Evidence of Coverage

Effective January 1, 2026

Kaiser Permanente Senior Advantage

Health Maintenance Organization (HMO)

Evidence of Coverage for the
Medicare Managed Health Care Plan

KAISER PERMANENTE®

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

CalPERS

January 1 – December 31, 2026

Evidence of Coverage for 2026

Your Medicare Health Benefits and Services and Drug Coverage as a Member of Kaiser Permanente Senior Advantage (HMO)

This document gives the details of your Medicare health and drug coverage from January 1 - December 31, 2026. **This is an important legal document. Keep it in a safe place.**

This document explains your benefits and rights. Use this document to understand:

- Our cost sharing;
- Our medical and drug benefits;
- How to file a complaint if you're not satisfied with a service or treatment;
- How to contact us
- Other protections required by Medicare law.

For questions about this document, call Member Services at 1-800-443-0815. (TTY users call 711.) Hours are 8 a.m. to 8 p.m., 7 days a week. This call is free.

This plan, Kaiser Permanente Senior Advantage (HMO), is offered by Kaiser Foundation Health Plan, Inc., Northern and Southern California Regions (Health Plan). When this *Evidence of Coverage* says "we," "us," or "our," it means Health Plan. When it says "plan" or "our plan," it means Kaiser Permanente Senior Advantage (Senior Advantage).

CA26_CALPERS_KPSAEOC
OMB Approval 0938-1051 (Expires: August 31, 2026)

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This document is available for free in Spanish. Call Member Services **1-800-443-0815**. (TTY users call **711**.) Hours are 8 a.m. to 8 p.m., 7 days a week.

Este documento está disponible de manera gratuita en español. Para obtener información adicional, comuníquese con Servicio a los Miembros al **1-800-443-0815** (Los usuarios de la línea TTY deben llamar al **711**). El horario es de 8 a. m. a 8 p. m., los 7 días de la semana.

This document is available in braille, large print, audio file, or data CD if you need it by calling Member Services.

Benefits, and/or copayments/coinsurance may change on January 1, 2027. Our formulary, pharmacy network, and/or provider network may change at any time. You'll get notice about any changes that may affect you at least 30 days in advance.

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Chapter 1 — Get started as a member

Section 1 — You're a member of Kaiser Permanente Senior Advantage

Section 1.1 – You're enrolled in Kaiser Permanente Senior Advantage, which is a Medicare HMO

You're covered by Medicare, and you chose to get your Medicare health and your drug coverage through our plan, Kaiser Permanente Senior Advantage. Our plan covers all Part A and Part B services. However, cost sharing and provider access in this plan are different from Original Medicare.

Kaiser Permanente Senior Advantage is a Medicare Advantage HMO Plan (HMO stands for Health Maintenance Organization) approved by Medicare and run by a private company.

Section 1.2 – Legal information about the Evidence of Coverage

This *Evidence of Coverage* is part of our contract with you about how Senior Advantage covers your care. Other parts of this contract include your enrollment form, the *List of Covered Drugs* (formulary), and any notices you get from us about changes to your coverage or conditions that affect your coverage. These notices are sometimes called *riders* or *amendments*.

The contract is in effect for the months you're enrolled in Senior Advantage between January 1, 2026, and December 31, 2026, unless amended.

Medicare allows us to make changes to our plans we offer each calendar year. This means we can change the costs and benefits of our plan after December 31, 2026. We can also choose to stop offering the plan in your service area, after December 31, 2026.

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

Section 2 — Plan eligibility requirements

Section 2.1 – Eligibility requirements

You're eligible for membership in our plan as long as you meet all these conditions:

- You have both Medicare Part A and Medicare Part B (or Part B only).
- You live in our geographic service area (described in Section 2.2). If you've been a member of our plan continuously since before January 1999 and you were living outside our service area before January 1999, you're still eligible for our plan as long as you haven't moved since before January 1999. People who are incarcerated aren't considered to be living in the geographic service area, even if they're physically located in it.

- You're a United States citizen or lawfully present in the United States.
- You're not enrolled in another Medicare Health Plan or Medicare prescription drug plan.
- You meet your group's eligibility requirements as described in Section 2.5.

If you're already a health plan member who lives in the Senior Advantage service area, we'll mail you information on how to join Senior Advantage and a Senior Advantage Election Form shortly before you reach age 65.

Section 2.2 – Plan service area for Senior Advantage

When you join Kaiser Permanente, you're enrolling in one of two health plan regions in California (either our Northern California region or Southern California region), which we call your "Home Region." The coverage information in this *Evidence of Coverage* applies when you obtain care in your Home Region. When you visit the other California region, you may receive care as described in Chapter 3, Section 2.4.

You must live in your Home Region service area, unless you have been continuously enrolled in Senior Advantage since December 31, 1998, and lived outside your Home Region service area during that entire time. In which case, you may continue your membership unless you move and are still outside your Home Region service area.

Moving from your Home Region service area to our other California region service area

You must complete a new Senior Advantage enrollment request to continue Senior Advantage coverage if you move from your Home Region service area to the service area of our other California Region.

Although Medicare is a federal program, our plan is only available to people who live in our plan service area. To stay a member of our plan, you must continue to live in our service area. The service areas are described below.

Northern California region service area

Our Northern California service area includes all of **Alameda, Contra Costa, Marin, Napa, Sacramento, San Francisco, San Joaquin, San Mateo, Santa Cruz, Solano, and Stanislaus counties**, and parts of these counties, in the **following ZIP codes only**:

- **Amador County**: 95640 and 95669.
- **El Dorado County**: 95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, and 95762.
- **Fresno County**: 93242, 93602, 93606-07, 93609, 93611-13, 93616, 93618-19, 93624-27, 93630-31, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93667-68, 93675, 93701-12, 93714-18, 93720-30, 93737, 93740-41, 93744-45, 93747, 93750, 93755, 93760-61, 93764-65, 93771-79, 93786, 93790-94, 93844, and 93888.
- **Kings County**: 93230, 93232, 93242, 93631, and 93656.
- **Madera County**: 93601-02, 93604, 93614, 93623, 93626, 93636-39, 93643-45, 93653, 93669, and 93720.

- **Mariposa County**: 93601, 93623, and 93653.
- **Placer County**: 95602-04, 95610, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677-78, 95681, 95703, 95722, 95736, 95746-47, and 95765.
- **Santa Clara County**: 94022-24, 94035, 94039-43, 94085-89, 94301-06, 94309, 94550, 95002, 95008-09, 95011, 95013-15, 95020-21, 95026, 95030-33, 95035-38, 95042, 95044, 95046, 95050-56, 95070-71, 95076, 95101, 95103, 95106, 95108-13, 95115-36, 95138-41, 95148, 95150-61, 95164, 95170, 95172-73, 95190-94, and 95196.
- **Sonoma County**: 94515, 94922-23, 94926-28, 94931, 94951-55, 94972, 94975, 94999, 95401-07, 95409, 95416, 95419, 95421, 95425, 95430-31, 95433, 95436, 95439, 95441-42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471-73, 95476, 95486-87, and 95492.
- **Sutter County**: 95626, 95645, 95659, 95668, 95674, 95676, 95692, and 95836-37.
- **Tulare County**: 93238, 93261, 93618, 93631, 93646, 93654, 93666, and 93673.
- **Yolo County**: 95605, 95607, 95612, 95615-18, 95620, 95645, 95691, 95694-95, 95697-98, 95776, and 95798-99.
- **Yuba County**: 95692, 95903, and 95961.

Southern California Region service area

Our Southern California service area includes **all of Orange County and Los Angeles County (except Catalina Island)**, and parts of these counties, in the **following ZIP codes only**:

- **Kern County**: 93203, 93205-06, 93215-16, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93249-52, 93263, 93268, 93276, 93280, 93285, 93287, 93301-09, 93311-14, 93380, 93383-90, 93501-02, 93504-05, 93518-19, 93531, 93536, 93560-61, and 93581.
- **Riverside County**: 91752, 92201-03, 92210-11, 92220, 92223, 92230, 92234-36, 92240-41, 92247-48, 92253, 92255, 92258, 92260-64, 92270, 92276, 92282, 92320, 92324, 92373, 92399, 92501-09, 92513-14, 92516-19, 92521-22, 92530-32, 92543-46, 92548, 92551-57, 92562-64, 92567, 92570-72, 92581-87, 92589-93, 92595-96, 92599, 92860, and 92877-83.
- **San Bernardino County**: 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758-59, 91761-64, 91766, 91784-86, 92305, 92307-08, 92313-18, 92321-22, 92324-25, 92329, 92331, 92333-37, 92339-41, 92344-46, 92350, 92352, 92354, 92357-59, 92369, 92371-78, 92382, 92385-86, 92391-95, 92397, 92399, 92401-08, 92410-11, 92413, 92415, 92418, 92423, 92427, and 92880.
- **San Diego County**: 91901-03, 91908-17, 91921, 91931-33, 91935, 91941-46, 91950-51, 91962-63, 91976-80, 91987, 92003, 92007-11, 92013-14, 92018-30, 92033, 92037-40, 92046, 92049, 92051-52, 92054-61, 92064-65, 92067-69, 92071-72, 92074-75, 92078-79, 92081-86, 92088, 92091-93, 92096, 92101-24, 92126-32, 92134-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-61, 92163, 92165-79, 92182, 92186-87, 92191-93, and 92195-99.
- **Ventura County**: 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93001-07, 93009-12, 93015-16, 93020-22, 93030-36, 93040-44, 93060-66, 93094, 93099, and 93252.

For each ZIP code listed for a county, your Home Region service area includes only the part of that ZIP code that is in that county. When a ZIP code spans more than one county, the part of that ZIP code that is in another county is not inside your Home Region service area unless that other county is listed above and that ZIP code is also listed for that other county. If you have a question about whether a ZIP code is in your Home Region service area, call Member Services. Also, the ZIP codes listed above may include ZIP codes for Post Office boxes and commercial rental mailboxes. A Post Office box or rental mailbox cannot be used to determine whether you meet the residence eligibility requirements for Senior Advantage. Your permanent residence address must be used to determine your Senior Advantage eligibility.

Moving outside our Northern and Southern California Regions' service areas

If you permanently move outside our Northern and Southern California regions' service areas, or you're temporarily absent from your Home Region service area for a period of more than six months in a row, you must notify us and you cannot continue your Senior Advantage membership under this *Evidence of Coverage*.

Send your notice to:

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

If you are not eligible to continue enrollment because you move to the service area of another region, contact your Health Benefits Officer (or, if you are retired, the CalPERS Health Account Management Division) to learn about your Group health care options. You may be able to enroll in the service area of another region if there is an agreement between CalPERS and that region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *Evidence of Coverage*.

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

If you move or change your mailing address, it's also important to call Social Security. Call Social Security at **1-800-772-1213** (TTY users call **1-800-325-0778**).

Section 2.3 – U.S. citizen or lawful presence

You must be a U.S. citizen or lawfully present in the United States to be a member of a Medicare health plan. Medicare (the Centers for Medicare & Medicaid Services) will notify us if you're not eligible to stay a member of our plan on this basis. We must disenroll you if you don't meet this requirement.

Section 2.4 – Group eligibility requirements

Information pertaining to eligibility, enrollment, termination of coverage, and conversion rights can be obtained through the CalPERS website at **www.calpers.ca.gov**, or by calling CalPERS. Refer to the CalPERS Health Program Guide for additional information about eligibility. Your coverage begins on the date established by CalPERS.

It is your responsibility to stay informed about your coverage. For an explanation of specific enrollment and eligibility criteria, consult your Health Benefits Officer or, if you are retired, the CalPERS Health Account Management Division at:

CalPERS
Health Account Management Division
P.O. Box 942715
Sacramento, CA 94229-2715
Or call: **888 CalPERS** (or **888-225-7377**) (**916**) **795-3240** (TDD)

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

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

Note: If you're a subscriber under this *Evidence of Coverage* and you have dependents who don't have Medicare Part B coverage, or for some other reason aren't eligible to enroll under this *Evidence of Coverage*, you may be able to enroll them as your dependents under your group's non-Medicare plan if that is permitted by your group (ask your group for details).

Section 2.5 – When you can enroll and when coverage begins

Your Group is required to inform you when you're eligible to enroll. After we receive your completed Senior Advantage enrollment request, we'll submit it to the Centers for Medicare & Medicaid Services for confirmation and send you a notice indicating the proposed effective date of your Senior Advantage coverage under this *Evidence of Coverage*.

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

Section 3 — Important membership materials

Section 3.1 – Our plan membership card

Use your membership card whenever you get services covered by our plan and for prescription drugs you get at network pharmacies. You should also show the provider your Medicaid card, if you have one. Sample plan membership card:

Northern California members:

Southern California members:

DON'T use your red, white, and blue Medicare card for covered medical services while you're a member of this plan. If you use your Medicare card instead of your Senior Advantage membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need hospital services, hospice services, or participate in Medicare-approved clinical research studies (also called clinical trials).

If our plan membership card is damaged, lost, or stolen, call Member Services at **1-800-443-0815** (TTY users call **711**) right away and we'll send you a new card.

Section 3.2 – Provider Directory

The *Provider Directory* (**kp.org/directory**) lists our current network providers and durable medical equipment suppliers. **Network providers** are the doctors and other health care professionals, medical groups, durable medical equipment suppliers, hospitals, and other health

care facilities that have an agreement with us to accept our payment and any plan cost sharing as payment in full.

You must use network providers to get your medical care and services. If you go elsewhere without proper authorization, you'll have to pay in full. The only exceptions are emergencies, urgently needed services when the network isn't available (that is, situations when it's unreasonable or not possible to get services in network), out-of-area dialysis services, and cases when our plan authorizes use of out-of-network providers.

Get the most recent list of providers and suppliers on our website at **kp.org/directory**.

If you don't have a *Provider Directory*, you can ask for a copy (electronically or in paper form) from Member Services at **1-800-443-0815** (TTY users call **711**). Requested paper provider directories will be mailed to you within 3 business days.

