward qualifying you for catastrophic coverage
 - ◆ save your receipt and send a copy to us

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. The "Coverage Decisions, Appeals, and Complaints" section has information about how to make an appeal.

How to Ask Us to Pay You Back or to Pay a Bill You Have Received

How and where to send us your request for payment

To file a claim, this is what you need to do:

- As soon as possible, request our claim form by calling our Member Service Contact Center toll free at **1-800-443-0815** or **1-800-390-3510** (TTY users call **711**). One of our representatives will be happy to assist you if you need help completing our claim form
- If you have paid for services, you must send us your request for reimbursement. Please attach any bills and receipts from the Non-Plan Provider
- You must complete and return to us any information that we request to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled. For example, we may require documents such as travel documents or original travel tickets to validate your claim
- The completed claim form must be mailed to the following address as soon as possible, but no later than 15 months after receiving the care (or up to 27 months according to Medicare rules, in some cases). Please do not send any bills or claims to Medicare. Any additional information we request should also be mailed to this address:

Kaiser Permanente
Claims Administration - NCAL
P.O. Box 12923
Oakland, CA 94604-2923

Note: If you are requesting payment of a Part D drug that was prescribed by a Plan Provider and obtained from a Plan Pharmacy, write to:

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

Contact our Member Service Contact Center if you have any questions. If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

We Will Consider Your Request for Payment and Say Yes or No

We check to see whether we should cover the service or Part D drug and how much we owe

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

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

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

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

For the details about how to make this appeal, go to the "Coverage Decisions, Appeals, and Complaints" section. The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading

“A Guide to the Basics of Coverage Decisions and Appeals” in the “Coverage Decisions, Appeals, and Complaints” section, which is an introductory section that explains the process for coverage decisions and appeals and gives you definitions of terms such as “appeal.” Then, after you have read “A Guide to the Basics of Coverage Decisions and Appeals,” you can go to the section in “Coverage Decisions, Appeals, and Complaints” that tells you what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to “Step-by-step: How to make a Level 2 appeal” under “Your Medical Care: How to Ask for a Coverage Decision or Make an Appeal” in the “Coverage Decisions, Appeals, and Complaints” section
- If you want to make an appeal about getting paid back for a Part D drug, go to “Step-by-step: How to make a Level 2 appeal” under “Your Part D Prescription Drugs: How to Ask for a Coverage Decision or Make an Appeal” in the “Coverage Decisions, Appeals, and Complaints” section

Other Situations in Which You Should Save Your Receipts and Send Copies to Us

In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your covered Part D prescription drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here is one situation when you should send us copies of receipts to let us know about payments you have made for your drugs:

- **When you get a drug through a patient assistance program offered by a drug manufacturer.** Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside our plan benefits. If you get any drugs through a program offered by a drug manufacturer, you may pay a copayment to the patient assistance program
 - ◆ save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage
 - ◆ note: Because you are getting your drug through the patient assistance program and not through our plan’s benefits, we will not pay for any share of

these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly

Since you are not asking for payment in the case described above, this situation is not considered a coverage decision. Therefore, you cannot make an appeal if you disagree with our decision.

Your Rights and Responsibilities

We must honor your rights as a Member of our plan

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

Our plan has people and free interpreter services available to answer questions from disabled and non-English-speaking members. This booklet is available in Spanish by calling our Member Service Contact Center. We can also give you information in braille, large print, or CD at no cost if you need it. We are required to give you information about our plan’s benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call our Member Service Contact Center or contact our Civil Rights Coordinator.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with our Member Service Contact Center. You may also file a complaint with Medicare by calling **1-800-MEDICARE (1-800-633-4227)** or directly with the Office for Civil Rights. Contact information is included in this *EOC* or you may contact our Member Service Contact Center for additional information.

Debemos proporcionar la información de un modo adecuado para usted (en idiomas distintos al inglés, en braille, en letra grande o en CD)

Para obtener información de una forma que se adapte a sus necesidades, por favor llame a la Central de Llamadas de Servicio a los Miembros (los números de teléfono están impresos en la contraportada de este folleto).

Nuestro plan cuenta con personas y servicios de interpretación disponibles sin costo para responder las

preguntas de los miembros discapacitados y que no hablan inglés. Este folleto está disponible en español; llame a la Central de Llamadas de Servicio a los Miembros. Si la necesita, también podemos darle, sin costo, información en braille, letra grande o CD. Tenemos la obligación de darle información acerca de los beneficios de nuestro plan en un formato que sea accesible y adecuado para usted. Para obtener nuestra información de una forma que se adapte a sus necesidades, por favor llame a la Central de Llamadas de Servicio a los Miembros o comuníquese con nuestro Coordinador de Derechos Civiles.

Si tiene algún problema para obtener información de nuestro plan en un formato que sea accesible y adecuado para usted, por favor llame para presentar una queja a la Central de Llamadas de Servicio a los Miembros (los números de teléfono están impresos en la contraportada de este folleto). También puede presentar una queja en Medicare llamando al 1-800-MEDICARE (1-800-633-4227) o directamente en la Oficina de Derechos Civiles. En esta Evidence of Coverage (Evidencia de Cobertura) o en esta carta se incluye la información de contacto, o bien puede comunicarse con nuestra Central de Llamadas de Servicio a los Miembros para obtener información adicional.

We must ensure that you get timely access to your covered services and Part D drugs

As a Member of our plan, you have the right to choose a primary care provider (PCP) in our network to provide and arrange for your covered services (the “How to Obtain Services” section explains more about this). Call our Member Service Contact Center to learn which doctors are accepting new patients. You also have the right to go to a women’s health specialist (such as a gynecologist), a mental health services provider, and an optometrist without a referral, as well as other providers described in the “How to Obtain Services” section.

As a plan Member, you have the right to get appointments and covered services from our network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, “How to make a complaint about quality of care, waiting times, customer service, or other concerns” in the “Coverage Decisions, Appeals, and Complaints” section tells you what you can do. (If we have denied coverage for your medical care or Part D drugs and you don’t agree with our decision, “A guide to the basics of coverage

decisions and appeals” in the “Coverage Decisions, Appeals, and Complaints” section tells you what you can do.)

We must protect the privacy of your personal health information

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

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

How do we protect the privacy of your health information?

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

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

You have the right to look at your medical records held by our plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also

have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

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

If you have questions or concerns about the privacy of your personal health information, please call our Member Service Contact Center.

We must give you information about our plan, our Plan Providers, and your covered services

As a Member of our plan, you have the right to get several kinds of information from us. You have the right to get information from us in a way that works for you. This includes getting the information in Spanish, braille, large print, or CD.

If you want any of the following kinds of information, please call our Member Service Contact Center:

- **Information about our plan.** This includes, for example, information about our plan's financial condition. It also includes information about the number of appeals made by Members and our plan's performance ratings, including how it has been rated by Members and how it compares to other Medicare health plans
- **Information about our network providers, including our network pharmacies**
 - ◆ for example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network
 - ◆ for a list of the providers in our network, see the *Provider Directory*
 - ◆ for a list of the pharmacies in our network, see the *Pharmacy Directory*
 - ◆ for more detailed information about our providers or pharmacies, you can call our Member Service Contact Center or visit our website at kp.org/directory
- **Information about your coverage and the rules you must follow when using your coverage**
 - ◆ in the “How to Obtain Services” and “Benefits and Your Cost Share” sections, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services
 - ◆ to get the details about your Part D prescription drug coverage, see “Outpatient Prescription Drugs,

Supplies, and Supplements” in the “Benefits and Your Cost Share” section plus our plan's *Drug List*. That section, together with the *Drug List*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs

- ◆ if you have questions about the rules or restrictions, please call our Member Service Contact Center
- **Information about why something is not covered and what you can do about it**
 - ◆ if a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or Part D drug from an out-of-network provider or pharmacy
 - ◆ if you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see the “Coverage Decisions, Appeals, and Complaints” section. It gives you the details about how to make an appeal if you want us to change our decision. (it also tells you about how to make a complaint about quality of care, waiting times, and other concerns)
 - ◆ if you want to ask us to pay our share of a bill you have received for medical care or a Part D drug, see the “Request for Payments” section

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

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

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

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

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs

our plan offers to help members manage their medications and use drugs safely

- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments
- **The right to say “no.”** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking a medication, you accept full responsibility for what happens to your body as a result
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. The “coverage Decisions, Appeals, and Complaints” section of this booklet tells you how to ask us for a coverage decision

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

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

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

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

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

- **Get the form.** If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about

Medicare. You can also contact our Member Service Contact Center to ask for the forms

- **Fill it out and sign it.** Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can’t. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home

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

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

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

What if your instructions are not followed?

If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Quality Improvement Organization listed in the “Important Phone Numbers and Resources” section.

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

If you have any problems or concerns about your covered services or care, the “Coverage Decisions, Appeals, and Complaints” section of this booklet tells you what you can do. It gives you the details about how to deal with all types of problems and complaints.

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

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call our Member Service Contact Center.

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

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

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

Is it about something else?

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

- You can call our Member Service Contact Center
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to the "Important Phone Numbers and Resources" section
- Or you can call Medicare at **1-800-MEDICARE (1-800-633-4227)** (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week

How to get more information about your rights

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

- **You can call our Member Service Contact Center**
- **You can call the State Health Insurance Assistance Program.** For details about this organization and how to contact it, go to the "Important Phone Numbers and Resources" section
- **You can contact Medicare:**
 - ♦ you can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at <https://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf>)
 - ♦ or you can call **1-800-MEDICARE (1-800-633-4227)** (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week

Information about new technology assessments

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

You can make suggestions about rights and responsibilities

As a Member of our plan, you have the right to make recommendations about the rights and responsibilities included in this section. Please call our Member Service Contact Center with any suggestions.

You have some responsibilities as a Member of our plan

What are your responsibilities?

Things you need to do as a Member of our plan are listed below. If you have any questions, please call our Member Service Contact Center. We're here to help.

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *EOC* booklet to learn what is covered for you and the rules you need to follow to get your covered services
 - ♦ the "How to Obtain Services" and "Benefits and Your Cost Share" sections give details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay
 - ♦ the "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section gives details about your coverage for Part D prescription drugs
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us.** Please call our Member Service Contact Center to let us know
 - ♦ we are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "coordination of benefits" because it involves coordinating the health and drug benefits you get from us with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to the "Exclusion, Limitations, Coordination of Benefits, and Reductions" section)

- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D drugs
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care**
 - ◆ to help your doctors and other health care providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon
 - ◆ make sure you understand your health problems and participate in developing mutually agreed upon treatment goals with your providers whenever possible
 - ◆ make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements
 - ◆ if you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices
- **Pay what you owe.** As a plan member, you are responsible for these payments:
 - ◆ in order to be eligible for our plan, you must have Medicare Part B. Most plan Members must pay a premium for Medicare Part B to remain a Member of our plan
 - ◆ for most of your Services or Part D drugs covered by our plan, you must pay your share of the cost when you get the Service or Part D drug. This will be a Copayment (a fixed amount) or Coinsurance (a percentage of the total cost). The "Benefits and Your Cost Share" section tells you what you must pay for your Services and Part D drugs
 - ◆ if you get any medical services or Part D drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost
 - ◆ if you disagree with our decision to deny coverage for a service or Part D drug, you can make an appeal. Please see the "Coverage Decisions, Appeals, and Complaints" section for information about how to make an appeal
- ◆ if you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage
- ◆ if you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a Member of our plan
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call our Member Service Contact Center
 - ◆ if you move outside of our Service Area, you cannot remain a Member of our plan. (The "Definitions" section tells you about our Service Area.) We can help you figure out whether you are moving outside our Service Area.
 - ◆ if you move within our Service Area, we still need to know so we can keep your membership record up-to-date and know how to contact you
 - ◆ if you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in the "Important Phone Numbers and Resources" section
- **Call our Member Service Contact Center for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan
 - ◆ phone numbers and calling hours for our Member Service Contact Center
 - ◆ for more information about how to reach us, including our mailing address, please see the "Important Phone Numbers and Resources" section

Coverage Decisions, Appeals, and Complaints

What to Do if You Have a Problem or Concern

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

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

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules,

procedures, and deadlines that must be followed by you and us.

Which one do you use? That depends upon the type of problem you are having. The guide under “To Deal with Your Problem, Which Process Should You Use?” in this “Coverage Decisions, Appeals, and Complaints” section will help you identify the right process to use.

Hospice care

If you have Medicare Part A, your hospice care is covered by Original Medicare and it is not covered under this *EOC*. Therefore, any complaints related to the coverage of hospice care must be resolved directly with Medicare and not through any complaint or appeal procedure discussed in this *EOC*. Medicare complaint and appeal procedures are described in the Medicare handbook *Medicare & You*, which is available from your local Social Security office, at

<https://www.medicare.gov>, or by calling toll free **1-800-MEDICARE (1-800-633-4227)** (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week. If you do not have Medicare Part A, Original Medicare does not cover hospice care. Instead, we will provide hospice care, and any complaints related to hospice care are subject to this “Coverage Decisions, Appeals, and Complaints” section.

What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this “Coverage Decisions, Appeals, and Complaints” section. Many of these terms are unfamiliar to most people and can be hard to understand.

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

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

You Can Get Help from Government Organizations That Are Not Connected with Us

Where to get more information and personalized assistance

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

Get help from an independent government organization

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

The services of the State Health Insurance Assistance Program counselors are free. You will find phone numbers in the “Important Phone Numbers and Resources” section.

You can also get help and information from Medicare

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

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

To Deal with Your Problem, Which Process Should You Use?

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

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

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

- **Is your problem or concern about your benefits or coverage?** (This includes problems about whether particular medical care or Part D drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or Part D drugs)
 - ◆ **yes, my problem is about benefits or coverage:** Go on to “A Guide to the Basics of Coverage Decisions and Appeals”
 - ◆ **no, my problem is not about benefits or coverage:** Skip ahead to “How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns”

A Guide to the Basics of Coverage Decisions and Appeals

Asking for coverage decisions and making appeals—The big picture

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

Asking for coverage decisions

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

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a service or Part D drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can “appeal” the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or “fast coverage decision” or fast appeal of a coverage decision.

If we say **no** to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an Independent Review Organization that is not connected to us. (In some situations, your case will be automatically sent to the Independent Review Organization for a Level 2 Appeal. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

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

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

- You can call our Member Service Contact Center (phone numbers are on the cover of this *EOC*)
- You can get free help from your State Health Insurance Assistance Program (see the “Important Phone Numbers and Resources” section)
- Your doctor can make a request for you
 - ◆ for medical care or Medicare Part B prescription drugs, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative
 - ◆ for Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative
- You can ask someone to act on your behalf. If you want to, you can name another person to act for you as your “representative” to ask for a coverage decision or make an appeal
 - ◆ there may be someone who is already legally authorized to act as your representative under state law

- ◆ if you want a friend, relative, your doctor or other provider, or other person to be your representative, call our Member Service Contact Center and ask for the “Appointment of Representative” form. (The form is also available on Medicare’s website at <https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> or on our website at kp.org.) The form gives that person permission to act on your behalf. It must be signed by you and by the person whom you would like to act on your behalf. You must give us a copy of the signed form
- You also have the right to hire a lawyer to act for you. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision

Which section gives the details for your situation?

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

- “Your Medical Care: How to Ask for a Coverage Decision or Make an Appeal”
- “Your Part D Prescription Drugs: How to Ask for a Coverage Decision or Make an Appeal”
- “How to Ask Us to Cover a Longer Inpatient Hospital Stay if You Think the Doctor Is Discharging You Too Soon”
- “How to Ask Us to Keep Covering Certain Medical Services if You Think Your Coverage is Ending Too Soon” (applies to these services only: home health care, Skilled Nursing Facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you’re not sure which section you should be using, please call our Member Service Contact Center (phone numbers are on the cover of this *EOC*). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (the “Important Phone Numbers and Resources” section has the phone numbers for this program).

Your Medical Care: How to Ask for a Coverage Decision or Make an Appeal

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

This section is about your benefits for medical care and services. These benefits are described in the “Benefits and Your Cost Share” section. To keep things simple, we generally refer to “medical care coverage” or “medical care” in the rest of this section, instead of repeating “medical care or treatment or services” every time. The term “medical care” includes medical items and services as well as Medicare Part B prescription drugs. In some cases, different rules apply to a request for a Medicare Part B prescription drug. In those cases, we will explain how the rules for Medicare Part B prescription drugs are different from the rules for medical items and services.

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

- You are not getting certain medical care you want, and you believe that this care is covered by our plan
- We will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by our plan
- You have received medical care that you believe should be covered by our plan, but we have said we will not pay for this care
- You have received and paid for medical care that you believe should be covered by our plan, and you want to ask us to reimburse you for this care
- You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health
- Note: If the coverage that will be stopped is for hospital care, home health care, Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section because special rules apply to these types of care. Here’s what to read in those situations:
 - ◆ go to “How to Ask Us to Cover a Longer Inpatient Hospital Stay if You Think the Doctor Is Discharging You Too Soon”
 - ◆ go to “How to Ask Us to Keep Covering Certain Medical Services if You Think Your Coverage Is Ending Too Soon.” This section is about three services only: home health care, Skilled Nursing

Facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

- For all other situations that involve being told that medical care you have been getting will be stopped, use this “Your Medical Care: How to Ask for a Coverage Decision or Make an Appeal” section as your guide for what to do.

Which of these situations are you in?

- To find out whether we will cover the medical care you want
 - ◆ you can ask us to make a coverage decision for you. **Go to “Step-by-step: How to ask for a coverage decision”**
- If we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for
 - ◆ you can make an appeal. (This means you are asking us to reconsider.) **Skip ahead to “Step-by-step: How to make a Level 1 Appeal”**
- If you want to ask us to pay you back for medical care you have already received and paid for
 - ◆ you can send us the bill. **Skip ahead to “What if you are asking us to pay you for our share of a bill you have received for medical care?”**

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

Step 1: You ask us to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a “fast coverage decision.” A “fast coverage decision” is called an “expedited determination.”

How to request coverage for the medical care you want

- Start by calling, writing, or faxing us to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this
- For the details about how to contact us, go to “How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care” in the “Important Phone Numbers and Resources” section

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the

“fast” deadlines. A standard coverage decision means we will give you an answer within 14 calendar days after we receive your request for a medical item or service. If your request is for a Medicare Part B prescription drug, we will give you an answer within 72 hours after we receive your request.