Section 3.3 – Pharmacy Directory

The *Pharmacy Directory* (**kp.org/directory**) lists our network pharmacies. **Network pharmacies** are pharmacies that agree to fill covered prescriptions for our plan members. Use the *Pharmacy Directory* to find the network pharmacy you want to use. Go to Chapter 5, Section 2.5, for information on when you can use pharmacies that aren't in our plan's network.

If you don't have a *Pharmacy Directory*, you can ask for a copy from Member Services at **1-800-443-0815** (TTY users call **711**). You can also find this information on our website at **kp.org/directory**.

Section 3.4 – Drug List (formulary)

Our plan has a *List of Covered Drugs* (also called the Drug List or formulary). It tells which prescription drugs are covered under the Part D benefit included in our plan. The drugs on this list are selected by our plan, with the help of doctors and pharmacists. The Drug List must meet Medicare's requirements. Drugs with negotiated prices under the Medicare Drug Price Negotiation Program will be included on your Drug List unless they have been removed and replaced as described in Chapter 5, Section 6. Medicare approved our plan's Drug List.

The Drug List also tells if there are any rules that restrict coverage for a drug.

We'll give you a copy of the Drug List. To get the most complete and current information about which drugs are covered, visit **kp.org/seniorrx** or call Member Services at **1-800-443-0815** (TTY users call **711**).

Section 4 — Your monthly costs for Senior Advantage

Your costs may include the following:

- Plan Premium (Section 4.1).
- Monthly Medicare Part B Premium (Section 4.2).
- Part D Late Enrollment Penalty (Section 4.3).

- Income Related Monthly Adjusted Amount (Section 4.4).
- Medicare Prescription Payment Plan Amount (Section 4.5)

Section 4.1 – Plan premium

Your group is responsible for paying premiums. If you're responsible for any contribution to the premiums that your group pays, your group will tell you the amount, when premiums are effective, and how to pay your Group.

Medicare Part B and Part D premiums differ for people with different incomes. If you have questions about these premiums, check your copy of *Medicare & You 2026* handbook, the section called *2026 Medicare Costs*. Download a copy from the Medicare website (**www.medicare.gov/medicare-and-you**) or order a printed copy by phone at **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**.

Section 4.2 – Monthly Medicare Part B premium

Many members are required to pay other Medicare premiums

In addition to any amount you must pay your group, **you must continue paying your Medicare premiums to stay a member of our plan.** This includes your premium for Part B. You may also pay a premium for Part A if you're not eligible for premium free Part A.

If you don't have Medicare Part A, you may be eligible to purchase Medicare Part A from Social Security. Contact Social Security for more information. If you get Medicare Part A, this may reduce the amount you would be expected to pay to your Group, check with your Health Benefits Officer (or, if you're retired, the CalPERS Health Account Management Division).

Section 4.3 – Part D Late Enrollment Penalty

Some members are required to pay a Part D **late enrollment penalty**. The Part D late enrollment penalty is an additional premium that must be paid for Part D coverage if at any time after your initial enrollment period is over, there was a period of 63 days or more in a row when you didn't have Part D or other creditable drug coverage. Creditable drug coverage is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard drug coverage. The cost of the late enrollment penalty depends on how long you went without Part D or other creditable drug coverage. You'll have to pay this penalty for as long as you have Part D coverage.

The Part D late enrollment penalty is added to your monthly premium. When you first enroll in our plan, we let you know the amount of the penalty.

You **don't** have to pay the Part D late enrollment penalty if:

- You get Extra Help from Medicare to help pay your drug costs.
- You went less than 63 days in a row without creditable coverage.

- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or in a newsletter from that plan. Keep this information because you may need it if you join a Medicare drug plan later.
  - **Note:** Any letter or notice must state that you had creditable prescription drug coverage that's expected to pay as much as Medicare's standard drug plan pays.
  - **Note:** Prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage.

Medicare determines the amount of the Part D late enrollment penalty. Here's how it works:

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, our plan will count the number of full months you didn't have coverage. The penalty is 1% for every month you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty percentage will be 14%.
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2025, this average premium amount was $36.78. This amount may change for 2026.
- To calculate your monthly penalty, multiply the penalty percentage by the national base beneficiary premium and round it to the nearest 10 cents. In the example here, it would be 14% times $36.78, which equals $5.14. This rounds to $5.10. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty**.

Three important things to know about the monthly Part D late enrollment penalty:

- **The penalty may change each year** because the national base beneficiary premium can change each year.
- **You'll continue to pay a penalty** every month for as long as you're enrolled in a plan that has Medicare Part D drug benefits, even if you change plans.
- If you're under 65 and enrolled in Medicare, the Part D late enrollment penalty will reset when you turn 65. After age 65, your Part D late enrollment penalty will be based only on the months you don't have coverage after your initial enrollment period for aging into Medicare.

If you disagree about your Part D late enrollment penalty, you or your representative can ask for a review. Generally, you must ask for this review **within 60 days** from the date on the first letter you get stating you have to pay a late enrollment penalty. However, if you were paying a penalty before you joined our plan, you may not have another chance to ask for a review of that late enrollment penalty.

Section 4.4 – Income Related Monthly Adjustment Amount

Some members may be required to pay an extra charge, known as the Part D Income Related Monthly Adjustment Amount (IRMAA). The extra charge is calculated using your modified adjusted gross income as reported on your IRS tax return from 2 years ago. If this amount is above a certain amount, you'll pay the standard premium amount and the additional IRMAA. For more information on the extra amount you may have to pay based on your income, visit **www.medicare.gov/health-drug-plans/part-d/basics/costs**.

If you have to pay an extra IRMAA, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay our plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you'll get a bill from Medicare. **You must pay the extra IRMAA to the government. It can't be paid with your monthly plan premium. If you don't pay the extra IRMAA, you'll be disenrolled from our plan and lose prescription drug coverage.**

If you disagree about paying an extra IRMAA, you can ask Social Security to review the decision. To find out how to do this, call Social Security at **1-800-772-1213**
(TTY users call **1-800-325-0778**).

Section 4.5 – Medicare Prescription Payment Plan Amount

If you're participating in the Medicare Prescription Payment Plan, you'll get a bill from your health or drug plan for your prescription drugs (instead of paying the pharmacy). Your monthly bill is based on what you owe for any prescriptions you get, plus your previous month's balance, divided by the number of months left in the year.

Chapter 2, Section 7 tells more about the Medicare Prescription Payment Plan. If you disagree with the amount billed as part of this payment option, you can follow the steps in Chapter 9 to make a complaint or appeal.

Section 5 — Keep your plan membership record up to date

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

The doctors, hospitals, pharmacists, and other providers in our plan's network **use your membership record to know what services and drugs are covered and your cost sharing amounts.** Because of this, it's very important you help to keep your information up to date.

If you have any of these changes, let us know:

- Changes to your name, address, or phone number.
- Changes in any other health coverage you have (such as from your employer, your spouse or domestic partner's employer, workers' compensation, or Medicaid).
- Any liability claims, such as claims from an automobile accident.

- If you're admitted to a nursing home.
- If you get care in an out-of-area or out-of-network hospital or emergency room.
- If your designated responsible party (such as a caregiver) changes.
- If you participate in a clinical research study. (**Note**: You're not required to tell our plan about clinical research studies you intend to participate in, but we encourage you to do so.)

If any of this information changes, let us know by calling Member Services at **1-800-443-0815** (TTY users call **711**).

It's also important to contact Social Security if you move or change your mailing address. Call Social Security at **1-800-772-1213** (TTY users call **1-800-325-0778**).

Section 6 — How other insurance works with our plan

Medicare requires us to collect information about any other medical or drug coverage you have so we can coordinate any other coverage with your benefits under our plan. This is called **Coordination of Benefits**.

Once a year, we'll send you a letter that lists any other medical or drug coverage we know about. Read over this information carefully. If it's correct, you don't need to do anything. If the information isn't correct, or if you have other coverage that's not listed, call Member Services at **1-800-443-0815** (TTY users call **711**). You may need to give your plan member ID number to your other insurers (once you confirm their identity) so your bills are paid correctly and on time.

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

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

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

- If you have Medicare because of ESRD, your group health plan will pay first for the first 30 months after you become eligible for Medicare.

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

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

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

Chapter 2 — Phone numbers and resources

Section 1 — Kaiser Permanente Senior Advantage contacts

For help with claims, billing, or member card questions, call or write to Senior Advantage Member Services at **1-800-443-0815** (TTY users call **711**). We'll be happy to help you.

	Member Services – Contact Information
Call	**1-800-443-0815** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services **1-800-443-0815** (TTY users call **711**) also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
Write	Your local Member Services office (see the *Provider Directory* for locations).
Website	**kp.org**

How to ask for a coverage decision, appeal, or make a complaint about your medical care

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical services. An appeal is a formal way of asking us to review and change a coverage decision.

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 doesn't involve coverage or payment disputes.

For more information on how to ask for a coverage decision, appeal, or make a complaint about your medical care, go to Chapter 9.

	Coverage Decisions, Appeals, or Complaints about medical care – Contact Information
Call	**1-800-443-0815** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. If your coverage decision, appeal, or complaint qualifies for a fast decision as described in Chapter 9, call the Expedited Review Unit at **1-888-987-7247**, 8:30 a.m. to 5 p.m., 7 days a week.
TTY	**711** Calls to this number are free. 7 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 Permanente 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 **www.medicare.gov/MedicareComplaintForm/home.aspx**.

How to ask for a coverage decision about your Part D drugs

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your Part D drugs. For more information on how to ask for coverage decisions about your Part D drugs, go to Chapter 9.

	Coverage Decisions for Part D drugs – Contact Information
Call	*Northern California members*: **1-877-645-1282** *Southern California members*: **1-888-791-7213** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
Fax	**1-844-403-1028**
Write	OptumRx c/o Prior Authorization P.O. Box 2975 Mission, KS 66201
Website	**kp.org**

How to ask for an appeal about your Part D drugs

An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for appeals about your Part D drugs, go to Chapter 9.

	Appeals for Part D drugs – Contact Information
Call	**1-866-206-2973** Calls to this number are free.7 days a week, 8:30 a.m. to 5 p.m.
TTY	**711** Calls to this number are free. 7 days a week, 8:30 a.m. to 5 p.m.
Fax	**1-866-206-2974**
Write	Kaiser Permanente Medicare Part D Unit P.O. Box 1809 Pleasanton, CA 94566
Website	**kp.org**

How to make a complaint about your Part D 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 doesn't involve coverage or payment disputes. For more information on how to make a complaint about your Part D drugs, go to Chapter 9.

	Complaints about Part D drugs – Contact Information
Call	**1-800-443-0815** Calls to this number are free. 7 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.,7 days a week. Go to Chapter 9 to find out if your issue qualifies for a fast decision.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
Fax	If your complaint qualifies for a fast decision, 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 Permanente Medicare Part D Unit P.O. Box 1809 Pleasanton, CA 94566
Medicare Website	To submit a complaint about our plan directly to Medicare, go to **www.medicare.gov/MedicareComplaintForm/home.aspx**.

How to ask us to pay our share of the cost for medical care or a drug you got

If you got a bill or paid for services (like a provider bill) you think we should pay for, you may need to ask us for reimbursement or to pay the provider bill. Go to Chapter 7 for more information.

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to Chapter 9 for more information.

	Payment Requests – Contact Information
Call	**1-800-443-0815** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Note: If you're requesting payment of a Part D drug that was prescribed by a network provider and obtained from a network pharmacy, call our Part D Unit at **1-866-206-2973**. 8:30 a.m. to 5 p.m.,7 days a week.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
Write	For medical care, ***Northern California*** *members* write to: Kaiser Permanente Claims Department P.O. Box 12923 Oakland, CA 94604-2923 For medical care, ***Southern California*** *members* write to: Kaiser Permanente Claims Department P.O. Box 7004 Downey, CA 90242-7004 For Part D drugs, write to: If you're requesting payment of a Part D drug that was prescribed and provided by a network provider, you can fax your request to **1-866-206-2974** or mail it to: Kaiser Permanente Medicare Part D Unit P.O. Box 1809 Pleasanton, CA 94566
Website	**kp.org**

Section 2 — Get help from Medicare

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 (CMS). This agency contracts with Medicare Advantage organizations, including our plan.

METHOD	Medicare – Contact Information
CALL	**1-800-MEDICARE** (**1-800-633-4227**) Calls to this number are free. 24 hours a day, 7 days a week.
TTY	**1-877-486-2048** This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.
CHAT LIVE	Chat live at **www.medicare.gov/talk-to-someone**.
WRITE	Medicare P.O. Box 1270 Lawrence, KS 66044
WEBSITE	**www.Medicare.gov** • Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide. • Find Medicare-participating doctors or other health care providers and suppliers. • Find out what Medicare covers, including preventive services (like • screenings, shots or vaccines, and yearly "Wellness" visits). • Get Medicare appeals information and forms. • Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals. • Look up helpful websites and phone numbers. You can also visit **www.Medicare.gov** to tell Medicare about any complaints you have about our plan: **To submit a complaint to Medicare,** go to **www.Medicare.gov/my/medicare-complaint**. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

Section 3 — State Health Insurance Assistance Program (SHIP)

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state that offers free help, information, and answers to your Medicare questions. In California, the SHIP is called the Health Insurance Counseling and Advocacy Program (HICAP).

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

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

	Health Insurance Counseling and Advocacy Program (California's SHIP) – Contact Information
Call	**1-800-434-0222**
TTY	**711**
Write	Your HICAP office for your county.
Website	**www.aging.ca.gov/HICAP/**

Section 4 — Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For California, the Quality Improvement Organization is called Commence Health.

Commence Health has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. Commence Health is an independent organization. It's not connected with our plan.

Contact Commence Health in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis.
- 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 is ending too soon.

	Commence Health (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. Weekends and holidays, 10 a.m. to 4 p.m.
TTY	**711**
Write	BFCC-QIO Program Commence Health P.O.Box 2687 Virginia Beach, VA 23450
Website	**https://www.livantaqio.cms.gov/en**

Section 5 — Social Security

Social Security determines Medicare eligibility and handles Medicare enrollment. 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, contact Social Security to let them know.