- However, for a request for a medical item or service, we can take up to 14 more calendar days if you ask for more time, or if we need information (such as medical records from Non-Plan Providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug
- If you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see “How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns” in this “Coverage Decisions, Appeals, and Complaints” section)

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

- A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours
 - ◆ however, for a request for a medical item or service, we can take up to 14 more calendar days if we find that some information that may benefit you is missing (such as medical records from Non-Plan Providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug
 - ◆ if you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see “How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns” in this “Coverage Decisions, Appeals, and Complaints” section.) We will call you as soon as we make the decision

- To get a fast coverage decision, you must meet two requirements:
 - ◆ you can get a fast coverage decision only if you are asking for coverage for medical care you have not yet received. (You cannot ask for a fast coverage decision if your request is about payment for medical care you have already received)
 - ◆ you can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function
- If your doctor tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision
- If you ask for a fast coverage decision on your own, without your doctor’s support, we will decide whether your health requires that we give you a fast coverage decision
 - ◆ if we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead)
 - ◆ this letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision
 - ◆ the letter will also tell how you can file a “fast complaint” about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see “How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns” in this “Coverage Decisions, Appeals, and Complaints” section)

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

Deadlines for a “fast coverage decision”

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer within 72 hours. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours
 - ◆ as explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug
 - ◆ if you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint,

we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see “How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns” in this “Coverage Decisions, Appeals, and Complaints” section)

- ◆ if we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), or within 24 hours if your request is for a Medicare Part B prescription drug, you have the right to appeal. “Step-by-step: How to make a Level 1 Appeal” below tells you how to make an appeal
- If our answer is **yes** to part or all of what you requested, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision on your request for a medical item or service, we will authorize or provide the coverage by the end of that extended period
- If our answer is **no** to part or all of what you requested, we will send you a detailed written explanation as to why we said **no**

Deadlines for a “standard coverage decision”

- Generally, for a standard coverage decision on your request for a medical item or service, we will give you our answer within 14 calendar days of receiving your request. If your request is for a Medicare Part B prescription drug, we will give you an answer within 72 hours of receiving your request
 - ◆ for a request for a medical item or service, we can take up to 14 more calendar days (“an extended time period”) under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug
 - ◆ if you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see “How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns” in this “Coverage Decisions, Appeals, and Complaints” section)
 - ◆ if we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), or within 72 hours if your request is for a Medicare Part B

prescription drug, you have the right to appeal.
“Step-by-step: How to make a Level 1 Appeal”
below tells you how to make an appeal

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

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

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

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

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

An appeal to our plan about a medical care coverage decision is called a plan “reconsideration.”

What to do:

- To start an appeal, you, your doctor, or your representative must contact us. For details about how to reach us for any purpose related to your appeal, go to “How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care” in the “Important Phone Numbers and Resources” section
- If you are asking for a standard appeal, make your standard appeal in writing by submitting a request
 - ♦ if you have someone appealing our decision for you other than your doctor, your appeal must include an “Appointment of Representative” form authorizing this person to represent you. To get the form, call our Member Service Contact Center and ask for the “Appointment of Representative” form. It is also available on Medicare’s website at

<https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf> or on our website at **kp.org**. While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal

- If you are asking for a fast appeal, make your appeal in writing or call us (see “How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care” in the “Important Phone Numbers and Resources” section)
- You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal
- You can ask for a copy of the information regarding your medical decision and add more information to support your appeal
 - ♦ you have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you
 - ♦ if you wish, you and your doctor may give us additional information to support your appeal

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

- A “fast appeal” is also called an “expedited reconsideration.”
- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a “fast appeal”
- The requirements and procedures for getting a “fast appeal” are the same as those for getting a “fast coverage decision.” To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section)

- If your doctor tells us that your health requires a “fast appeal,” we will give you a fast appeal

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

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

Deadlines for a “fast appeal”

- When we are using the fast deadlines, we must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires us to do so
 - ◆ however, if you ask for more time, or if we need to gather more information that may benefit you, we can take up to 14 more calendar days on your request for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug
 - ◆ if we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process
- If our answer is **yes** to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal
- If our answer is **no** to part or all of what you requested, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal

Deadlines for a “standard appeal”

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service within 30 calendar days after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer within 7 calendar days after we receive your appeal. We will give you our decision sooner if your health condition requires us to
 - ◆ however, if you ask for more time, or if we need to gather more information that may benefit you, we can take up to 14 more calendar days if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug
 - ◆ if you believe we should not take extra days, you can file a “fast complaint” about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see “How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns” in this “Coverage Decisions, Appeals, and Complaints” section)
 - ◆ if we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process
- If our answer is **yes** to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 30 calendar days if your request is for a medical item or service, or within 7 calendar days if your request is for a Medicare Part B prescription drug
- If our answer is **no** to part or all of what you requested, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal

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

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

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

If we say **no** to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the Independent Review Organization reviews our decision for your first appeal. This organization decides whether the decision we made should be changed. The formal name for the Independent Review Organization is the “Independent Review Entity.” It is sometimes called the “IRE.”

Step 1: The Independent Review Organization reviews your appeal

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

If you had a “fast appeal” at Level 1, you will also have a “fast appeal” at Level 2

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

time to make a decision if your request is for a Medicare Part B prescription drug

If you had a “standard appeal” at Level 1, you will also have a “standard appeal” at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. If your request is for a medical item or service, the review organization must give you an answer to your Level 2 Appeal within 30 calendar days of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal within 7 calendar days of when it receives your appeal
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days. The Independent Review Organization can’t take extra time to make a decision if your request is for a Medicare Part B prescription drug

Step 2: The Independent Review Organization gives you their answer

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- If the review organization says **yes** to part or all of a request for a medical item or service, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests or within 72 hours from the date we receive the decision from the review organization for expedited requests
- If the review organization says **yes** to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug under dispute within 72 hours after we receive the decision from the review organization for standard requests or within 24 hours from the date we receive the decision from the review organization for expedited requests.
- If this organization says **no** to part or all of your appeal, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called “upholding the decision.” It is also called “turning down your appeal”)
 - ◆ if the Independent Review Organization “upholds the decision,” you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage

you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process

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

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

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

If you want to ask us for payment for medical care, start by reading the “Requests for Payment” section, which describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells you how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see “Asking for coverage decisions and making appeals—*The big picture*” in this “Coverage Decisions, Appeals, and Complaints” section). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see the “Benefits and Your Cost Share” section). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in the “How to Obtain Services” section).

We will say yes or no to your request

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

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

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

To make this appeal, follow the process for appeals that we describe under “Step-by-step: How to make a Level 1 Appeal.” Go to this section for step-by-step instructions. When you are following these instructions, please note:

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

Your Part D Prescription Drugs: How to Ask for a Coverage Decision or Make an Appeal

What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a Member of our plan include coverage for many prescription drugs. Please refer to our *2021 Comprehensive Formulary*. To be covered, the Part D drug must be used for a medically accepted indication.

(A “medically accepted indication” is a use of the drug that is either approved by the federal Food and Drug Administration or supported by certain reference books.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say “drug” in the rest of this section, instead of repeating “covered outpatient prescription drug” or “Part D drug” every time
- For details about what we mean by Part D drugs, the *2021 Comprehensive Formulary*, rules and restrictions on coverage, and cost information, see “Outpatient Prescription Drugs, Supplies, and Supplements” in the “Benefits and Your Cost Share” section

Part D coverage decisions and appeals

As discussed under “A Guide to the Basics of Coverage Decisions and Appeals” in this “Coverage Decisions, Appeals, and Complaints” section, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. An initial coverage decision about your Part D drugs is called a “coverage determination.”

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
 - ◆ asking us to cover a Part D drug that is not on our *2021 Comprehensive Formulary*
 - ◆ asking us to waive a restriction on our plan’s coverage for a drug (such as limits on the amount of the drug you can get)
 - ◆ asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. For example, when your drug is on our *2021 Comprehensive Formulary*, but we require you to get approval from us before we will cover it for you
 - ◆ note: if your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment

If you disagree with a coverage decision we have made, you can appeal our decision.

Which of these situations are you in?

This section tells you both how to ask for coverage decisions and how to request an appeal. Use this guide to help you determine which part has information for your situation:

- If you need a drug that isn’t on our *Drug List* or need us to waive a rule or restriction on a drug we cover. You can ask us to make an exception. (This is a type of coverage decision.) **Start with “What is a Part D exception?”**
- If you want us to cover a drug on our *Drug List* and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need. You can ask us for a coverage decision. **Skip ahead to “Step-by-step: How to ask for a coverage decision, including a Part D exception”**
- If you want to ask us to pay you back for a drug you have already received and paid for. You can ask us to pay you back. (This is a type of coverage decision.) **Skip ahead to “Step-by-step: How to ask for a coverage decision, including a Part D exception”**
- If we already told you that we will not cover or pay for a drug in the way that you want it to be covered or paid for. You can make an appeal. (This means you are asking us to reconsider.) **Skip ahead to “Step-by-step: How to make a Level 1 Appeal”**

What is a Part D exception?

If a Part D drug is not covered in the way you would like it to be covered, you can ask us to make an “exception.” An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are two examples of exceptions that you or your doctor or other prescriber can ask us to make:

- **Covering a Part D drug for you that is not on our *2021 Comprehensive Formulary*.** (We call it the “*Drug List*” for short.) Asking for coverage of a drug that is not on the *Drug List* is sometimes called asking for a “formulary exception”
 - ◆ if we agree to make an exception and cover a drug that is not on the *Drug List*, you will need to pay the Cost Share amount that applies to drugs in the brand-name drug tier. You cannot ask for an exception to the Copayment or Coinsurance amount we require you to pay for the drug
 - ◆ you cannot ask for coverage of any “excluded drugs” or other non-Part D drugs that Medicare

does not cover. (For more information about excluded drugs, see “Outpatient Prescription Drugs, Supplies, and Supplements” in the “Benefits and Your Cost Share” section)

- **Removing a restriction on our coverage for a covered Part D drug.** There are extra rules or restrictions that apply to certain drugs on our *2021 Comprehensive Formulary* (for more information, go to “Outpatient Prescription Drugs, Supplies, and Supplements” in the “Benefits and Your Cost Share” section). Asking for a removal of a restriction on coverage for a drug is sometimes called asking for a “formulary exception”
 - ◆ the extra rules and restrictions on coverage for certain drugs include 1) being required to use the generic version of a drug instead of the brand-name drug, and 2) getting **plan approval in advance** before we will agree to cover the drug for you. (This is sometimes called “prior authorization”)
 - ◆ if we agree to make an exception and waive a restriction for you, you can ask for an exception to the Copayment or Coinsurance amount we require you to pay for the Part D drug

Important things to know about asking for a Part D exception

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting a Part D exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called “alternative” drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception. If you ask us for a tiering exception, we will generally not approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won’t work as well for you or are likely to cause an adverse reaction or other harm.

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

- If we approve your request for a Part D exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition

- If we say **no** to your request for a Part D exception, you can ask for a review of our decision by making an appeal. The “Step-by-step: How to make a Level 1 Appeal” section tells how to make an appeal if we say no

The next section tells you how to ask for a coverage decision, including a Part D exception.

Step-by-step: How to ask for a coverage decision, including a Part D exception

Step 1: You ask us to make a coverage decision about the drug(s) or payment you need.

If your health requires a quick response, you must ask us to make a “fast coverage decision.” You **cannot** ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

What to do:

- Request the type of coverage decision you want. Start by calling, writing, or faxing OptumRx Prior Authorization Member Services Desk to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to “How to contact us when you are asking for a coverage decision about your Part D prescription drugs” in the “Important Phone Numbers and Resources” section. Or if you are asking us to pay you back for a drug, go to “Where to send a request asking us to pay for our share of the cost for medical care or a Part D drug you have received” in the “Important Phone Numbers and Resources” section
- You or your doctor or someone else who is acting on your behalf can ask for a coverage decision. The “A Guide to the Basics of Coverage Decisions and Appeals” section tells you how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf
- If you want to ask us to pay you back for a drug, start by reading the “Requests for Payment” section, which describes the situations in which you may need to ask for reimbursement. It also tells you how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for
- If you are requesting a Part D exception, provide the “supporting statement.” Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the “supporting statement.”) Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and

follow up by faxing or mailing a written statement if necessary. See “What is a Part D exception?” and “Important things to know about asking for a Part D exception” for more information about exception requests

- We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website

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

A “fast coverage decision” is called an “expedited coverage determination.”

- When we give you our decision, we will use the “standard” deadlines unless we have agreed to use the “fast” deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor’s statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor’s statement
- To get a fast coverage decision, you must meet two requirements:
 - ◆ you can get a fast coverage decision only if you are asking for a drug you have not yet received. (You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you have already bought)
 - ◆ you can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function
- If your doctor or other prescriber tells us that your health requires a “fast coverage decision,” we will automatically agree to give you a fast coverage decision
- If you ask for a fast coverage decision on your own (without your doctor’s or other prescriber’s support), we will decide whether your health requires that we give you a fast coverage decision
 - ◆ if we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead)
 - ◆ this letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision
 - ◆ the letter will also tell you how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells you how to file a “fast complaint,” which means you would get our answer to your complaint within 24 hours

of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see “How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns” in this “Coverage Decisions, Appeals, and Complaints” section

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

Deadlines for a “fast coverage decision”

- If we are using the fast deadlines, we must give you our answer within 24 hours
 - ◆ generally, this means within 24 hours after we receive your request. If you are requesting a Part D exception, we will give you our answer within 24 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to
 - ◆ if we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2
- If our answer is **yes** to part or all of what you requested, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor’s statement supporting your request
- If our answer is **no** to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal

Deadlines for a “standard coverage decision” about a Part D drug you have not yet received

- If we are using the standard deadlines, we must give you our answer within 72 hours
 - ◆ generally, this means within 72 hours after we receive your request. If you are requesting a Part D exception, we will give you our answer within 72 hours after we receive your doctor’s statement supporting your request. We will give you our answer sooner if your health requires us to
 - ◆ if we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2

- If our answer is **yes** to part or all of what you requested:
 - ◆ if we approve your request for coverage, we must provide the coverage we have agreed to provide within 72 hours after we receive your request or doctor's statement supporting your request
- If our answer is **no** to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal

Deadlines for a “standard coverage decision” about payment for a drug you have already bought

- We must give you our answer within 14 calendar days after we receive your request
 - ◆ if we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2
- If our answer is **yes** to part or all of what you requested, we are also required to make payment to you within 14 calendar days after we receive your request
- If our answer is **no** to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal

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

- If we say **no**, you have the right to request an appeal. Requesting an appeal means asking us to reconsider—and possibly change—the decision we made

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

An appeal to our plan about a Part D drug coverage decision is called a plan “redetermination.”

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

What to do:

- To start your appeal, you (or your representative or your doctor or other prescriber) must contact us
 - ◆ for details about how to reach us by phone, fax, or mail, or on our website for any purpose related to

your appeal, go to “How to contact us when you are making an appeal about your Part D prescription drugs” in the “Important Phone Numbers and Resources” section

- If you are asking for a standard appeal, make your appeal by submitting a written request
- If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown under “How to contact us when you are making an appeal about your Part D prescription drugs” in the “Important Phone Numbers and Resources” section
- We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website
- You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal
- You can ask for a copy of the information in your appeal and add more information
 - ◆ you have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you
 - ◆ if you wish, you and your doctor or other prescriber may give us additional information to support your appeal

If your health requires it, ask for a “fast appeal”

A “fast appeal” is also called an “expedited redetermination.”

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a “fast appeal”
- The requirements for getting a “fast appeal” are the same as those for getting a “fast coverage decision” in “Step-by-step: How to ask for a coverage decision, including a Part D exception”

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

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

Deadlines for a “fast appeal”

- If we are using the fast deadlines, we must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires it
 - ◆ if we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process
- If our answer is **yes** to part or all of what you requested, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal
- If our answer is **no** to part or all of what you requested, we will send you a written statement that explains why we said **no** and how you can appeal our decision

Deadlines for a “standard appeal”

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we receive your appeal for a drug you have not received yet. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for a “fast appeal”
 - ◆ if we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process
- If our answer is **yes** to part or all of what you requested:
 - ◆ if we approve a request for coverage, we must provide the coverage we have agreed to provide as quickly as your health requires, but no later than 7 calendar days after we receive your appeal
 - ◆ if we approve a request to pay you back for a drug you already bought, we are required to send

payment to you within 30 calendar days after we receive your appeal request

- If our answer is **no** to part or all of what you requested, we will send you a written statement that explains why we said **no** and how you can appeal our decision
- If you are requesting that we pay you back for a drug you have already bought, we must give you our answer within 14 calendar days after we receive your request
 - ◆ If we do not give you a decision within 14 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- If our answer is yes to part or all of what you requested, we are also required to make payment to you within 30 calendar days after we receive your request
- If our answer is **no** to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal our decision

Step 3: If we say **no** to your appeal, you decide if you want to continue with the appeals process and make another appeal

- If we say **no** to your appeal, you then choose whether to accept this decision or continue by making another appeal
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below)

Step-by-step: How to make a Level 2 Appeal

If we say **no** to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Organization reviews the decision we made when we said **no** to your first appeal. This organization decides whether the decision we made should be changed.

The formal name for the Independent Review Organization is the “Independent Review Entity.” It is sometimes called the “IRE.”

Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber)

must contact the Independent Review Organization and ask for a review of your case

- If we say **no** to your Level 1 Appeal, the written notice we send you will include instructions about how to make a Level 2 Appeal with the Independent Review Organization. These instructions will tell you who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your “case file.” You have the right to ask us for a copy of your case file. We are allowed to charge you a fee for copying and sending this information to you
- You have a right to give the Independent Review Organization additional information to support your appeal

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it

Deadlines for “fast appeal” at Level 2

- If your health requires it, ask the Independent Review Organization for a fast appeal
- If the review organization agrees to give you a fast appeal, the review organization must give you an answer to your Level 2 Appeal within 72 hours after it receives your appeal request
- If the Independent Review Organization says **yes** to part or all of what you requested, we must provide the drug coverage that was approved by the review organization within 24 hours after we receive the decision from the review organization

Deadlines for “standard appeal” at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal within 7 calendar days after it receives your appeal if it is for a drug you have not received yet. If you are requesting that we pay you back for a drug

you have already bought, the review organization must give you an answer to your Level 2 appeal within 14 calendar days after it receives your request

- If the Independent Review Organization says **yes** to part or all of what you requested:
 - ♦ if the Independent Review Organization approves a request for coverage, we must provide the drug coverage that was approved by the review organization within 72 hours after we receive the decision from the review organization
 - ♦ if the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive the decision from the review organization

What if the review organization says no to your appeal?