	Social Security – Contact Information
Call	**1-800-772-1213** Calls to this number are free. Available 8 a.m. to 7 p.m., Monday through Friday. Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.
TTY	**1-800-325-0778** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 a.m. to 7 p.m., Monday through Friday.
Website	**www.SSA.gov**

Section 6 — Medicaid

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. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

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

To find out more about Medicaid and Medicare Savings Programs, contact Medi-Cal.

	Medi-Cal (California's Medicaid program) – Contact Information
Call	**1-800-430-4263** Calls to this number are free. Monday through Friday, 8 a.m. to 6 p.m.
TTY	**1-800-430-7077** This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.
Write	CA Department of Health Care Services Health Care Options P.O. Box 989009 West Sacramento, CA 95798-9850
Website	**www.healthcareoptions.dhcs.ca.gov/**

Section 7 — Programs to help people pay for prescription drugs

The Medicare website (**www.Medicare.gov/basics/costs/help/drug-costs**) has information on ways to lower your prescription drug costs. The programs below can help people with limited incomes.

Extra Help from Medicare

Medicare and Social Security have a program called Extra Help that can help pay drug costs for people with limited income and resources. If you qualify, you get help paying for your Medicare drug plan's monthly plan premium, yearly deductible, and copayments. Extra Help also counts toward your out-of-pocket costs.

If you automatically qualify for Extra Help, Medicare will mail you a purple letter to let you know. If you don't automatically qualify, you can apply anytime. To see if you qualify for getting Extra Help:

- Visit **https://secure.ssa.gov/i1020/start** to apply online.
- Call Social Security at **1-800-772-1213**. TTY users call **1-800-325-0778**.

When you apply for Extra Help, you can also start the application process for a Medicare Savings Program (MSP). These state programs provide help with other Medicare costs. Social Security will send information to your state to initiate an MSP application, unless you tell them not to on the Extra Help application.

If you qualify for Extra Help and you think that you're paying an incorrect amount for your prescription at a pharmacy, our plan has a process to help you get evidence of the right copayment amount. If you already have evidence of the right amount, we can help you share this evidence with us.

If you aren't sure what evidence to provide us, contact a network pharmacy or Member Services. The evidence is often a letter from either the state Medicaid or Social Security office that confirms you're qualified for Extra Help. The evidence may also be state-issued documentation with your eligibility information associated with Home and Community-Based Services.

You or your appointed representative may need to provide the evidence to a network pharmacy when obtaining covered Part D prescriptions so that we may charge you the appropriate cost-sharing amount until the Centers for Medicare & Medicaid Services (CMS) updates its records to reflect your current status. Once CMS updates its records, you will no longer need to present the evidence to the pharmacy. Provide your evidence in one of the following ways so we can forward it to CMS for updating:

- Write to Kaiser Permanente at:
  California Service Center
  Attn: Best Available Evidence
  P.O. Box 232400
  San Diego, CA 92193-2400
- Fax it to 1-877-528-8579.
- Take it to a network pharmacy or your local Member Services office at a network facility.

When we get the evidence showing the right copayment level, we'll update our system so you can pay the right amount when you get your next prescription. If you overpay your copayment, we'll pay you back, either by check or a future copayment credit. If the pharmacy didn't collect your copayment and you owe them a debt, we may make the payment directly to the pharmacy.

If a state paid on your behalf, we may make the payment directly to the state. Call Member Services at **1-800-443-0815** (TTY users call **711**) if you have questions.

What if you have Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)?
The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the California AIDS Drug Assistance Program.

Note: To be eligible for the ADAP in your state, people must meet certain criteria, including proof of state residence and HIV status, low income (as defined by the state), and uninsured/under-insured status. If you change plans, notify your local ADAP enrollment worker so you can continue to get help. For information on eligibility criteria, covered drugs, or how to enroll in the program, call the ADAP call center at **1-844-421-7050** between 8 a.m. and 5 p.m. (excluding holidays).

Medicare Prescription Payment Plan

The Medicare Prescription Payment Plan is a payment option that works with your current drug coverage to help you manage your out-of-pocket costs for drugs covered by our plan by spreading them across **the calendar year** (January – December). Anyone with a Medicare drug plan or Medicare health plan with drug coverage (like a Medicare Advantage plan with drug coverage) can use this payment option. **This payment option might help you manage your expenses, but it doesn't save you money or lower your drug costs. If you're participating in the Medicare Prescription Payment Plan and stay in the same Part D plan, your participation will be automatically renewed for 2026.** To learn more about this payment option, call Member Services at **1-800-443-0815** (TTY users call **711**) or visit **www.Medicare.gov**.

	Medicare Prescription Payment Plan – Contact Information
Call	**1-800-443-0815** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
Write	Your local Member Services office (see the *Provider Directory* for locations).
Website	**kp.org**

Section 8 — Railroad Retirement Board (RRB)

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 get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

	Railroad Retirement Board (RRB) – Contact Information
Call	**1-877-772-5772** Calls to this number are free. Press "0," to 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. Press "1," to access the automated RRB HelpLine and get 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 hearing or speaking. Calls to this number aren't free.
Website	**https://RRB.gov/**

Chapter 3 — Using our plan for your medical services

Section 1 — How to get medical care as a member of our plan

This chapter explains what you need to know about using our plan to get your medical care covered.

For details on what medical care our plan covers and how much you pay when you get care, go to the Medical Benefits Chart in Chapter 4.

Section 1.1 – Network providers and covered services

- **Providers** are doctors and other health care professionals licensed by the state to provide medical services and care. The term "providers" also includes hospitals and other health care facilities.
- **Network providers** are the doctors and other health care professionals, medical groups, hospitals, and other health care facilities that have an agreement with us to accept our payment and your cost-sharing amount as payment in full. We arranged for these providers to deliver covered services to members in our plan. The providers in our network bill us directly for care they give you. When you see a network provider, you pay only your share of the cost for their services.
- **Covered services** include all the medical care, health care services, supplies, equipment, and prescription drugs that are covered by our plan. Your covered services for medical care are listed in the Medical Benefits Chart in Chapter 4. Your covered services for prescription drugs are discussed in Chapter 5.

Section 1.2 – Basic rules for your medical care to be covered by our plan

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

Our plan will generally cover your medical care as long as:

- **The care you get is included in our plan's Medical Benefits Chart** (in Chapter 4).
- **The care you get is considered medically necessary.** Medically necessary means that the services, supplies, equipment, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- **You have a network primary care provider (a PCP) providing and overseeing your care.** As a member of our plan, you may choose a network PCP (go to Section 2.1 for more information).
    - In most situations, your network PCP must give you approval in advance (a referral) before you can use other providers in our plan's network, such as specialists, hospitals, skilled nursing facilities, or home health care agencies. For more information go to Section 2.3.

- You don't need referrals from your PCP for emergency care or urgently needed services. To learn about other kinds of care you can get without getting approval in advance from your PCP (go to Section 2.2).

- **You must get your care from a network provider** (go to Section 2). In most cases, care you get from an out-of-network provider (a provider who's not part of our plan's network) won't be covered. This means you have to pay the provider in full for services you get. Here are 4 exceptions:
  - Our plan covers emergency care or urgently needed services you get from an out-of-network provider. For more information, and to see what emergency or urgently needed services are, go to Section 3.
  - If you need medical care that Medicare requires our plan to cover but there are no specialists in our network that provide this care, you can get this care from an out-of-network provider at the same cost-sharing you normally pay in-network if we or our Medical Group authorize the services before you get the care. In this situation, you pay the same as you'd pay if you got the care from a network provider. For information about getting approval to see an out-of-network doctor, go to Section 2.4.
  - Our plan covers kidney dialysis services you get at a Medicare-certified dialysis facility when you're temporarily outside our service area or when your provider for this service is temporarily unavailable or inaccessible. The cost-sharing you pay our plan for dialysis can never be higher than the cost-sharing in Original Medicare. If you're outside our plan service area and get dialysis from a provider that's outside our plan's network, your cost-sharing can't be higher than the cost-sharing you pay in-network. However, if your usual in-network provider for dialysis is temporarily unavailable and you choose to get services inside our service area from a provider outside our plan's network, your cost-sharing for the dialysis may be higher.
  - If you receive care from network providers in other Kaiser Permanente regions described in Section 2.4.

Section 2 — Use providers in our plan's network to get medical care

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

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

As a member, you may choose one of our available network providers to be your primary care provider. Your primary care provider is a physician who meets state requirements and is trained to give you primary medical care. Your PCP will usually practice general medicine (also called adult or internal medicine and family practice) and sometimes obstetrics/gynecology. At some network facilities, if you prefer, you may choose an available nurse practitioner or physician assistant to be your primary care provider. PCPs are identified in the Provider Directory.

Your PCP provides, prescribes, or authorizes medically necessary covered services. Your PCP will provide most of your routine or basic care and provide a referral as needed to see other

network providers for other care you need. For example, to see a specialist, you usually need to get your PCP's approval first (this is called getting a "referral" to a specialist). There are a few types of covered services you can get on your own without contacting your PCP first (got to Section 2.2).

Your PCP will also coordinate your care. "Coordinating" your care includes checking or consulting with other network providers about your care and how it is going. In some cases, your PCP will need to get prior authorization (prior approval) from us (go to Section 2.3 for more information).

How to choose or change your PCP

You can change your PCP for any reason, at any time. It's also possible that your PCP might leave our plan's network of providers, and you'd need to choose a new PCP. Your PCP selection will be effective immediately.

To choose or change your PCP, call our personal physician selection number at **1-888-956-1616** (TTY users call **711**), Monday through Friday, 7 a.m. to 7 p.m. You can also make your selection at **kp.org/finddoctors**.

When you call, tell us if you're seeing specialists or getting other covered services that need your PCP's approval (such as home health services and durable medical equipment) so we can tell you if you need to get a referral from your new PCP to continue the services. Also, if there's a particular network specialist or hospital that you want to use, check with us to find out if your PCP makes referrals to that specialist or uses that hospital.

See your *Provider Directory* or call Member Services for more information about selecting a PCP and which providers are accepting new patients.

Section 2.2 – Medical care you can get without a PCP referral

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

- Routine women's health care, including breast exams, screening mammograms (X-rays of the breast), Pap tests, and pelvic exams, as long as you get them from a network provider.
- Flu shots, COVID-19 vaccines, Hepatitis B vaccines, and pneumonia vaccines, as long as you get them from a network provider.
- Emergency services from network providers or from out-of-network providers.
- Urgently needed plan-covered services are services that require immediate medical attention (but not an emergency) if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our plan's service area. If possible, call Member Services at

1-800-443-0815 (TTY users call **711**) before you leave the service area so we can help arrange for you to have maintenance dialysis while you're away.

- Second opinions from another network provider except for certain specialty care.
- Appointments in the following areas: optometry, substance abuse, and psychiatry.
- Medicare covered chiropractic care as long as you get them from a network provider.
- Preventive care except for abdominal aortic aneurysm screenings, medical nutritional therapy, flexible sigmoidoscopy, screening colonoscopy, bone density screening, and lab tests.

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

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

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

Referrals from your PCP

You will usually see your PCP first for most of your routine health care needs. There are only a few types of covered services you may get on your own, without getting approval from your PCP first, which are described in Section 2.2.

Referrals to network providers

When your PCP prescribes care that isn't available from a PCP (for example, specialty care), he or she will give you a referral to see a network specialist or another network provider as needed. If your PCP refers you to a network specialist, the referral will be for a specific treatment plan. Your treatment plan may include a standing referral if ongoing care from the specialist is prescribed. We'll send you a written referral to authorize an initial consultation or a specified number of visits with a network specialist. After your initial consultation with the network specialist, you must then return to your PCP unless we have authorized more visits as specified in the written referral that we gave you. Don't return to the network specialist after your initial consultation visit unless we have authorized additional visits in your referral. Otherwise, the services may not be covered.

Prior authorization

For the services and items listed below, your network provider will need to get approval in advance from our plan or Medical Group (this is called getting "prior authorization"). Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals. If you ever disagree with authorization decisions, you can file an appeal as described in Chapter 9.

- Services and items identified in Chapter 4 with a footnote (†).
- If your network provider decides that you require covered services not available from network providers, he or she will recommend to Medical Group that you be referred to an

out-of-network provider inside or outside our service area. The appropriate Medical Group designee will authorize the services if he or she determines that the covered services are medically necessary and aren't available from a network provider. Referrals to out-of-network providers will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. It specifies the duration of the referral without having to get additional approval from us. Ask your network provider what services have been authorized if you're not certain. If the out-of-network specialist wants you to come back for more care, be sure to check if the referral covers the additional care. If it doesn't, contact your network provider.

- After we are notified that you need post-stabilization care from an out-of-network provider following emergency care, we'll discuss your condition with the out-of-network provider. If we decide that you require post-stabilization care and that this care would be covered if you received it from a network provider, we'll authorize your care from the out-of-network provider only if we cannot arrange to have a network provider (or other designated provider) provide the care. Go to Section 3.1 for more information.
- Medically necessary transgender surgery and associated procedures.
- Care from a religious nonmedical health care institution described in Section 6.
- If your network provider makes a written or electronic referral for a transplant evaluation, Medical Group's regional transplant advisory committee or board or case conference (if one exists) will authorize the referral if it determines that you're a potential candidate for organ transplant and the service is covered in accord with Medicare guidelines. In cases where no transplant committee or board exists, Medical Group will refer you to physician(s) at a transplant center, and Medical Group will authorize the services if the transplant center's physician(s) determine that they are medically necessary or covered in accord with Medicare guidelines. Note: A network physician may provide or authorize a corneal transplant without using this Medical Group transplant authorization procedure.
- Durable medical equipment, ostomy, urological, and specialized wound care supplies. The prior authorization process for durable medical equipment, ostomy, urological and specialized wound care supplies, includes the use of formulary guidelines. These guidelines were developed by a multidisciplinary clinical and operational work group with review and input from network physicians and medical professionals with clinical expertise. The formulary guidelines are periodically updated to keep pace with changes in medical technology and clinical practice. If your network physician prescribes one of these items, he or she will submit a written referral to our hospital's durable medical equipment coordinator. If the formulary or Medicare guidelines don't specify that the prescribed item is appropriate for your medical condition, the referral will be submitted to Medical Group's designee network physician, who will make an authorization decision as described under "Medical Group's decision time frames" in this "Prior authorization" section.

Prior authorization may be needed for certain services (go to Chapter 4 for information on which services require prior authorization). Authorization can be obtained from our plan. You or your provider, including a noncontracted provider, can ask our plan before a service is furnished whether our plan will cover it. You or your provider can request that this determination be in writing. This process is called an organization determination. If we say we'll not cover your

services, you, or your provider, have the right to appeal our decision not to cover your care. Chapter 9 has more information about what to do if you want a coverage decision from us or want to appeal a decision we have already made.

If you don't have an organization determination, authorization can also be obtained from a network provider who refers an enrollee to a specialist outside our plan's network for a service, provided that service is not explicitly always excluded from plan coverage as discussed in Chapter 4.

When a specialist or another network provider leaves our plan

We may make changes to the hospitals, doctors, and specialists (providers) in our plan's network during the year. If your doctor or specialist leaves our plan, you have these rights and protections:

- Even though our network of providers may change during the year, Medicare requires that you have uninterrupted access to qualified doctors and specialists.
- We'll notify you that your provider is leaving our plan so that you have time to choose a new provider.
  - If your primary care or behavioral health provider leaves our plan, we'll notify you if you visited that provider within the past 3 years.
  - If any of your other providers leave our plan, we'll notify you if you're assigned to the provider, currently get care from them, or visited them within the past 3 months.
- We'll help you choose a new qualified in-network provider for continued care.
- If you're undergoing medical treatment or therapies with your current provider, you have the right to ask to continue getting medically necessary treatment or therapies. We'll work with you so you can continue to get care.
- We'll give you information about available enrollment periods and options you may have for changing plans.
- When an in-network provider or benefit is unavailable or inadequate to meet your medical needs, we'll arrange for any medically necessary covered benefit outside of our provider network, at in-network cost-sharing. The appropriate Medical Group designee will authorize the services if he or she determines that the covered services are medically necessary and aren't available from a network provider. Referrals to out-of-network providers will be for a specific treatment plan, which may include a standing referral if ongoing care is prescribed. It specifies the duration of the referral without having to get additional approval from us. Ask your network provider what services have been authorized if you're not certain. If the out-of-network specialist wants you to come back for more care, be sure to check if the referral covers the additional care. If it doesn't, contact your network provider.
- If you find out your doctor or specialist is leaving our plan, contact us so we can help you choose a new provider to manage your care.
- If you believe we haven't furnished you with a qualified provider to replace your previous provider or that your care isn't being appropriately managed, you have the right to file a quality-of-care complaint to the QIO, a quality-of-care grievance to our plan, or both (go to Chapter 9).

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

Care you receive from an out-of-network provider won't be covered except in the following situations:

- Emergency or urgently needed services that you get from an out-of-network provider. For more information about this, and to see what emergency or urgently needed services mean, go to Section 3.
- We or Medical Group authorize a referral to an out-of-network provider described in Section 2.3.
- Kidney dialysis services that you get at a Medicare-certified dialysis facility when you're temporarily outside our service area.
- COVID-19 services and drugs when covered as described in the Medical Benefits Chart in Chapter 4. If you receive COVID-19 services out-of-network, you may have to pay for the services and file a claim for reimbursement. For information on how to file a claim, go to Chapter 7.
- If you visit the service area of another Kaiser Permanente region, you can receive certain care covered under this *Evidence of Coverage* from designated providers in that service area. Call our Away From Home Travel Line at **1-951-268-3900** (TTY users call **711**), 24 hours a day, 7 days a week (closed holidays), or visit our website at **kp.org/travel** for more information about getting care when visiting another Kaiser Permanente Region's service area, including coverage information and facility locations. Kaiser Permanente is located in California, District of Columbia, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. **Note:** Our Away from Home Travel Line can also answer questions about covered emergency or urgent care services you receive out-of-network, including how to get reimbursement.

Section 3 — How to get services in an emergency, disaster, or urgent need for care

Section 3.1 – Get care if you have a medical emergency

A **medical emergency** is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse.

If you have a medical emergency:

- **Get help as quickly as possible.** Call 911 for help or go to the nearest emergency room or hospital. Call for an ambulance if you need it. You don't need to get approval or a referral first from your PCP. You don't need to use a network doctor. You can get covered emergency medical care whenever you need it, anywhere inside or outside the United States.

- **As soon as possible, make sure our plan has been told about your emergency.** We need to follow up on your emergency care. You or someone else should call to tell us about your emergency care, usually within 48 hours. The number to call is listed on the back of our plan membership card.

Covered services in a medical emergency

Our plan covers ambulance services in situations where getting to the emergency room in any other way could endanger your health. We also cover medical services during the emergency.

The doctors giving you emergency care will decide when your condition is stable, and the medical emergency is over.

We'll partner with the doctors providing the emergency care to help manage and follow up on your care. After the emergency is over, you're entitled to follow-up care to be sure your condition continues to be stable. Your doctors will continue to treat you until your doctors contact us and make plans for additional care. We'll cover your follow-up post-stabilization care in accord with Medicare guidelines. It is very important that your provider call us to get authorization for post-stabilization care before you receive the care from the out-of-network provider. In most cases, you will only be held financially liable if you're notified by the out-of-network provider or us about your potential liability.

If your emergency care is provided by out-of-network providers, we'll try to arrange for network providers to take over your care as soon as your medical condition and the circumstances allow.

What if it wasn't a medical emergency?

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

However, after the doctor says it wasn't an emergency, we'll cover additional care only if you get the additional care in one of these 2 ways:

- You go to a network provider to get the additional care, or
- The additional care you get is considered urgently needed services and you follow the rules below for getting this urgent care.

Section 3.2 – Get care when you have an urgent need for services

A service that requires immediate medical attention (but isn't an emergency) is an urgently needed service if you're either temporarily outside our plan's service area, or if it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. However, medically necessary routine provider visits such as annual checkups aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

We know that sometimes it's difficult to know what type of care you need. That's why we have telephone advice nurses available to assist you. Our advice nurses are registered nurses specially

trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. Whether you're calling for advice or to make an appointment, you can speak to an advice nurse.

They can often answer questions about a minor concern, tell you what to do if a network facility is closed, or advise you about what to do next, including making a same-day urgent care appointment for you if it's medically appropriate. To speak with an advice nurse 24 hours a day, 7 days a week or make an appointment, refer to your *Provider Directory* for appointment and advice telephone numbers.

Our plan covers worldwide emergency and urgent care services outside the United States under the following circumstances:

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

Section 3.3 – Get care during a disaster

If the Governor of your state, the U.S. Secretary of Health and Human Services, or the President of the United States declares a state of disaster or emergency in your geographic area, you're still entitled to care from our plan.

Visit the **kp.org** for information on how to get needed care during a disaster.

If you can't use a network provider during a disaster, our plan will allow you to get care from out-of-network providers at in-network cost-sharing. If you can't use a network pharmacy during a disaster, you may be able to fill your prescriptions at an out-of-network pharmacy. Go to Chapter 5, Section 2.5.

Section 4 — What if you're billed directly for the full cost of covered services?

If you paid more than our plan cost-sharing for covered services, or if you get a bill for the full cost of covered medical services, you can ask us to pay our share of the cost of covered services. Go to Chapter 7 for information about what to do.

Section 4.1 – If services aren't covered by our plan, you must pay the full cost

Our plan covers all medically necessary services as listed in the Medical Benefits Chart in Chapter 4. If you get services that aren't covered by our plan or you get services out-of-network without authorization, you're responsible for paying the full cost of services.

For covered services that have a benefit limitation, you also pay the full cost of any services you get after you use up your benefit for that type of covered service. Any amounts you pay after the benefit has been exhausted won't count toward the maximum out-of-pocket amount.

Section 5 — Medical services in a clinical research study

Section 5.1 – What is a clinical research study

A clinical research study (also called a clinical trial) is a way that doctors and scientists test new types of medical care, like how well a new cancer drug works. Certain clinical research studies are approved by Medicare. Clinical research studies approved by Medicare typically ask for volunteers to participate in the study. When you're in a clinical research study, you can stay enrolled in our plan and continue to get the rest of your care (care that's not related to the study) through our plan.

If you participate in a Medicare-approved study, Original Medicare pays most of the costs for covered services you get as part of the study. If you tell us you're in a qualified clinical trial, you're only responsible for the in-network cost-sharing for the services in that trial. If you paid more for example, if you already paid the Original Medicare cost-sharing amount we'll reimburse the difference between what you paid and the in-network cost-sharing. You'll need to provide documentation to show us how much you paid.

If you want to participate in any Medicare-approved clinical research study, you don't need to tell us or get approval from us or your PCP. The providers that deliver your care as part of the clinical research study don't need to be part of our plan's network (This doesn't apply to covered benefits that require a clinical trial or registry to assess the benefit, including certain benefits requiring coverage with evidence development (NCDs-CED) and investigational device exemption (IDE) studies. These benefits may also be subject to prior authorization and other plan rules.)

While you don't need our plan's permission to be in a clinical research study we encourage you to notify us in advance when you choose to participate in Medicare-qualified clinical trials.

If you participate in a study not approved by Medicare, you'll be responsible for paying all costs for your participation in the study.

Section 5.2 – Who pays for services in a clinical research study

Once you join a Medicare-approved clinical research study, Original Medicare covers the routine items and services you get as part of the study, including:

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

After Medicare pays its share of the cost for these services, our plan will pay the difference between the cost-sharing in Original Medicare and your in-network cost-sharing as a member of our plan. This means you'll pay the same amount for services you get as part of the study as you would if you got these services from our plan. However, you must submit documentation showing how much cost-sharing you paid. Go to Chapter 7 for more information on submitting requests for payments.

> Example of cost-sharing in a clinical trial: Let's say you have a lab test that costs $100 as part of the research study. Your share of the costs for this test is $20 under Original Medicare, but the test would be $10 under our plan. In this case, Original Medicare would pay $80 for the test, and you would pay the $20 copay required under Original Medicare. You would notify our plan that you got a qualified clinical trial service and submit documentation (like a provider bill) to our plan. Our plan would then directly pay you $10. This makes your net payment for the test $10, the same amount you'd pay under our plan's benefits.

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

- Generally, Medicare won't pay for the new item or service the study is testing, unless Medicare would cover the item or service even if you weren't in a study.
- Items or services provided only to collect data and not used in your direct health care. For example, Medicare won't pay for monthly CT scans done as part of a study if your medical condition would normally require only one CT scan.
- Items and services provided by the research sponsors free of charge for people in the trial.
- Items and services provided solely to determine trial eligibility.

Get more information about joining a clinical research study

Get more information about joining a clinical research study in the Medicare publication *Medicare and Clinical Research Studies* available at **www.medicare.gov/Pubs/pdf/02226-Medicare-and-Clinical-Research-Studies.pdf**. You can also call **1-800-MEDICARE (1-800-633-4227)**. TTY users call **1-877-486-2048**.

Section 6 — Rules for getting care in a religious non-medical health care institution

Section 6.1 – A religious non-medical health care institution

A religious non-medical health care institution is a facility that provides care for a condition that would ordinarily be treated in a hospital or skilled nursing facility. If getting care in a hospital or a skilled nursing facility is against a member's religious beliefs, we'll instead cover care in a religious non-medical health care institution. This benefit is provided only for Part A inpatient services (non-medical health care services).

Section 6.2 – How to get care from a religious non-medical health care institution

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan only covers non-religious aspects of care.
- If you get services from this institution provided to you in a facility, the following conditions apply:
  - You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care.
  - – and – you must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered.

Note: Covered services are subject to the same limitations and cost-sharing required for services provided by network providers as described in Chapter 4 and Chapter 12.

Section 7 — Rules for ownership of durable medical equipment

Section 7.1 – You won't own some durable medical equipment after making a certain number of payments under our plan

Durable medical equipment (DME) includes items like oxygen equipment and supplies, wheelchairs, walkers, powered mattress systems, crutches, diabetic supplies, speech-generating devices, IV infusion pumps, nebulizers, and hospital beds ordered by a provider for members to use in the home. The member always owns some DME items, like prosthetics. Other types of DME you must rent.

In Original Medicare, people who rent certain types of DME own the equipment after paying copayments for the item for 13 months. **As a member of our plan, you won't get ownership of rented DME items no matter how many copayments you make for the item while a member of our plan**. You won't get ownership even if you made up to 12 consecutive payments for the DME item under Original Medicare before you joined our plan.

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

If you didn't get ownership of the DME item while in our plan, you'll have to make 13 new consecutive payments after you switch to Original Medicare to own the DME item. The payments you made while enrolled in our plan don't count towards these 13 payments.

Example 1: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. The payments you made in Original Medicare don't count. You'll have to make 13 payments to our plan before owning the item.

Example 2: You made 12 or fewer consecutive payments for the item in Original Medicare and then joined our plan. You didn't get ownership of the item while in our plan. You then go back to Original Medicare. You'll have to make 13 consecutive new payments to own the item once you rejoin Original Medicare. Any payments you already made (whether to our plan or to Original Medicare) don't count.

Section 8 — Rules for oxygen equipment, supplies, and maintenance

If you qualify for Medicare oxygen equipment coverage, our plan will cover:

- Rental of oxygen equipment.
- Delivery of oxygen and oxygen contents.
- Tubing and related oxygen accessories for the delivery of oxygen and oxygen contents.
- Maintenance and repairs of oxygen equipment.

If you leave our plan or no longer medically require oxygen equipment, then the oxygen equipment must be returned.

What happens if you leave our plan and return to Original Medicare?