If this organization says **no** to your appeal, it means the organization agrees with our decision not to approve your request. (This is called “upholding the decision.” It is also called “turning down your appeal.”)

If the Independent Review Organization “upholds the decision,” you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further

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

How to Ask Us to Cover a Longer Inpatient Hospital Stay if You Think the Doctor Is Discharging You Too Soon

When you are admitted to a hospital, you have the right to get all of your covered hospital Services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see the “Benefits and Your Cost Share” section.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

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

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

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

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

- ◆ your right to appeal your discharge decision if you think you are being discharged from the hospital too soon
- ◆ the written notice from Medicare tells you how you can “request an immediate review.” Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. “Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date” tells you how you can request an immediate review
- **You will be asked to sign the written notice to show that you received it and understand your rights**
 - ◆ you or someone who is acting on your behalf will be asked to sign the notice. (“A Guide to the Basics of Coverage Decisions and Appeals” in this “Coverage Decisions, Appeals, and Complaints” section tells you how you can give written permission to someone else to act as your representative)
 - ◆ signing the notice shows only that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice does not mean you are agreeing on a discharge date
- **Keep your copy of the notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it**
 - ◆ if you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged
 - ◆ to look at a copy of this notice in advance, you can call our Member Service Contact Center or **1-800-MEDICARE (1-800-633-4227)** (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week. You can also see the notice online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>

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

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

- **Follow the process.** Each step in the first two levels of the appeals process is explained below
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do
- **Ask for help if you need it.** If you have questions or need help at any time, please call our Member Service Contact Center (phone numbers are on the cover of this *EOC*). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see the “Important Phone Numbers and Resources” section)

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

Step 1: Contact the Quality Improvement Organization for your state and ask for a “fast review” of your hospital discharge. You must act quickly

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in the “Important Phone Numbers and Resources” section)

Act quickly

- To make your appeal, you must contact the Quality Improvement Organization before you leave the hospital and no later than midnight the day of your discharge date. (Your “planned discharge date” is the date that has been set for you to leave the hospital)
 - ◆ if you meet this deadline, you are allowed to stay in the hospital after your discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization
 - ◆ if you do not meet this deadline, and you decide to stay in the hospital after your planned discharge

date, you may have to pay all of the costs for hospital care you receive after your planned discharge date

- If you miss the deadline for contacting the Quality Improvement Organization and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see “What if you miss the deadline for making your Level 1 Appeal?”

Ask for a “fast review” (a “fast review” is also called an “immediate review” or an “expedited review”)

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

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish
- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives you your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date. This written explanation is called the *Detailed Notice of Discharge*. You can get a sample of this notice by calling our Member Service Contact Center or **1-800-MEDICARE (1-800-633-4227)** (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week. Or you can see a sample notice online at <https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html>

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

What happens if the answer is yes?

- If the review organization says **yes** to your appeal, we must keep providing your covered inpatient hospital services for as long as these services are medically necessary
- You will have to keep paying your share of the costs (such as Cost Share, if applicable). In addition, there may be limitations on your covered hospital services. (See the “Benefits and Your Cost Share” section)

What happens if the answer is no?

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

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

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

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

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

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

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

- You must ask for this review within 60 calendar days after the day the Quality Improvement Organization

said **no** to your Level 1 Appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended

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

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

Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision

If the review organization says yes

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

If the review organization says no

- It means they agree with the decision they made on your Level 1 Appeal and will not change it. This is called “upholding the decision”
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an administrative law judge or attorney adjudicator

Step 4: If the answer is **no**, you will need to decide whether you want to take your appeal further by going on to Level 3

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an administrative law judge or attorney adjudicator
- The “Taking Your Appeal to Level 3 and Beyond” section tells you more about Levels 3, 4, and 5 of the appeals process

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

You can appeal to us instead

As explained under “Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date” in this “Coverage Decisions, Appeals, and Complaints” section, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. (“Quickly” means before you leave the hospital and no later than your planned discharge date whichever comes first.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

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

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

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines. A “fast review” (or “fast appeal”) is also called an “expedited appeal.”

Step 1: Contact us and ask for a “fast review”

- For details about how to contact us, go to “How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care” in the “Important Phone Numbers and Resources” section
- Be sure to ask for a “fast review.” This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines

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

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

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

- If we say **yes** to your fast appeal, it means we have agreed with you that you still need to be in the

hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs, and there may be coverage limitations that apply)

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

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

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

Step-by-step: Level 2 Alternate Appeal Process

During the Level 2 Appeal, an Independent Review Organization reviews the decision we made when we said **no** to your “fast appeal.” This organization decides whether the decision we made should be changed. The formal name for the Independent Review Organization is the “Independent Review Entity.” It is sometimes called the “IRE.”

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

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying **no** to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeals process. “How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns” in this “Coverage Decisions, Appeals, and Complaints” section tells you how to make a complaint)

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

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

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

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say **no** to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal
- “Taking Your Appeal to Level 3 and Beyond” in this “Coverage Decisions, Appeals, and Complaints” section tells you more about Levels 3, 4, and 5 of the appeals process

How to Ask Us to Keep Covering Certain Medical Services if You Think Your Coverage Is Ending Too Soon

Home health care, Skilled Nursing Facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is only about the following types of care:

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

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information about your covered services, including your share of the cost and any limitations to coverage that may apply, see the “Benefits and Your Cost Share” section.

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

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

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

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

legal way to request a change to our coverage decision about when to stop your care. “Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time” tells you how you can request a fast-track appeal

- ◆ the written notice is called the *Notice of Medicare Non-Coverage*
- **You will be asked to sign the written notice to show that you received it**
 - ◆ you or someone who is acting on your behalf will be asked to sign the notice. (“A Guide to the Basics of Coverage Decisions and Appeals” in this “Coverage Decisions, Appeals, and Complaints” section tells you how you can give written permission to someone else to act as your representative.)
 - ◆ signing the notice shows only that you have received the information about when your coverage will stop. Signing it does not mean you agree with us that it’s time to stop getting the care

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

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

- **Follow the process.** Each step in the first two levels of the appeals process is explained below
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. “How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns” in this “Coverage Decisions, Appeals, and Complaints” section tells you how to file a complaint)
- **Ask for help if you need it.** If you have questions or need help at any time, please call our Member Service Contact Center (phone numbers are on the front cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see the “Important Phone Numbers and Resources” section)

If you ask for a Level 1 Appeal on time, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: Contact the Quality Improvement Organization for your state and ask for a review. You must act quickly

What is the Quality Improvement Organization?

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

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in the “Important Phone Numbers and Resources” section)

What should you ask for?

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

Your deadline for contacting this organization

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date of the *Notice of Medicare Non-Coverage*
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see “Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time”

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

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them “the reviewers” for short) will ask you (or your representative) why you believe coverage for the services should continue. You don’t have to prepare anything in writing, but you may do so if you wish
- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them

- By the end of the day the reviewers inform us of your appeal, you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services. This notice of explanation is called the *Detailed Explanation of Non-Coverage*

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

What happens if the reviewers say yes to your appeal?

- If the reviewers say **yes** to your appeal, then we must keep providing your covered services for as long as it is medically necessary
- You will have to keep paying your share of the costs (such as Cost Share, if applicable). In addition, there may be limitations on your covered services (see the “Benefits and Your Cost Share” section)

What happens if the reviewers say no to your appeal?

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

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

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

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

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or Skilled Nursing Facility care, or Comprehensive Outpatient

Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

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

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

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

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

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

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision

What happens if the review organization says yes to your appeal?

- We must reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary
- You must continue to pay your share of the costs and there may be coverage limitations that apply

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an administrative law judge or attorney adjudicator

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by a judge
- “Taking Your Appeal to Level 3 and Beyond” in this “Coverage Decisions, Appeals, and Complaints” section tells you more about Levels 3, 4, and 5 of the appeals process

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

You can appeal to us instead

As explained under “Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time,” you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.

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

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a “fast review.” A fast review is an appeal that uses the fast deadlines instead of the standard deadlines. A “fast review” (or “fast appeal”) is also called an “expedited appeal.”

Here are the steps for a Level 1 Alternate Appeal:

Step 1: Contact us and ask for a “fast review”

- For details about how to contact us, go to “How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care” in the “Important Phone Numbers and Resources” section
- Be sure to ask for a “fast review.” This means you are asking us to give you an answer using the “fast” deadlines rather than the “standard” deadlines

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

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

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

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

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

- If we say **no** to your fast appeal, then your coverage will end on the date we told you and we will not pay any share of the costs after this date
- If you continued to get home health care, or Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end, then you will have to pay the full cost of this care yourself

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

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

Step-by-step: Level 2 Alternate Appeal Process

During the Level 2 Appeal, the Independent Review Organization reviews the decision we made when we said **no** to your “fast appeal.” This organization decides whether the decision we made should be changed. The formal name for the Independent Review Organization is the “Independent Review Entity.” It is sometimes called the “IRE.”

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

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying **no** to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeals process. “How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns” in this “Coverage Decisions, Appeals, and Complaints” section tells how to make a complaint)

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

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of

being the Independent Review Organization. Medicare oversees its work

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

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

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

Taking Your Appeal to Level 3 and Beyond

Levels of Appeal 3, 4, and 5 for Medical Service Requests

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

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

explain whom to contact and what to do to ask for a Level 3 Appeal.

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

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

- If the administrative law judge or attorney adjudicator says **yes** to your appeal, the appeals process may or may not be over. We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you
 - ◆ if we decide not to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the administrative law judge’s or attorney adjudicator’s decision
 - ◆ if we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute
- If the administrative law judge or attorney adjudicator says **no** to your appeal, the appeals process may or may not be over
 - ◆ if you decide to accept this decision that turns down your appeal, the appeals process is over
 - ◆ if you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge or attorney adjudicator says **no** to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal

Level 4 Appeal: The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the federal government

- If the answer is yes, or if the Council denies our request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over. We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you if the value of the item or medical service meets the required dollar value
 - ◆ if we decide not to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision
 - ◆ if we decide to appeal the decision, we will let you know in writing
- If the answer is **no** or if the Council denies the review request, the appeals process may or may not be over
 - ◆ if you decide to accept this decision that turns down your appeal, the appeals process is over
 - ◆ if you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says **no** to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what to do next if you choose to continue with your appeal

Level 5 Appeal: A judge at the Federal District Court will review your appeal

- This is the last step of the appeals process

Levels of Appeal 3, 4, and 5 for Part D Drug Requests

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

If the value of the Part D drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

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

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

- If the answer is **yes**, the appeals process is over. What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the administrative law judge or attorney adjudicator within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision
- If the answer is **no**, the appeals process may or may not be over
 - ◆ If you decide to accept this decision that turns down your appeal, the appeals process is over
 - ◆ If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge or attorney adjudicator says **no** to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal

Level 4 Appeal: The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the federal government

- If the answer is **yes**, the appeals process is over. What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the Council within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision
- If the answer is **no**, the appeals process may or may not be over
 - ◆ if you decide to accept this decision that turns down your appeal, the appeals process is over
 - ◆ if you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says **no** to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what to do next if you choose to continue with your appeal

Level 5 Appeal: A judge at the Federal District Court will review your appeal

- This is the last step of the appeals process

How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns

If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to “A Guide to the Basics of Coverage Decisions and Appeals” in this “Coverage Decisions, Appeals, and Complaints” section.

What kinds of problems are handled by the complaint process?

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

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

If you have any of these kinds of problems, you can “make a complaint”

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

Information you get from our plan

- ◆ do you believe we have not given you a notice that we are required to give?
- ◆ do you think written information we have given you is hard to understand?

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

The process of asking for a coverage decision and making appeals is explained in this “Coverage Decisions, Appeals, and Complaints” section. If you are asking for a coverage decision or making an appeal, you use that process, not the complaint process.

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

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

Step-by-step: Making a complaint

- What this section calls a “complaint” is also called a “grievance”
- Another term for “making a complaint” is “filing a grievance”
- Another way to say “using the process for complaints” is “using the process for filing a grievance”

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

- Usually calling our Member Service Contact Center is the first step. If there is anything else you need to do, our Member Service Contact Center will let you know. Please call us at **1-800-443-0815** (TTY users call **711**), 8 a.m. to 8 p.m., seven days a week

- If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you put your complaint in writing, we will respond to you in writing. We will also respond in writing when you make a complaint by phone if you request a written response or your complaint is related to quality of care
- If you have a complaint, we will try to resolve your complaint over the phone. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. Your grievance must explain your concern, such as why you are dissatisfied with the services you received. Please see the “Important Phone Numbers and Resources” section for whom you should contact if you have a complaint
 - ◆ you must submit your grievance to us (orally or in writing) within 60 calendar days of the event or incident. We must address your grievance as quickly as your health requires, but no later than 30 calendar days after receiving your complaint. We may extend the time frame to make our decision by up to 14 calendar days if you ask for an extension, or if we justify a need for additional information and the delay is in your best interest
 - ◆ you can file a fast grievance about our decision not to expedite a coverage decision or appeal, or if we extend the time we need to make a decision about a coverage decision or appeal. We must respond to your fast grievance within 24 hours
- Whether you call or write, you should contact our Member Service Contact Center right away. The complaint must be made within 60 calendar days after you had the problem you want to complain about
- If you are making a complaint because we denied your request for a “fast coverage decision” or a “fast appeal,” we will automatically give you a “fast complaint.” If you have a “fast complaint,” it means we will give you an answer within 24 hours. What this section calls a “fast complaint” is also called an “expedited grievance”

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

- If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that
- Most complaints are answered within 30 calendar days. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days

total) to answer your complaint. If we decide to take extra days, we will tell you in writing

- If we do not agree with some or all of your complaint or don’t take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not

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

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

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

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

You can also tell Medicare about your complaint

- You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to <https://www.medicare.gov/MedicareComplaintForm/home.aspx>. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.
- If you have any other feedback or concerns, or if you feel our plan is not addressing your issue, please call **1-800-MEDICARE (1-800-633-4227)**. TTY/TDD users should call **1-877-486-2048**.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review:

- If your Group's benefit plan is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (1-866-444-3272)
- If your Group's benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Binding Arbitration

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

Scope of arbitration

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

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *EOC* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc. ("Health Plan"), including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of the legal theories upon which the claim is asserted
- The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
- Governing law does not prevent the use of binding arbitration to resolve the claim

Members enrolled under this *EOC* thus give up their right to a court or jury trial, and instead accept the use of

binding arbitration except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeal procedure as applicable to Kaiser Permanente Senior Advantage Members
- Claims that cannot be subject to binding arbitration under governing law

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

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

"Kaiser Permanente Parties" include:

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

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

Rules of Procedure

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

Initiating arbitration

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

Serving Demand for Arbitration

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

Kaiser Foundation Health Plan, Inc.
Legal Department
1950 Franklin St., 17th Floor
Oakland, CA 94612

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

Filing fee

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

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

Number of arbitrators

The number of arbitrators may affect the Claimants’ responsibility for paying the neutral arbitrator’s fees and expenses (see the Rules of Procedure).

If the Demand for Arbitration seeks total damages of \$200,000 or less, the dispute shall be heard and

determined by one neutral arbitrator, unless the parties otherwise agree in writing after a dispute has arisen and a request for binding arbitration has been submitted that the arbitration shall be heard by two party arbitrators and one neutral arbitrator. The neutral arbitrator shall not have authority to award monetary damages that are greater than \$200,000.

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

Payment of arbitrators’ fees and expenses

Health Plan will pay the fees and expenses of the neutral arbitrator under certain conditions as set forth in the Rules of Procedure. In all other arbitrations, the fees and expenses of the neutral arbitrator shall be paid one-half by the Claimants and one-half by the Respondents.

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

Costs

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

General provisions

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

given due notice thereof, the neutral arbitrator may proceed to determine the controversy in the party's absence.

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

Arbitrations shall be governed by this "Binding Arbitration" section, Section 2 of the Federal Arbitration Act, and the California Code of Civil Procedure provisions relating to arbitration that are in effect at the time the statute is applied, together with the Rules of Procedure, to the extent not inconsistent with this "Binding Arbitration" section. In accord with the rule that applies under Sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this "Binding Arbitration" section shall not be denied, stayed, or otherwise impeded because a dispute between a Member Party and a Kaiser Permanente Party involves both arbitrable and nonarbitrable claims or because one or more parties to the arbitration is also a party to a pending court action with a third party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Termination of Membership

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2022, your last minute of coverage was at 11:59 p.m. on December 31, 2021). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *EOC* after your membership terminates, except:

- As provided under "Payments after Termination" in this "Termination of Membership" section
- If you are receiving covered Services as an acute care hospital inpatient on the termination date, we will continue to cover those hospital Services (but not physician Services or any other Services) until you are discharged

Until your membership terminates, you remain a Senior Advantage Member and must continue to receive your medical care from us, except as described in the "Emergency Services and Urgent Care" section about Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care and the "Benefits and Your Cost Share" section about out-of-area dialysis care.

Note: If you enroll in another Medicare Health Plan or a prescription drug plan, your Senior Advantage membership will terminate as described under "Disenrolling from Senior Advantage" in this "Termination of Membership" section.

Termination Due to Loss of Eligibility

If you meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership will end at 11:59 p.m. on the last day of that month. For example, if you become ineligible on December 5, 2021, your termination date is January 1, 2022, and your last minute of coverage is at 11:59 p.m. on December 31, 2021.

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

- Are temporarily absent from our Service Area for more than six months in a row
- Permanently move from our Service Area
- No longer have Medicare Part B
- Enroll in another Medicare Health Plan (for example, a Medicare Advantage Plan or a Medicare prescription drug plan). The Centers for Medicare & Medicaid Services will automatically terminate your Senior Advantage membership when your enrollment in the other plan becomes effective
- Are not a U.S. citizen or lawfully present in the United States. The Centers for Medicare & Medicaid Services will notify us if you are not eligible to remain a Member on this basis. We must disenroll you if you do not meet this requirement
- In addition, if you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our Senior Advantage Plan and you will lose prescription drug coverage.