Original Medicare requires an oxygen supplier to provide you services for 5 years. During the first 36 months you rent the equipment. For the remaining 24 months, the supplier provides the equipment and maintenance (you're still responsible for the copayment for oxygen). After 5 years, you can choose to stay with the same company or go to another company. At this point, the 5-year cycle starts over again, even if you stay with the same company, and you're again required to pay copayments for the first 36 months. If you join or leave our plan, the 5-year cycle starts over.

Chapter 4 — Medical Benefits Chart (what's covered and what you pay)

Section 1 — Understanding your out-of-pocket costs for covered services

The Medical Benefits Chart lists your covered services and shows how much you pay for each covered service as a member of our plan. This section also gives information about medical services that aren't covered and explains limits on certain services. In addition, go to Chapter 3, Chapter 11, and Chapter 12 for additional coverage information, including limitations (for example, coordination of benefits, durable medical equipment, home health care, skilled nursing facility care, and third-party liability).

Section 1.1 – Out-of-pocket costs you may pay for covered services

Types of out-of-pocket costs you may pay for covered services include:

- **Copayment:** the fixed amount you pay each time you get certain medical services. You pay a copayment at the time you get the medical service unless we don't collect all cost-sharing at that time and send you a bill later. (The Medical Benefits Chart tells you more about your copayments.)
- **Coinsurance:** the percentage you pay of the total cost of certain medical services. You pay a coinsurance at the time you get the medical service unless we don't collect all cost-sharing at that time and send you a bill later. (The Medical Benefits Chart tells you more about your coinsurance.)

If you have questions about the copayments or coinsurance for specific services that you expect to receive or that your provider orders during a visit or procedure, visit our website at **kp.org** to use our cost estimate tool or call Member Services. **Note:** If charges for services are less than the copayment described in this *Evidence of Coverage*, you will pay the lesser amount.

Most people who qualify for Medicaid or for the Qualified Medicare Beneficiary (QMB) program don't pay deductibles, copayments, or coinsurance. If you're in one of these programs, be sure to show your proof of Medicaid or QMB eligibility to your provider.

Section 1.2 – What's the most you'll pay for Medicare Part A and Part B covered medical services?

Medicare Advantage Plans have limits on the total amount you have to pay out-of-pocket each year for in-network medical services covered under Medicare Part A and Part B. This limit is called the maximum out-of-pocket (MOOP) amount for medical services. **For calendar year 2026 the MOOP amount is $1,500.**

The amounts you pay for copayments and coinsurance for in-network covered services count toward this maximum out-of-pocket amount. The amounts you pay for plan premiums and

Part D drugs don't count toward your maximum out-of-pocket amount. In addition, amounts you pay for some services don't count toward your maximum out-of-pocket amount. These services are marked with an asterisk (*) in the Medical Benefits Chart. If you reach the maximum out-of-pocket amount of **$1,500**, you won't have to pay any out-of-pocket costs for the rest of the year for in-network covered Part A and Part B services. However, you must continue to pay our plan premium and the Medicare Part B premium (unless your Part B premium is paid for you by Medicaid or another third party).

Section 1.3 – Providers aren't allowed to balance bill you

As a member of our plan, you have an important protection because you only have to pay your cost-sharing amount when you get services covered by our plan. Providers can't bill you for additional separate charges, called **balance billing**. This protection applies even if we pay the provider less than the provider charges for a service, and even if there's a dispute and we don't pay certain provider charges.

Here's how protection from balance billing works:

- If your cost-sharing is a copayment (a set amount of dollars, for example, $15), you pay only that amount for any covered services from a network provider.
- If your cost-sharing is a coinsurance (a percentage of the total charges), you never pay more than that percentage. However, your cost depends on which type of provider you see:
  - If you get covered services from a network provider, you pay the coinsurance percentage multiplied by our plan's reimbursement rate (this is set in the contract between the provider and our plan).
  - If you get covered services from an out-of-network provider who participates with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or urgently needed services.)
  - If you get covered services from an out-of-network provider who doesn't participate with Medicare, you pay the coinsurance percentage multiplied by the Medicare payment rate for non-participating providers. (Our plan covers services from out-of-network providers only in certain situations, such as when you get a referral or for emergencies or for urgently needed services outside the service area.)
- If you think a provider has balance billed you, call Member Services at **1-800-443-0815** (TTY users call **711**).

Section 2 — The Medical Benefits Chart shows your medical benefits and costs

The Medical Benefits Chart on the next pages lists the services our plan covers and what you pay out of pocket for each service (Part D drug coverage is in Chapter 5). The services listed in the Medical Benefits Chart are covered only when these are met:

- Your Medicare-covered services must be provided according to the Medicare coverage guidelines.
- Your services (including medical care, services, supplies, equipment, and Part B drugs) must be medically necessary. Medically necessary means that the services, supplies, or drugs are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.
- For new enrollees, your MA coordinated care plan must provide a minimum 90-day transition period, during which time the new MA plan can't require prior authorization for any active course of treatment, even if the course of treatment was for a service that commenced with an out-of-network provider.
- You get your care from a network provider. In most cases, care you get from an out-of-network provider won't be covered, unless it's emergency or urgent care or unless our plan or a network provider gave you a referral. This means you pay the provider in full for out-of-network services you get.
- You have a primary care provider (a PCP) providing and overseeing your care. In most situations, your PCP must give you approval in advance (a referral) before you can see other providers in our plan's network.
- Some services listed in the Medical Benefits Chart are covered only if your doctor or other network provider gets approval from us in advance (sometimes called prior authorization). Covered services that need approval in advance are marked in the Medical Benefits Chart with a footnote (†). Go to Section 2.2 and Chapter 3, Section 2.3, for more information about prior authorization, including other services that require prior authorization that aren't listed in the Medical Benefits Chart.
- If your coordinated care plan provides approval of a prior authorization request for a course of treatment, the approval must be valid for as long as medically reasonable and necessary to avoid disruptions in care in accordance with applicable coverage criteria, your medical history, and the treating provider’s recommendation.

Other important things to know about our coverage

- Like all Medicare health plans, we cover everything that Original Medicare covers. For some of these benefits, you pay *more* in our plan than you would in Original Medicare. For others, you pay *less*. (To learn more about the coverage and costs of Original Medicare, go to your *Medicare & You 2026* handbook. View it online at **www.Medicare.gov** or ask for a copy by calling **1-800-MEDICARE** (**1-800-633-4227**) TTY users call **1-877-486-2048**.
- For preventive services covered at no cost under Original Medicare, we also cover those services at no cost to you. However, if you're also treated or monitored for an existing medical condition during the visit when you receive the preventive service, cost sharing will apply for the care you got for the existing medical condition.
- If Medicare adds coverage for any new services during 2026, either Medicare or our plan will cover those services.

This apple shows preventive services in the Medical Benefits Chart.

Medical Benefits Chart

Covered Service	What you pay
Abdominal aortic aneurysm screening A one-time screening ultrasound for people at risk. Our plan only covers this screening if you have certain risk factors and if you get a referral for it from your physician, physician assistant, nurse practitioner, or clinical nurse specialist.	There is no coinsurance, copayment, or deductible for members eligible for this preventive screening.
Acupuncture for chronic low back pain† Covered services include: Up to 12 visits in 90 days are covered under the following circumstances: For the purpose of this benefit, chronic low back pain is defined as: • lasting 12 weeks or longer; • nonspecific, in that it has no identifiable systemic cause (i.e., not associated with metastatic, inflammatory, infectious disease, etc.); • not associated with surgery; and • not associated with pregnancy. An additional 8 sessions covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing. **Provider Requirements:** Physicians (as defined in 1861(r)(1) of the Social Security Act (the Act)) may furnish acupuncture in accordance with applicable state requirements. Physician assistants (PAs), nurse practitioners (NPs)/clinical nurse specialists (CNSs) (as	**$10 per visit**

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

Covered Service	What you pay
identified in 1861(aa) (5) of the Act), and auxiliary personnel may furnish acupuncture if they meet all applicable state requirements and have: • a master's or doctoral level degree in acupuncture or Oriental Medicine from a school accredited by the Accreditation Commission on Acupuncture and Oriental Medicine (ACAOM); and, • a current, full, active, and unrestricted license to practice acupuncture in a State, Territory, or Commonwealth (i.e., Puerto Rico) of the United States, or District of Columbia. Auxiliary personnel furnishing acupuncture must be under the appropriate level of supervision of a physician, PA, or NP/CNS required by regulations at 42 CFR §§ 410.26 and 410.27.	
Acupuncture not covered by Medicare† Acupuncture typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain. Also, refer to Section 2.2 for a description of additional acupuncture coverage.	**$10 per visit**
Ambulance services Covered ambulance services, whether for an emergency or non-emergency situation, include fixed wing, rotary wing, and ground ambulance services, to the nearest appropriate facility that can provide care if they're furnished to a member whose medical condition is such that other means of transportation could endanger the person's health or if authorized by our plan. If the covered ambulance services aren't for an emergency situation, it should be documented that the	**$0**

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

Covered Service	What you pay
member's condition is such that other means of transportation could endanger the person's health and that transportation by ambulance is medically required. We also cover the services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) if you reasonably believe that you have an emergency medical condition and you reasonably believe that your condition requires the clinical support of ambulance transport services. Also, refer to "Transportation services" in this Medical Benefits Chart for a description of additional transportation coverage.	
Annual routine physical exams Routine physical exams are covered if the exam is medically appropriate preventive care in accord with generally accepted professional standards of practice.	There is no coinsurance, copayment, or deductible for this preventive care.
Annual wellness visit If you've had Part B for longer than 12 months, you can get an annual wellness visit to develop or update a personalized prevention plan based on your current health and risk factors. This is covered once every 12 months. **Note**: Your first annual wellness visit can't take place within 12 months of your Welcome to Medicare preventive visit. However, you don't need to have had a Welcome to Medicare visit to be covered for annual wellness visits after you've had Part B for 12 months.	There is no coinsurance, copayment, or deductible for the annual wellness visit.

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

Covered Service	What you pay
Bariatric surgery We cover hospital inpatient care related to bariatric surgical procedures (including room and board, imaging, laboratory, other diagnostic and treatment services, and plan physician services) when performed to treat obesity by modification of the gastrointestinal tract to reduce nutrient intake and absorption, if all of the following requirements are met: • You complete the medical group–approved, pre-surgical educational preparatory program regarding lifestyle changes necessary for long term bariatric surgery success. • A plan physician who is a specialist in bariatric care determines that the surgery is medically necessary.	For covered services related to bariatric surgical procedures that you receive, you will pay the **cost share you would pay if the services were not related to a bariatric surgical procedure**. For example, go to "Inpatient hospital care" in this Medical Benefits Chart for the cost share that applies for hospital inpatient care.
Bone mass measurement For qualified people (generally, this means people at risk of losing bone mass or at risk of osteoporosis), the following services are covered every 24 months or more frequently if medically necessary: procedures to identify bone mass, detect bone loss, or determine bone quality, including a physician's interpretation of the results.	There is no coinsurance, copayment, or deductible for Medicare-covered bone mass measurement.
Breast cancer screening (mammograms) Covered services include: • One baseline mammogram between the ages of 35 and 39. • One screening mammogram every 12 months for women aged 40 and older. • Clinical breast exams once every 24 months.	There is no coinsurance, copayment, or deductible for covered screening mammograms.

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

Covered Service	What you pay
Cardiac rehabilitation services Comprehensive programs of cardiac rehabilitation services that include exercise, education, and counseling are covered for members who meet certain conditions with a doctor's order. Our plan also covers intensive cardiac rehabilitation programs that are typically more rigorous or more intense than cardiac rehabilitation programs.	**$10 per visit**
Cardiovascular disease risk reduction visit (therapy for cardiovascular disease) We cover one visit per year with your primary care doctor to help lower your risk for cardiovascular disease. During this visit, your doctor may discuss aspirin use (if appropriate), check your blood pressure, and give you tips to make sure you're eating healthy.	There is no coinsurance, copayment, or deductible for the intensive behavioral therapy cardiovascular disease preventive benefit.
Cardiovascular disease screening tests Blood tests for the detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) once every 5 years (60 months).	There is no coinsurance, copayment, or deductible for cardiovascular disease testing that is covered once every 5 years.
Cervical and vaginal cancer screening Covered services include: • For all women: Pap tests and pelvic exams are covered once every 24 months. • If you're at high risk of cervical or vaginal cancer or you're of childbearing age and have had an abnormal Pap test within the past 3 years: one Pap test every 12 months.	There is no coinsurance, copayment, or deductible for Medicare-covered preventive Pap and pelvic exams.

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

Covered Service	What you pay
Chiropractic services Covered services include: • We cover only manual manipulation of the spine to correct subluxation. ♦ †For *Northern California members*, these Medicare-covered services are provided by a network provider or a chiropractor if authorized by a network provider. For the list of network chiropractors, refer to the *Provider Directory*. ♦ For *Southern California members*, these Medicare-covered services are provided by a network chiropractor. For the list of network chiropractors, refer to the *Provider Directory*. Refer to Section 2.2 for a description of additional chiropractic coverage.	**$10 per visit**
Chronic pain management and treatment services Covered monthly services for people living with chronic pain (persistent or recurring pain lasting longer than 3 months). Services may include pain assessment, medication management, and care coordination and planning.	Cost sharing for this service will vary depending on individual services provided under the course of treatment. **$10 per visit**
Colorectal cancer screening The following screening tests are covered: • Colonoscopy has no minimum or maximum age limitation and is covered once every 120 months (10 years) for patients not at high risk, or 48 months after a previous flexible sigmoidoscopy for patients who aren't at high risk for colorectal cancer, and once every 24 months for high-risk patients after a previous screening colonoscopy.	There is no coinsurance, copayment, or deductible for a Medicare-covered colorectal cancer screening exam. If your doctor finds and removes a polyp or other tissue during the colonoscopy or flexible sigmoidoscopy, the screening exam becomes a diagnostic exam and you pay **$0**.

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

Covered Service	What you pay
• Computed tomography colonography for patients 45 year and older who are not at high risk of colorectal cancer and is covered when at least 59 months have passed following the month in which the last screening computed tomography colonography was performed or 47 months have passed following the month in which the last screening flexible sigmoidoscopy or screening colonoscopy was performed. For patients at high risk for colorectal cancer, payment may be made for a screening computed tomography colonography performed after at least 23 months have passed following the month in which the last screening computed tomography colonography or the last screening colonoscopy was performed. • Flexible sigmoidoscopy for patients 45 years and older. Once every 120 months for patients not at high risk after the patient received a screening colonoscopy. Once every 48 months for high-risk patients from the last flexible sigmoidoscopy or computed tomography colonography. • Screening fecal-occult blood tests for patients 45 years and older. Once every 12 months. • Multitarget stool DNA for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. • Blood-based Biomarker Tests for patients 45 to 85 years of age and not meeting high-risk criteria. Once every 3 years. • Colorectal cancer screening tests include a follow-on screening colonoscopy after a Medicare-covered non-invasive stool-based colorectal cancer screening test returns a positive result.	

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

Covered Service	What you pay
• Colorectal cancer screening tests include a planned screening flexible sigmoidoscopy or screening colonoscopy that involves the removal of tissue or other matter, or other procedure furnished in connection with, as a result of, and in the same clinical encounter as the screening test.	
• Procedures performed during a screening colonoscopy (for example, removal of polyps). • Colonoscopies following a positive gFOBT or FIT test or a flexible sigmoidoscopy screening. **Note**: All other colonoscopies are subject to the applicable cost-sharing listed elsewhere in this chart.	**$0**
Dental services In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation.	For covered dental services that you receive, you will pay the **cost share you would pay if the services were not related to dental**. For example, go to "Inpatient hospital care" in this Medical Benefits Chart for the cost share that applies for hospital inpatient care.
Depression screening We cover one screening for depression per year. The screening must be done in a primary care setting that can provide follow-up treatment and/or referrals.	There is no coinsurance, copayment, or deductible for an annual depression screening visit.

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

Covered Service	What you pay
Diabetes screening We cover this screening (includes fasting glucose tests) if you have any of these risk factors: high blood pressure (hypertension), history of abnormal cholesterol and triglyceride levels (dyslipidemia), obesity, or a history of high blood sugar (glucose). Tests may also be covered if you meet other requirements, like being overweight and having a family history of diabetes. You may be eligible for up to 2 diabetes screenings every 12 months following the date of your most recent diabetes screening test.	There is no coinsurance, copayment, or deductible for the Medicare-covered diabetes screening tests.
Diabetes self-management training, diabetic services, and supplies For all people who have diabetes (insulin and non-insulin users). Covered services include: • †Supplies to monitor your blood glucose: blood glucose monitor, blood glucose test strips, lancet devices and lancets, and glucose-control solutions for checking the accuracy of test strips and monitors. • †For people with diabetes who have severe diabetic foot disease: one pair per calendar year of therapeutic custom-molded shoes (including inserts provided with such shoes) and 2 additional pairs of inserts, or one pair of depth shoes and 3 pairs of inserts (not including the non-customized removable inserts provided with such shoes). Coverage includes fitting. • †Diabetes self-management training is covered under certain conditions. **Note:** You may choose to receive diabetes self-management training from a program outside our plan that is recognized by the American Diabetes Association and approved by Medicare.	**$0**

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

Covered Service	What you pay
Durable medical equipment (DME) and related supplies† (For a definition of durable medical equipment, go to Chapter 12 and Chapter 3.) Inside California, covered items include, but aren't limited to: wheelchairs, crutches, powered mattress systems, diabetic supplies, hospital beds ordered by a provider for use in the home, IV infusion pumps, speech-generating devices, oxygen equipment, nebulizers, and walkers. We cover all medically necessary DME covered by Original Medicare. If our supplier in your area doesn't carry a particular brand or manufacturer, you can ask them if they can special order it for you. The most recent list of suppliers is available on our website at **kp.org/directory**. We also cover the following DME not covered by Medicare when medically necessary: • Bed accessories for a hospital bed when bed extension is required. • Heel or elbow protectors to prevent or minimize advanced pressure relief equipment use. • Iontophoresis device to treat hyperhidrosis when antiperspirants are contraindicated and the hyperhidrosis has created medical complications (for example skin infection) or is preventing daily living activities. • Resuscitation bag if tracheostomy patient has significant secretion management problems, needing lavage and suction technique aided by deep breathing via resuscitation bag.	**$0**

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

Covered Service	What you pay
• Ultraviolet light therapy equipment for conditions other than psoriasis as medically necessary, including ultraviolet light therapy equipment for home use, if (1) the equipment has been approved for you through our plan's prior authorization process, as described in Chapter 3 and (2) the equipment is provided inside our service area. (Coverage for ultraviolet light therapy equipment is limited to the standard item of equipment that adequately meets your medical needs. We decide whether to rent or purchase the equipment, and we select the vendor. You must return the equipment to us or pay us the fair market price of the equipment when we are no longer covering it.).	
Emergency care Emergency care refers to services that are: • Furnished by a provider qualified to furnish emergency services, and • Needed to evaluate or stabilize an emergency medical condition. A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb. The medical symptoms may be an illness, injury, severe pain, or a medical condition that's quickly getting worse. Cost sharing for necessary emergency services you get out-of-network is the same as when you get these services in-network. **You have worldwide emergency care coverage**.	**$50 per Emergency Department visit**. This copayment doesn't apply if you're held for observation in a hospital unit outside the Emergency Department or if admitted directly to the hospital as an inpatient within 24 hours. †If you get emergency care at an out-of-network hospital and need inpatient care after your emergency condition is stabilized, you must move to a network hospital for your care to continue to be covered OR you must have your inpatient care at the out-of-network hospital authorized by our plan and your cost is the cost-sharing you would pay at a network hospital.

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

Covered Service	What you pay
Fitness benefit (One Pass™) A fitness benefit is provided through the One Pass program to help members take control of their health and feel their best. The One Pass program includes: • Gyms and Fitness Locations: You receive a membership with access to a wide variety of in-network gyms through the core and premium networks. Fitness locations include national, local, and community fitness centers and boutique studios. You can use any in-network location, and you may use multiple participating fitness locations during the same month. • Online Fitness: You have access to live, digital fitness classes and on-demand workouts through the One Pass member website or mobile app. • Fitness and Social Activities: You also have access to groups, clubs, and social events through the One Pass member website. • Home Fitness Kits: If you prefer to work out at home, you can select a home fitness kit for Strength, Yoga, or Dance. • Brain Health: Access to online brain health cognitive training programs. For more information about participating gyms and fitness locations, the program's benefits, or to set up your online account, visit www.YourOnePass.com or call **1-877-614-0618** (TTY users call **711**), Monday through Friday, 6 a.m. to 7 p.m. The following aren't covered: Additional services (such as personal training, fee-based group fitness classes, expanded access hours, or additional classes outside of the standard membership offering).	**$0**

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

Covered Service	What you pay
One Pass® is a registered trademark of Optum, Inc. in the U.S. and other jurisdictions and is a voluntary program. The One Pass program and amenities vary by plan, area, and location. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. One Pass is not responsible for the services or information provided by third parties. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them.	
Health and wellness education programs As part of our Healthy Lifestyle Programs, our plan covers a number of group health education classes including: healthy heart, living with chronic conditions and depression. The Healthy Lifestyle Programs are provided by a certified health educator or other qualified health professional. We also cover a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for chronic conditions (such as diabetes and asthma). You can also participate in programs that we don't cover, which may require that you pay a fee. For more information about our health education counseling, programs, and materials, contact your local Health Education Department, call Member Services or go to our website at **kp.org**.	You pay **$0** for most health education services. However, for certain individual visits you pay the following: • **$10 per visit**

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

Covered Service	What you pay
Hearing services Diagnostic hearing and balance evaluations performed by your provider to determine if you need medical treatment are covered as outpatient care when you get them from a physician, audiologist, or other qualified provider.	**$10 per visit**
Hearing aid coverage We cover the hearing aid services listed below when prescribed by a network provider (clinical audiologist): • A **$1,000 allowance** toward the purchase price of hearing aids every 36 months when prescribed by a Plan Physician or by a Plan Provider who is an audiologist. We'll cover hearing aids for both ears only if both aids are required to provide significant improvement that is not obtainable with only one hearing aid. We'll not provide the Allowance if we have provided an Allowance toward (or otherwise covered) a hearing aid for that same ear within the previous 36 months. Also, the Allowance can only be used at the initial point of sale. If you don't use all of your Allowance at the initial point of sale, you cannot use it later. We select the provider or vendor that will furnish the covered hearing aids. Coverage is limited to the types and models of hearing aids furnished by the provider or vendor.	*If the hearing aid(s) you purchase costs more than **$1,000**, you pay the difference.
• Evaluation and fitting for hearing aids. • Visits to verify that the hearing aids conforms to the prescription. • Visits for counseling, adjustment, cleaning, and inspection during the 3-year warranty.	**$0**

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

Covered Service	What you pay
HIV screening For people who ask for an HIV screening test or are at increased risk for HIV infection, we cover: • One screening exam every 12 months. If you're pregnant, we cover: • Up to 3 screening exams during a pregnancy.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered preventive HIV screening.
Home-delivered meals We cover meals delivered to your home immediately following discharge from a network hospital or skilled nursing facility as an inpatient, up to three meals per day in a consecutive four-week period, once per calendar year, as follows: • When you're discharged from a network hospital or skilled nursing facility, the meal delivery vendor will contact you to review your meal options and arrange meal delivery to your home in California. In most cases, the meals must be initiated within 30 days of discharge. You can contact Member Services if you have any questions about your meals coverage. • In addition to meals for general health, there are menus to support specific conditions and diets. We'll not cover meals if more than 30 days have passed since your discharge (except in limited circumstances) or if you're discharged as follows: • To another facility that provides meals (for example, inpatient rehabilitation). • From a non-plan hospital or skilled nursing facility, hospital observation, outpatient surgery, or Emergency Department visits. • To a home outside of California.	**$0**

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

Covered Service	What you pay
Home health agency care Before you get home health services, a doctor must certify that you need home health services and will order home health services to be provided by a home health agency. You must be homebound, which means leaving home is a major effort. Inside California, covered services include, but aren't limited to: • Part-time or intermittent skilled nursing and home health aide services (to be covered under the home health care benefit, your skilled nursing and home health aide services combined must total fewer than 8 hours per day and 35 hours per week). • Physical therapy, occupational therapy, and speech therapy. • Medical and social services. • Medical equipment and supplies.	**Note:** There is no cost-sharing for home health care services and items provided in accord with Medicare guidelines. However, the applicable cost-sharing listed elsewhere in this Medical Benefits Chart will apply if the item is covered under a different benefit; for example, durable medical equipment not provided by a home health agency.
Home infusion therapy† Home infusion therapy involves the intravenous or subcutaneous administration of drugs or biologicals to a person at home. The components needed to perform home infusion include the drug (for example, antivirals, immune globulin), equipment (for example, a pump), and supplies (for example, tubing and catheters). Covered services include, but aren't limited to: • Professional services, including nursing services, furnished in accordance with our plan of care. • Patient training and education not otherwise covered under the durable medical equipment benefit. • Remote monitoring.	**$0** for professional services, training, and monitoring. **Note:** The components (such as, Medicare Part B drugs, DME, and medical supplies) needed to perform home infusion may be subject to the applicable cost-sharing listed elsewhere in this Medical Benefits Chart depending on the item.

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

Covered Service	What you pay
• Monitoring services for the provision of home infusion therapy and home infusion drugs furnished by a qualified home infusion therapy supplier.	
We cover home infusion supplies and drugs if all of the following are true: • Your prescription drug is on our Medicare Part D formulary. • We approved your prescription drug for home infusion therapy. • Your prescription is written by a network provider and filled at a network home-infusion pharmacy.	**$0** **Note**: If a covered home infusion supply or drug is not filled by a network home-infusion pharmacy, the supply or drug may be subject to the applicable cost-sharing listed elsewhere in this document depending on the service.
Home medical care not covered by Medicare (Advanced Care at Home) for members enrolled in our Northern California region service area who live in certain counties We cover medical care in your home that is not otherwise covered by Medicare when found medically appropriate by a physician based on your health status to provide you with an alternative to receiving acute care in a hospital and post-acute care services in the home to support your recovery. Services in the home must be: • Prescribed by a network hospitalist who has determined that based on your health status, treatment plan, and home setting that you can be treated safely and effectively in the home. • Elected by you because you prefer to receive the care described in your treatment plan in your home.	**$0**

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

Covered Service	What you pay
Our network provider will provide the following services and items in your home in accord with your treatment plan for as long as they are prescribed by a network hospitalist: • Home visits by RNs, physical therapists, occupational therapists, speech therapists, respiratory therapists, nutritionist, home health aides, and other healthcare professionals in accord with the home care treatment plan and the provider's scope of practice and license. • Communication devices to allow you to contact the Advanced Care at Home command center 24 hours a day, 7 days a week. This includes needed communication technology to support reliable communication, and an PERS alert device to contact the command center if you're unable to get to a phone. • The following equipment necessary to ensure that you're monitored appropriately in your home: blood pressure cuff/monitor, pulse oximeter, scale, and thermometer. • Mobile imaging and tests such as X-rays, labs, and EKGs. • The following safety items: shower stools, raised toilet seats, grabbers, long handle shoehorn, and sock aid. • Up to 21 meals per week while you're receiving acute care in the home.	
In addition, for Medicare-covered services and items listed below, the cost-sharing indicated elsewhere in this Medical Benefits Chart doesn't apply when the services and items are prescribed as part of your home treatment plan: • Durable medical equipment.	**$0**

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

Covered Service	What you pay
• Medical supplies. • Non-emergent ambulance transportation to and from network facilities when scheduled ambulance transport is medically necessary. • Physician assistant and nurse practitioner house calls or office visits. • The following services at a network facility if the services are part of your home treatment plan: ♦ Network Emergency Department visits associated with this benefit. ♦ Physical, speech, or occupational therapy office visits. ♦ X-rays, labs, ultrasounds, and EKGs. The cost-sharing indicated elsewhere in this Medical Benefits Chart will apply to all other services and items that aren't part of your home treatment plan (for example, DME unrelated to your home treatment plan) or are part of your home treatment plan, but aren't provided in your home except as listed above. Note: For prescription drug cost-sharing information, refer to the Medicare Part B prescription drug section in this chart and Chapter 6 for Medicare Part D prescription drugs.	
Hospice care for members with Medicare Parts A and B You're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have 6 months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's service area, including those programs we own,	When you enroll in a Medicare-certified hospice program, your hospice services and your Part A and Part B services related to your terminal prognosis are paid for by Original Medicare, not our plan.