Note: If you lose eligibility for Senior Advantage due to any of these circumstances, you may be eligible to transfer your membership to another Kaiser Permanente

plan offered by your Group. Please contact your Group for information.

Termination of Agreement

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

Disenrolling from Senior Advantage

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

If you request disenrollment during your Group's open enrollment, your disenrollment effective date is determined by the date your written request is received by us and the date your Group coverage ends. The effective date will not be earlier than the first day of the following month after we receive your written request, and no later than three months after we receive your request.

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

You may request disenrollment by calling toll free 1-800-MEDICARE/1-800-633-4227 (TTY users call 1-877-486-2048), 24 hours a day, seven days a week, or sending written notice to the following address:

Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 232400
San Diego, CA 92193-2400

Other Medicare Health Plans. If you want to enroll in another Medicare Health Plan or a Medicare prescription drug plan, you should first confirm with the other plan and your Group that you are able to enroll. Your new plan or your Group will tell you the date when your membership in the new plan begins and your Senior Advantage membership will end on that same day (your disenrollment date).

The Centers for Medicare & Medicaid Services will let us know if you enroll in another Medicare Health Plan, so you will not need to send us a disenrollment request.

Original Medicare. If you request disenrollment from Senior Advantage and you do not enroll in another Medicare Health Plan, you will automatically be enrolled in Original Medicare when your Senior Advantage membership terminates (your disenrollment date). On your disenrollment date, you can start using your red, white, and blue Medicare card to get services under Original Medicare. You will not get anything in writing that tells you that you have Original Medicare after you disenroll. If you choose Original Medicare and you want to continue to get Medicare Part D prescription drug coverage, you will need to enroll in a prescription drug plan.

If you receive Extra Help from Medicare to pay for your prescription drugs, and you switch to Original Medicare and do not enroll in a separate Medicare Part D prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may need to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, as least as much as Medicare's standard prescription drug coverage.) See "Medicare Premiums" in the "Premiums, Eligibility, and Enrollment" section for more information about the late enrollment penalty.

Termination of Contract with the Centers for Medicare & Medicaid Services

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

Termination for Cause

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

- If you continuously behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for our other members. We cannot make

you leave our Senior Advantage Plan for this reason unless we get permission from Medicare first

- If you let someone else use your Plan membership card to get medical care. We cannot make you leave our Senior Advantage Plan for this reason unless we get permission from Medicare first. If you are disenrolled for this reason, the Centers for Medicare & Medicaid Services may refer your case to the Inspector General for additional investigation
- You commit theft from Health Plan, from a Plan Provider, or at a Plan Facility
- You intentionally misrepresent membership status or commit fraud in connection with your obtaining membership. We cannot make you leave our Senior Advantage Plan for this reason unless we get permission from Medicare first
- If you become incarcerated (go to prison)
- You knowingly falsify or withhold information about other parties that provide reimbursement for your prescription drug coverage

If we terminate your membership for cause, you will not be allowed to enroll in Health Plan in the future until you have completed a Member Orientation and have signed a statement promising future compliance. We may report fraud and other illegal acts to the authorities for prosecution.

Termination for Nonpayment of Premiums

If your Group fails to pay us Premiums for your Family, we may terminate the memberships of everyone in your Family.

Termination of a Product or all Products

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

Payments after Termination

If we terminate your membership for cause or for nonpayment, we will:

- Refund any amounts we owe your Group for Premiums paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Requests for Payment" section. We will deduct any amounts you owe Health Plan or Plan Providers from any payment we make to you

Review of Membership Termination

If you believe that we terminated your Senior Advantage membership because of your ill health or your need for care, you may file a complaint as described in the "Coverage Decisions, Appeals, and Complaints" section.

Continuation of Membership

If your membership under this Senior Advantage *EOC* ends, you may be eligible to continue Health Plan membership without a break in coverage. You may be able to continue Group coverage under this Senior Advantage *EOC* as described under "Continuation of Group Coverage." Also, you may be able to continue membership under an individual plan as described under "Conversion from Group Membership to an Individual Plan." If at any time you become entitled to continuation of Group coverage, please examine your coverage options carefully before declining this coverage. Individual plan premiums and coverage will be different from the premiums and coverage under your Group plan.

Continuation of Group Coverage

COBRA

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

If your Group is subject to COBRA and you are eligible for COBRA coverage, in order to enroll, you must submit a COBRA election form to your Group within the COBRA election period. Please ask your Group for details about COBRA coverage, such as how to elect coverage, how much you must pay for coverage, when

coverage and Premiums may change, and where to send your Premium payments.

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

Coverage for a disabling condition

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

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

Your coverage will be subject to the terms of this *EOC*, including Cost Share, but we will not cover Services for any condition other than your totally disabling condition.

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

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

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

Conversion from Group Membership to an Individual Plan

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

Kaiser Permanente Conversion Plan

If you want to remain a Health Plan Member, one option that may be available is our Senior Advantage Individual Plan. You may be eligible to enroll in our individual plan if you no longer meet the eligibility requirements described under “Who Is Eligible” in the “Premiums, Eligibility, and Enrollment” section. Individual plan coverage begins when your Group coverage ends. The premiums and coverage under our individual plan are different from those under this *EOC* and will include Medicare Part D prescription drug coverage.

However, if you are no longer eligible for Senior Advantage and Group coverage, you may be eligible to convert to our non-Medicare individual plan, called “Kaiser Permanente Individual–Conversion Plan.” You may be eligible to enroll in our Individual–Conversion Plan if we receive your enrollment application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later).

You may not be eligible to convert if your membership ends for the reasons stated under “Termination for Cause” or “Termination of *Agreement*” in the “Termination of Membership” section.

Miscellaneous Provisions

Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of your Group’s *Agreement*, including this *EOC*.

Amendment of Agreement

Your Group’s *Agreement* with us will change periodically. If these changes affect this *EOC*, your Group is required to inform you in accord with applicable law and your Group’s *Agreement*.

Applications and Statements

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

Assignment

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

Attorney and Advocate Fees and Expenses

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

Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this *EOC* and we have the discretionary authority to review and evaluate claims that arise under this *EOC*. We conduct this evaluation independently by interpreting the provisions of this *EOC*. We may use medical experts to help us review claims. If coverage under this *EOC* is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), then we are a "named claims fiduciary" to review claims under this *EOC*.

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*.

ERISA Notices

This "ERISA Notices" section applies only if your Group's health benefit plan is subject to the Employee Retirement Income Security Act (ERISA). We provide these notices to assist ERISA-covered groups in complying with ERISA. Coverage for Services described in these notices is subject to all provisions of this *EOC*.

Newborns' and Mother's Health Protection Act

Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act

If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same Cost Share applicable to other medical and surgical benefits provided under this plan.

Governing Law

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

Group and Members not our Agents

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

No Waiver

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

Notices Regarding Your Coverage

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call our Member Service Contact Center and Social Security toll free at **1-800-772-1213** (TTY users call **1-800-325-0778**) as soon as possible to give us their new address. If a Member does not reside with the Subscriber, or needs to have confidential information sent to an address other than the Subscriber's address, they should contact our Member Service Contact Center to discuss alternate delivery options.

Note: When we tell your Group about changes to this EOC or provide your Group other information that affects you, your Group is required to notify the Subscriber within 30 days after receiving the information from us.

Notice about Medicare Secondary Payer Subrogation Rights

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

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.

Public Policy Participation

The Kaiser Foundation Health Plan, Inc., Board of Directors establishes public policy for Health Plan. A list of the Board of Directors is available on our website at **kp.org** or from our Member Service Contact Center. If you would like to provide input about Health Plan

public policy for consideration by the Board, please send written comments to:

Kaiser Foundation Health Plan, Inc.
Office of Board and Corporate Governance
Services
One Kaiser Plaza, 19th Floor
Oakland, CA 94612

Telephone Access (TTY)

If you use a text telephone device (TTY, also known as TDD) to communicate by phone, you can use the California Relay Service by calling 711.

Important Phone Numbers and Resources

Kaiser Permanente Senior Advantage

How to contact our plan's Member Services

For assistance, please call or write to our plan's Member Services. We will be happy to help you.

Member Services – contact information

Call 1-800-443-0815

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

Member Services also has free language interpreter services available for non-English speakers.

TTY 711

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

Write Your local Member Services office (see the *Provider Directory* for locations).

Website kp.org

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

- A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services
- An appeal is a formal way of asking us to review and change a coverage decision we have made
- You can make a complaint about us or one of our network providers, including a complaint about the

quality of your care. This type of complaint does not involve coverage or payment disputes

For more information about asking for coverage decisions or making appeals or complaints about your medical care, see the “Coverage Decisions, Appeals, and Complaints” section.

Coverage decisions, appeals, or complaints for Services – contact information

Call 1-800-443-0815

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

If your coverage decision, appeal, or complaint **qualifies for a fast decision** as described in the “Coverage Decisions, Appeals, and Complaints” section, call the Expedited Review Unit at **1-888-987-7247**, 8:30 a.m. to 5 p.m., Monday through Saturday.