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

Covered Service	What you pay
control, or have a financial interest in. Your hospice doctor can be a network provider or an out-of-network provider. Covered services include: • Drugs for symptom control and pain relief. • Short-term respite care. • Home care. When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan, you must continue to pay plan premiums. ***For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis:** Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing. **For services covered by Medicare Part A or B not related to your terminal prognosis:** If you need non-emergency, non-urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a provider in our plan's network and follow plan rules (like if there's a requirement to get prior authorization). • If you get the covered services from a network provider and follow plan rules for getting service, you pay only our plan cost-sharing amount for in-network services. • *If you get the covered services from an out-of-network provider, you pay the cost-sharing under Original Medicare.	

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

Covered Service	What you pay
For services covered by our plan but not covered by Medicare Part A or B: Our plan will continue to cover plan-covered services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay our plan cost-sharing amount for these services. **For drugs that may be covered by our plan's Part D benefit:** If these drugs are unrelated to your terminal hospice condition, you pay cost sharing. If they're related to your terminal hospice condition, you pay Original Medicare cost-sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to Chapter 5, Section 9.4. **Note:** If you need non-hospice care (care that's not related to your terminal prognosis), contact us to arrange the services.	
Hospice care for Part B Only plan members We cover the hospice services listed below if all of the following requirements are met: • A network physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less. • The services are provided inside our service area (or inside California but within 15 miles or 30 minutes from our service area if you live outside our service area, and you have been a Senior Advantage member continuously since before January 1, 1999, at the same home address). • The services are provided by a licensed hospice agency that is a network provider. • A network physician determines that the services are necessary for the palliation and	**$0**

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

Covered Service	What you pay
management of your terminal illness and related conditions. If all of the above requirements are met, we cover the following hospice services, if necessary for your hospice care: • Network physician services. • Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers. • Physical, occupational, or speech therapy for purposes of symptom control or to enable you to maintain activities of daily living. • Respiratory therapy. • Medical social services. • Home health aide and homemaker services. • Palliative drugs prescribed for pain control and symptom management of the terminal illness for up to a 100-day supply in accord with our drug formulary guidelines. You must obtain these drugs from network pharmacies. Certain drugs are limited to a maximum 30-day supply in any 30-day period. • Durable medical equipment. • Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time. • Counseling and bereavement services. • Dietary counseling. • We also cover the following hospice services only during periods of crisis when they are medically necessary to achieve palliation or management of acute medical symptoms:	

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

Covered Service	What you pay
♦ Nursing care on a continuous basis for as much as 24 hours a day as necessary to maintain you at home. ♦ Short-term inpatient care required at a level that cannot be provided at home.	
We cover hospice consultation services (one time only) for a terminally ill person who hasn't elected the hospice benefit.	**$10 per visit**
Immunizations Covered Medicare Part B services include: • Pneumonia vaccines. • Flu/influenza shots (or vaccines), once each flu/influenza season in the fall and winter, with additional flu/influenza shots (or vaccines) if medically necessary. • Hepatitis B vaccines if you're at high or intermediate risk of getting Hepatitis B. • COVID-19 vaccines. • Other vaccines if you're at risk and they meet Medicare Part B coverage rules. We also cover most other adult vaccines under our Part D drug benefit. Go to Chapter 6, Section 7 for more information.	There is no coinsurance, copayment, or deductible for the pneumonia, flu/influenza, Hepatitis B, and COVID-19 vaccines. Note: For COVID19 immunizations (including the vaccine) administered by out-of-network providers (except for providers of emergency services or out-of-area urgent care), you pay **50% coinsurance**.
Inpatient hospital care Includes inpatient acute, inpatient rehabilitation, long-term care hospitals and other types of inpatient hospital services. Inpatient hospital care starts the day you're formally admitted to the hospital with a doctor's order. The day before you're discharged is your last inpatient day. Covered services include, but aren't limited to: • Semi-private room (or a private room if medically necessary).	**$0**

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

Covered Service	What you pay
• Meals including special diets. • Regular nursing services. • Costs of special care units (such as intensive care or coronary care units). • Drugs and medications. • Lab tests. • X-rays and other radiology services. • Necessary surgical and medical supplies. • Use of appliances, such as wheelchairs. • Operating and recovery room costs. • Physical, occupational, and speech language therapy. • Inpatient substance abuse services. • †Under certain conditions, the following types of transplants are covered: corneal, kidney, kidney-pancreatic, heart, liver, lung, heart/lung, bone marrow, stem cell, and intestinal/multivisceral. If you need a transplant, we'll arrange to have your case reviewed by a Medicare-approved transplant center that will decide whether you're a candidate for a transplant. Transplant providers may be local or outside of the service area. If our in-network transplant services are outside the community pattern of care, you may choose to go locally as long as the local transplant providers are willing to accept the Original Medicare rate. If our plan provides transplant services at a location outside the pattern of care for transplants in your community and you choose to get transplants at this distant location, we'll arrange or pay for appropriate lodging and transportation costs for you and a companion, in accord with our travel and lodging	

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*Cost-sharing for these services or items doesn't apply to the maximum out-of-pocket amount.

Covered Service	What you pay
guidelines, which are available from Member Services. • Blood, including storage and administration. • Physician services. **Note:** To be an inpatient, your provider must write an order to admit you formally as an inpatient of the hospital. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you're not sure if you're an inpatient or an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at **www.medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf** or by calling **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**.	
Inpatient services in a psychiatric hospital Covered services include mental health care services that require a hospital stay.	**$0**
Inpatient stay: Covered services you get in a hospital or SNF during a non-covered inpatient stay† If you've used up your inpatient benefits or if the inpatient stay isn't reasonable and necessary, we won't cover your inpatient stay. In some cases, we'll cover certain services you get while you're in the hospital or skilled nursing facility (SNF). Covered services include, but aren't limited to: • Physician services. • Diagnostic tests (like lab tests). • X-ray, radium, and isotope therapy, including technician materials and services. • Surgical dressings.	If your inpatient or SNF stay is no longer covered, we'll continue to cover Medicare Part B services at the applicable cost-sharing listed elsewhere in this Medical Benefits Chart when provided by network providers.

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

Covered Service	What you pay
• Splints, casts, and other devices used to reduce fractures and dislocations. • Prosthetics and orthotics devices (other than dental) that replace all or part of an internal body organ (including contiguous tissue), or all or part of the function of a permanently inoperative or malfunctioning internal body organ, including replacement or repairs of such devices. • Leg, arm, back, and neck braces; trusses, and artificial legs, arms, and eyes including adjustments, repairs, and replacements required because of breakage, wear, loss, or a change in the patient's physical condition. • Physical therapy, speech therapy, and occupational therapy.	
Medical nutrition therapy This benefit is for people with diabetes, renal (kidney) disease (but not on dialysis), or after a kidney transplant when ordered by your doctor. We cover 3 hours of one-on-one counseling services during the first year you get medical nutrition therapy services under Medicare (this includes our plan, any other Medicare Advantage plan, or Original Medicare), and 2 hours each year after that. If your condition, treatment, or diagnosis changes, you may be able to get more hours of treatment with a physician's order. A physician must prescribe these services and renew their order yearly if your treatment is needed into the next calendar year.	There is no coinsurance, copayment, or deductible for members eligible for Medicare-covered medical nutrition therapy services.

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Covered Service	What you pay
We also cover nutrition/dietary counseling with a network provider not related to diabetes or ESRD.	You pay the following depending on the type of visit: • **$10** per individual visit. • **$0** per group visit.
Medicare Diabetes Prevention Program (MDPP) MDPP services are covered for eligible people under all Medicare health plans. MDPP is a structured health behavior change intervention that provides practical training in long-term dietary change, increased physical activity, and problem-solving strategies for overcoming challenges to sustaining weight loss and a healthy lifestyle.	There is no coinsurance, copayment, or deductible for the MDPP benefit.
Medicare Part B drugs† These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include: • Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services. • Insulin furnished through an item of durable medical equipment (such as a medically necessary insulin pump). • Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan. • The Alzheimer's drug, Leqembi® (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor	You pay the following for Part B drugs on our formulary when obtained from a network pharmacy: • **$0** for home infusion drugs (up to a 100-day supply) and Epogen for home dialysis (up to a 30-day supply). **For all other generic drugs:** • a **$5** Copayment for up to a 30-day supply, a **$10** Copayment for a 31- to 60-day supply, or a **$15** Copayment for a 61- to 100-day supply at a Plan Pharmacy. • a **$5** Copayment for up to a 30-day supply or a **$10** Copayment for a 31- to 100-day supply through our mail-order service.

†Your provider must obtain prior authorization from our plan.
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Covered Service	What you pay
about what scans and tests you may need as part of your treatment. • Clotting factors you give yourself by injection if you have hemophilia. • Transplant/immunosuppressive drugs; Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them. • Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug. • Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who could be you, the patient) gives them under appropriate supervision. • Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn’t cover them, Part D does. • Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they’re administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic	**For all other brand-name or specialty drugs:** • a **$20** Copayment for up to a 30-day supply, a **$40** Copayment for a 31- to 60-day supply, or a **$60** Copayment for a 61- to 100-day supply at a Plan Pharmacy. • a **$20** Copayment for up to a 30-day supply or a **$40** Copayment for a 31- to 100-day supply through our mail-order service.

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

Covered Service	What you pay
replacement for an intravenous anti-nausea drug. • Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B. • Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv® and the oral medication Sensipar®. • Certain drugs for home dialysis, including heparin, the antidote for heparin when medically necessary and topical anesthetics. • Erythropoiesis-stimulating agents; Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Epogen®, Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa, Mircera®, or Methoxy polyethylene glycol-epoetin beta). • Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases. • Parenteral and enteral nutrition (intravenous and tube feeding). We also cover some vaccines under Part B and most adult vaccines under our Part D drug benefit. Chapter 5 explains our Part D drug benefit, including rules you must follow to have prescriptions covered. What you pay for Part D drugs through our plan is explained in Chapter 6.	

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

Covered Service	What you pay
Non-Medicare prescription drugs, supplies, and supplements If a drug, supply, or supplement is not covered by Medicare Part B or D, we cover the following additional items in accord with our non–Part D drug formulary: • Drugs for which a prescription is required by law that aren't covered by Medicare Part B or D. We also cover certain over-the counter drugs and items (drugs and items that don't require a prescription by law), if they are listed on our drug formulary applicable to non-Part D items and prescribed by a Plan Physician, except a prescription is not required for over-the-counter contraceptives. • Diaphragms, cervical caps, contraceptive rings, and contraceptive patches. • Disposable needles and syringes needed for injecting covered drugs, pen delivery devices, and visual aids required to ensure proper dosage (except eyewear), that aren't covered by Medicare Part B or D. • Inhaler spacers needed to inhale covered drugs. • Continuity non–Part D drugs: If this *Evidence of Coverage* is amended to exclude a non–Part D drug that we have been covering and providing to you under this *Evidence of Coverage*, we'll continue to provide the non–Part D drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the Federal Food and Drug Administration.	**Generic drugs** • a **$5** Copayment for up to a 30-day supply, a **$10** Copayment for a 31- to 60-day supply, or a **$15** Copayment for a 61- to 100-day supply at a network pharmacy. • a **$5** Copayment for up to a 30-day supply or a **$10** Copayment for a 31- to 100-day supply through our mail-order pharmacy. **Brand-name or specialty drugs** • a **$20** Copayment for up to a 30-day supply, a **$40** Copayment for a 31- to 60-day supply, or a **$60** Copayment for a 61- to 100-day supply at a network pharmacy. • a **$20** Copayment for up to a 30-day supply or a **$40** Copayment for a 31- to 100-day supply through our mail-order pharmacy.
• Drugs prescribed for the treatment of sexual dysfunction disorders.	**50% coinsurance** for up to a 100-day supply.

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*Cost-sharing for these services or items doesn't apply to the maximum out-of-pocket amount.