TTY 711

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

Fax If your coverage decision, appeal, or complaint **qualifies for a fast decision**, fax your request to our Expedited Review Unit at **1-888-987-2252**.

Write For a **standard coverage decision or complaint**, write to your local Member Services office (see the *Provider Directory* for locations).

For a **standard appeal**, write to the address shown on the denial notice we send you.

- If your coverage decision, appeal, or complaint **qualifies for a fast decision**, write to:
Kaiser Foundation Health Plan, Inc.
Expedited Review Unit
P.O. Box 1809
Pleasanton, CA 94566

Medicare Website. You can submit a complaint about our Plan directly to Medicare. To submit an online complaint to Medicare, go to <https://www.medicare.gov/MedicareComplaintForm/home.aspx>.

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

- A coverage decision is a decision we make about your benefits and coverage or about the amount we will

pay for your prescription drugs covered under the Part D benefit included in your plan

For more information about asking for coverage decisions about your Part D prescription drugs, see the “Coverage Decisions, Appeals, and Complaints” section.

Coverage decisions for Part D prescription drugs – contact information

Call 1-877-645-1282

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

TTY 711

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

Fax 1-844-403-1028

- **Write** OptumRx
c/o Prior Authorization
P.O. Box 25183
Santa Ana, CA 92799

Website kp.org

How to contact us when you are making an appeal about your Part D prescription drugs

- An appeal is a formal way of asking us to review and change a coverage decision we have made

For more information about making appeals about your Part D prescription drugs, see the “Coverage Decisions, Appeals, and Complaints” section. You may call us if you have questions about our appeals process.

Appeals for Part D prescription drugs – contact information

Call 1-866-206-2973

Calls to this number are free.

Seven days a week, 8:30 a.m. to 5 p.m.

TTY 711

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

Fax 1-866-206-2974

- **Write** Kaiser Foundation Health Plan, Inc.
CA Medicare PDU/MSU Operations
P.O. Box 1809
Pleasanton, CA 94566

Website kp.org

How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about our plan's coverage or payment, you should look at the section above about requesting coverage decisions or making appeals.) For more information about making a complaint about your Part D prescription drugs, see the "Coverage Decisions, Appeals, and Complaints" section.

Complaints for Part D prescription drugs – contact information

Call 1-800-443-0815

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

If your complaint **qualifies for a fast decision**, call the Part D Unit at **1-866-206-2973**, 8:30 a.m. to 5 p.m., seven days a week. See the "Coverage Decisions, Appeals, and Complaints" section to find out if your issue qualifies for a fast decision.

TTY 711

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

Fax

If your complaint qualifies for a fast review, fax your request to our Part D Unit at **1-866-206-2974**.

Write

For a **standard complaint**, write to your local Member Services office (see the *Provider Directory* for locations).

If your complaint **qualifies for a fast decision**, write to:

Kaiser Foundation Health Plan, Inc.
CA Medicare PDU/MSU Operations
P.O. Box 1809
Pleasanton, CA 94566

Medicare Website. You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to <https://www.medicare.gov/MedicareComplaintForm/home.aspx>.

Where to send a request asking us to pay for our share of the cost for Services or a Part D drug you have received

For more information about situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see the "Requests for Payment" section.

Note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See the "Coverage Decisions, Appeals, and Complaints" section for more information.

Payment Requests – contact information

Call 1-800-443-0815

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

Note: If you are requesting payment of a Part D drug that was prescribed by a Plan Provider and obtained from a Plan Pharmacy, call our Part D unit at **1-866-206-2973**, 8:30 a.m. to 5 p.m., seven days a week.

TTY 711

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

Write

Kaiser Permanente
Claims Administration - NCAL
P.O. Box 12923
Oakland, CA 94604-2923

If you are requesting payment of a Part D drug that was prescribed and provided by a Plan Provider, you can fax your request to **1-866-206-2974** or write us at P.O. Box 23170, Oakland, CA 94623-0170 (Attention: Part D Unit).

Website kp.org

Medicare

How to get help and information directly from the federal Medicare program

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant). The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage organizations, including our plan.

Medicare – contact information

Call 1-800-MEDICARE or 1-800-633-4227

Calls to this number are free. 24 hours a day, seven days a week.

TTY 1-877-486-2048

Calls to this number are free.

Website <https://www.medicare.gov>

This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.

The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:

Medicare Eligibility Tool: Provides Medicare eligibility status information.

Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare Health Plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

You can also use the website to tell Medicare about any complaints you have about our plan.

Tell Medicare about your complaint: You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to

<https://www.medicare.gov/MedicareComplaintForm/home.aspx>. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. You can call Medicare at **1-800-MEDICARE (1-800-633-4227)** (TTY users call **1-877-486-2048**), 24 hours a day, 7 days a week.

State Health Insurance Assistance Program

Free help, information, and answers to your questions about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In California, the State Health Insurance Assistance Program is called the Health Insurance Counseling and Advocacy Program (HICAP).

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

The Health Insurance Counseling and Advocacy Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your Services or treatment, and help you straighten out problems with your Medicare bills. The Health Insurance Counseling and Advocacy Program counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Health Insurance Counseling and Advocacy Program (California's State Health Insurance Assistance Program) – contact information

Call 1-800-434-0222

Calls to this number are free.

TTY 711

Write Your HICAP office for your county.

Website www.aging.ca.gov/HICAP/

Quality Improvement Organization

Paid by Medicare to check on the quality of care for people with Medicare

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For California, the Quality Improvement Organization is called Livanta.

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

You should contact Livanta in any of these situations:

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

Livanta (California's Quality Improvement Organization) – contact information

- **Call 1-877-588-1123**

Calls to this number are free. Monday through Friday, 9 a.m. to 5 p.m. and weekends 11 a.m. to 3 p.m.

- **TTY 1-855-887-6668**

Write Livanta
BFCC – QIO Program
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701–1105

- **Website www.livantaqio.com/en**

Social Security

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

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

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

Social Security – contact information

Call 1-800-772-1213

Calls to this number are free. Available 7 a.m. to 7 p.m., Monday through Friday.

You can use Social Security's automated telephone services and get recorded information 24 hours a day.

TTY 1-800-325-0778

Calls to this number are free. Available 7 a.m. to 7 p.m., Monday through Friday.

Website <https://www.ssa.gov>

Medicaid

A joint federal and state program that helps with medical costs for some people with limited income and resources

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

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

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

To find out more about Medicaid and its programs, contact Medi-Cal.

Medi-Cal (California's Medicaid program) – contact information

Call 1-800-541-5555

Calls to this number are free. Monday through Friday, 8 a.m. to 8 p.m.

TTY 711

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

administrator can help you determine how your current prescription drug coverage will work with our plan.

Write California Department of Health Care Services
P.O. Box 997417, MS 4607
Sacramento, CA 95899-7417

Website <http://www.cdss.ca.gov>

Railroad Retirement Board

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

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

Railroad Retirement Board – contact information

Call 1-877-772-5772

Calls to this number are free. If you press “0,” you may speak with an RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9 a.m. to 12 p.m. on Wednesday.

If you press “1,” you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.

TTY 1-312-751-4701

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.

Website rrb.gov/

Group Insurance or Other Health Insurance from an Employer

If you have any questions about your employer-sponsored Group plan, please contact your Group's benefits administrator. You can ask about your employer or retiree health benefits, any contributions toward the Group's premium, eligibility, and enrollment periods.

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact that group's benefits administrator. The benefits

Notice of Nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate

on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
 - ◆ Qualified sign language interpreters.
 - ◆ Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
 - ◆ Qualified interpreters.
 - ◆ Information written in other languages.

If you need these services, call Member Services at **1-800-443-0815 (TTY 711)**, 8 a.m. to 8 p.m., seven days a week.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at **<https://ocrportal.hhs.gov/ocr/portal/lobby.jsf>**, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **<http://www.hhs.gov/ocr/office/file/index.html>**.

Multi-language Interpreter Services

English

ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-800-443-0815** (TTY: **711**).

Spanish

ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüística. Llame al **1-800-443-0815** (TTY: **711**).

Chinese

注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-443-0815** (TTY: **711**)。

Vietnamese

CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phí dành cho bạn. Gọi số **1-800-443-0815** (TTY: **711**).

Tagalog

PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-443-0815** (TTY: **711**).

Korean

주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-443-0815 (TTY: **711**)번으로 전화해 주십시오.

Armenian

ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-800-443-0815** (TTY (հեռատիպ) **711**):

Russian

ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-443-0815** (телетайп: **711**).

Japanese

注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-443-0815** (TTY:**711**) まで、お電話にてご連絡ください。

Punjabi

ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।
1-800-443-0815 (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

Cambodian

ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតថ្លៃ គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-800-443-0815 (TTY: 711)**។

Hmong

LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj. Hu rau **1-800-443-0815 (TTY: 711)**.

Hindi

ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं। **1-800-443-0815 (TTY: 711)** पर कॉल करें।

Thai

เรียน: ถ้าคุณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-443-0815 (TTY: 711)**.

Farsi

توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می باشد. با **1-800-443-0815 (TTY: 711)** تماس بگیرید.

Arabic

ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم - **5180-344-008-1 (رقم هاتف الصم والبكم: 117)**.

Member Service Contact Center: toll free 1-800-443-0815 (TTY users call 711) seven days a week, 8 a.m.–8 p.m.