Covered Service	What you pay
• Drugs prescribed for the treatment of infertility.	**50% coinsurance** for up to a 100-day supply.
• Diabetes urine-testing supplies.	**$0** for up to a 100-day supply.
• Tobacco cessation drugs.	**$0** for up to a 100-day supply.
• Therapeutics for COVID-19 obtained from network pharmacies. You may have to pay charges for the item and file a claim for reimbursement as described in Chapter 7.	**$0** for up to a 30-day supply.
• Therapeutics for COVID-19 obtained from out-of-network providers (except for providers of emergency services or out-of-area urgent care). If you fill the prescription at a network pharmacy, you may have to pay charges for the item and file a claim for reimbursement as described in Chapter 7.	**50% coinsurance** for up to a 30-day supply.
Note: We'll not cover prescription drugs for which there's an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the prescription drug). This exclusion doesn't apply to: • Insulin. • Over-the-counter tobacco cessation drugs and contraceptive drugs. • An entire class of prescription drugs when one drug within that class becomes available over-the-counter. • Drugs covered by Medicare Parts B or D. **Non–Part D drug formulary.** The non–Part D drug formulary includes a list of drugs that our Pharmacy and Therapeutics Committee has approved for our members. Our Pharmacy and Therapeutics Committee, which is primarily composed of plan physicians and pharmacists, selects drugs for the drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature. The drug formulary is updated monthly based on new information or new drugs that become available. To find out which drugs are on the formulary for your plan, refer to the California Commercial HMO formulary on our website at **kp.org/formulary**. The formulary also discloses requirements or limitations	

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Covered Service	What you pay
that apply to specific drugs, such as whether there's a limit on the amount of the drug that can be dispensed and whether the drug must be obtained at certain specialty pharmacies. If you would like to request a copy of this non–Part D drug formulary, call Member Services. **Note:** The presence of a drug on the drug formulary doesn't necessarily mean that your Plan Physician will prescribe it for a particular medical condition. Drug formulary guidelines allow you to obtain nonformulary prescription drugs (those not listed on our drug formulary for your condition) if they would otherwise be covered and a plan physician determines that they are medically necessary. If you disagree with your plan physician's determination that a nonformulary prescription drug is not medically necessary, you may file an appeal as described in Chapter 9, "What to do if you have a problem or complaint (coverage decisions, appeals & complaints)." Also, our non–Part D formulary guidelines may require you to participate in a behavioral intervention program approved by Medical Group for specific conditions and you may be required to pay for the program. **About specialty drugs.** Specialty drugs are high-cost drugs that are on our specialty drug list. If your Plan Physician prescribes more than a 30-day supply for an outpatient drug, you may be able to obtain more than a 30-day supply at one time, up to the day supply limit for that drug. However, most specialty drugs are limited to a 30-day supply in any 30-day period. Your plan pharmacy can tell you if a drug you take is one of these drugs. **Manufacturer coupon program.** For outpatient prescription drugs or items that are covered under this "Non-Medicare prescription drugs, supplies, and supplements" section and obtained at a plan pharmacy, you may be able to use approved manufacturer coupons as payment for the cost share that you owe, as allowed under Health Plan's coupon program. You will owe any additional amount if the coupon doesn't cover the entire amount of your cost share for your prescription. Certain health plan coverages aren't eligible for coupons. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at **kp.org/rxcoupons**.	
Obesity screening and therapy to promote sustained weight loss If you have a body mass index of 30 or more, we cover intensive counseling to help you lose weight. This counseling is covered if you get it in a primary care setting, where it can be coordinated with your comprehensive prevention plan. Talk to your primary care doctor or practitioner to find out more.	There is no coinsurance, copayment, or deductible for preventive obesity screening and therapy.

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Covered Service	What you pay
Opioid treatment program services† Members of our plan with opioid use disorder (OUD) can get coverage of services to treat OUD through an Opioid Treatment Program (OTP) which includes the following services: • U.S. Food and Drug Administration (FDA) - approved opioid agonist and antagonist medication-assisted treatment (MAT) medications. • Dispensing and administration of MAT medications (if applicable).	**$0** for clinically administered Medicare Part B drugs when provided by an Opioid Treatment Program.
• Substance use counseling. • Individual and group therapy. • Toxicology testing. • Intake activities. • Periodic assessments.	**$0**
Outpatient diagnostic tests and therapeutic services and supplies Covered services include, but aren't limited to: • X-rays. • Ultrasounds.	**$0**
• Electrocardiograms (EKGs), holter monitoring, and electroencephalograms (EEGs). • Sleep studies.	**$0**
• Laboratory tests to diagnose or screen for COVID-19 obtained from network providers.	**$0**

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Covered Service	What you pay
• Laboratory tests to diagnose or screen for COVID-19 obtained from out-of-network providers (except for providers of emergency or out-of-area urgent care).	**50% coinsurance**
• COVID-19 over-the-counter tests self-administered tests that deliver results at home and are available without a prescription, when obtained at a network pharmacy (up to a total of 8 tests per calendar month for both network and out-of-network pharmacies or retailers).	**$0**
• COVID-19 over-the-counter tests self-administered tests that deliver results at home and are available without a prescription, when obtained at an out-of-network pharmacy (up to a total of 8 tests per calendar month for both network and out-of-network pharmacies or retailers).	**50% coinsurance** (not to exceed $12 per test, including all fees and taxes).
• Radiation (radium and isotope) therapy, including technician materials and supplies. • Surgical supplies, such as dressings. • Splints, casts, and other devices used to reduce fractures and dislocations. • Blood, including storage and administration.	**$0**
• Other outpatient diagnostic tests: ♦ Magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET).	**$0**

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*Cost-sharing for these services or items doesn't apply to the maximum out-of-pocket amount.

Covered Service	What you pay
♦ Any diagnostic test or special procedure that is provided in an outpatient department of a hospital or ambulatory surgery center or in a hospital operating room, or if it is provided in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort.	**$10 per procedure**
Outpatient hospital observation Observation services are hospital outpatient services given to determine if you need to be admitted as an inpatient or can be discharged. For outpatient hospital observation services to be covered, they must meet Medicare criteria and be considered reasonable and necessary. Observation services are covered only when provided by the order of a physician or another person authorized by state licensure law and hospital staff bylaws to admit patients to the hospital or order outpatient tests. **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you're an outpatient, ask the hospital staff. Get more information in the Medicare fact sheet *Medicare Hospital Benefits*. This fact sheet is available at **https://Medicare.gov/publications/11435-Medicare-Hospital-Benefits.pdf** or by calling **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**.	**$0**

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Covered Service	What you pay
Outpatient hospital services We cover medically necessary services you get in the outpatient department of a hospital for diagnosis or treatment of an illness or injury. Covered services include, but aren't limited to: • Services in an Emergency Department or outpatient clinic such as observation services or outpatient surgery.	**Emergency Department** • **$50 per visit** **Outpatient surgery** • **$10 per procedure** Refer to the "Outpatient hospital observation" section of this Medical Benefits Chart for the cost-sharing applicable to observation services.
• Laboratory and diagnostic tests billed by the hospital. •	**$0**
• X-rays and other radiology services billed by the hospital.	**X-rays and ultrasounds** **$0** **MRI, CT, and PET** For magnetic resonance imaging (MRI), computed tomography (CT), and positron emission tomography (PET), you pay the following: **$0**
• Medical supplies such as splints and casts. • Certain drugs and biologicals that you can't give yourself.	**$0**
• Mental health care, including care in a partial-hospitalization program, if a doctor certifies that inpatient treatment would be required without it.	**$0** for partial hospitalization.

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Covered Service	What you pay
• For dental procedures at a network facility, we provide general anesthesia and the facility's services associated with the anesthesia if all of the following are true: ♦ You're developmentally disabled, or your health is compromised. ♦ Your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center. ♦ The dental procedure would not ordinarily require general anesthesia. We don't cover any other services related to the dental procedure, such as the dentist's services, unless the service is covered in accord with Medicare guidelines as described under "Dental services." **Note:** Unless the provider has written an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient hospital services. Even if you stay in the hospital overnight, you might still be considered an outpatient. If you aren't sure if you are an outpatient, ask the hospital staff.	**$10 per procedure** Refer to "Outpatient surgery" listed at the beginning of this section for the cost-sharing applicable to outpatient hospital facility charges.
Outpatient mental health care Covered services include: Mental health services provided by a state-licensed psychiatrist or doctor, clinical psychologist, clinical social worker, clinical nurse specialist, licensed professional counselor (LPC), licensed marriage and family therapist (LMFT), nurse practitioner (NP), physician assistant (PA), or other Medicare-qualified mental health care professional as allowed under applicable state laws.	You pay the following depending on the type of visit: • **$10** per individual therapy visit. • **$5** per group therapy visit.

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*Cost-sharing for these services or items doesn't apply to the maximum out-of-pocket amount.

Covered Service	What you pay
Outpatient rehabilitation services Covered services include physical therapy, occupational therapy, and speech language therapy. Outpatient rehabilitation services are provided in various outpatient settings, such as hospital outpatient departments, independent therapist offices, and Comprehensive Outpatient Rehabilitation Facilities (CORFs).	You pay the following depending on the type of visit: • **$10** per individual therapy visit. • **$5** per group therapy visit.
• Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program.	**$10 per day**
• Physical therapy to prevent falls for adults who are at risk for falls when ordered by your doctor.	**$0**
Outpatient substance use disorder services We cover the following services for treatment of substance abuse: • Day-treatment programs. • Intensive outpatient programs.	**$5 per day**
• Group and individual substance abuse counseling by a qualified clinician, including a licensed marriage and family therapist (LMFT). • Medical treatment for withdrawal symptoms.	You pay the following depending on the type of visit: • **$10** per individual visit • **$5** per group visit.

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

Covered Service	What you pay
Outpatient surgery, including services provided at hospital outpatient facilities and ambulatory surgical centers **Note:** If you're having surgery in a hospital facility, you should check with your provider about whether you'll be an inpatient or outpatient. Unless the provider writes an order to admit you as an inpatient to the hospital, you're an outpatient and pay the cost-sharing amounts for outpatient surgery. Even if you stay in the hospital overnight, you might still be considered an outpatient.	**Provider office visits** • **$10 per visit** **Outpatient surgery and other procedures** You pay the following, when it is provided in an outpatient or ambulatory surgery center, or in a hospital operating room, or in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort: • **$10 per procedure**
Over-the-Counter (OTC) Health and Wellness We cover OTC items listed in our OTC catalog for free home delivery. You may order OTC items up to the **$70** quarterly benefit limit. Each order must be at least **$25**. Your order may not exceed your quarterly benefit limit. Any unused portion of the quarterly benefit limit doesn't carry forward to the next quarter. (Your benefit limit resets on January 1, April 1, July 1, and October 1). To view our catalog and place an order online, visit **kp.org/otc/ca**. You may place an order over the phone or request a printed catalog be mailed to you by calling **1-833-569-2360** (TTY users call **711**), 7 a.m. to 5 p.m. PST, Monday through Friday.	You pay **$0** up to the **$70** quarterly benefit limit.

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

Covered Service	What you pay
Partial hospitalization services and intensive outpatient services *Partial hospitalization* is a structured program of active psychiatric treatment provided as a hospital outpatient service or by a community mental health center, that's more intense than the care received in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office and is an alternative to inpatient hospitalization.	**$0**
Intensive outpatient service is a structured program of active behavioral (mental) health therapy treatment provided in a hospital outpatient department, a community mental health center, a federally qualified health center, or a rural health clinic that's more intense than care you get in your doctor's, therapist's, licensed marriage and family therapist's (LMFT), or licensed professional counselor's office but less intense than partial hospitalization.	**$0**
Physician/practitioner services, including doctor's office visits Covered services include: • Medically necessary medical care or surgery services you get in a physician's office, certified ambulatory surgical center, hospital outpatient department, or any other location. • Consultation, diagnosis, and treatment by a specialist. • Basic hearing and balance exams performed by a network provider, if your doctor orders it to see if you need medical treatment. • Second opinion by another network provider prior to surgery.	**Provider office visits** • **$10 per visit** **Outpatient surgery** You pay the following when it is provided in an outpatient or ambulatory surgery center, or in a hospital operating room, or in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort: • **$10 per procedure**

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

Covered Service	What you pay
• House calls by a network physician (or a network provider who is a registered nurse) inside our service area when care can best be provided in your home as determined by a network provider. • Pre- and post-operative visits.	
• Allergy injection visits.	**$3 per visit**
• Certain telehealth services, including: primary and specialty care, which includes inpatient hospital services, skilled nursing facility services, cardiac rehabilitation services, pulmonary rehabilitation services, emergency services, urgently needed services, partial hospitalization, home health services, occupational therapy services, mental health, podiatry, psychiatric services, physical therapy and speech-language pathology services, opioid treatment program services, outpatient X-ray services, outpatient hospital services, observation services, outpatient substance abuse, dialysis services, nutritional/dietary services, health education, kidney disease education services, diabetes self-management training, and hearing exams, preparation for surgery or a hospital stay, and follow up visits after a hospital stay, surgery, or Emergency Department visit. Services will only be provided by telehealth when deemed clinically appropriate by the network provider rendering the service. ♦ You have the option of getting these services through an in-person visit or by telehealth. If you choose to get one of these services by telehealth, you must use a network provider who offers the service	**$0**

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

Covered Service	What you pay
by telehealth. We offer the following means of telehealth: ○ Interactive video visits for professional services when care can be provided in this format as determined by a network provider. ○ Scheduled telephone appointment visits for professional services when care can be provided in this format as determined by a network provider. • Telehealth services for monthly end-stage renal disease-related visits for home dialysis members in a hospital-based or critical access hospital-based renal dialysis center, renal dialysis facility, or the member's home. • Telehealth services to diagnose, evaluate, or treat symptoms of a stroke, regardless of your location. • Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location. • Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if: ♦ You have an in-person visit within 6 months prior to your first telehealth visit. ♦ You have an in-person visit every 12 months while getting these telehealth services. ♦ Exceptions can be made to the above for certain circumstances. • Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers.	

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Covered Service	What you pay
• Virtual check-ins (for example, by phone or video chat) with your doctor for 5–10 minutes if: ♦ You're not a new patient and ♦ The check-in isn't related to an office visit in the past 7 days and ♦ The check-in doesn't lead to an office visit within 24 hours or the soonest available appointment. • Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if: ♦ You're not a new patient and ♦ The evaluation isn't related to an office visit in the past 7 days and ♦ The evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment.	
• Consultation your doctor has with other doctors by phone, internet, or electronic health record. • Ultraviolet light treatments.	**$0**
Podiatry services Covered services include: • Diagnosis and the medical or surgical treatment of injuries and diseases of the feet (such as hammer toe or heel spurs). • Routine foot care for members with certain medical conditions affecting the lower limbs.	**Office visits** • **$10 per visit** **Outpatient surgery** You pay the following when it is provided in an outpatient or ambulatory surgery center, or in a hospital operating room, or in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort: • **$10 per procedure**

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

Covered Service	What you pay
Pre-exposure prophylaxis (PrEP) for HIV prevention If you don't have HIV, but your doctor or other health care practitioner determines you're at an increased risk for HIV, we cover pre-exposure prophylaxis (PrEP) medication and related services. If you qualify, covered services include: • FDA-approved oral or injectable PrEP medication. If you're getting an injectable drug, we also cover the fee for injecting the drug. • Up to 8 individual counseling sessions (including HIV risk assessment, HIV risk reduction, and medication adherence) every 12 months. • Up to 8 HIV screenings every 12 months. A one-time hepatitis B virus screening.	There is no coinsurance, copayment, or deductible for the PrEP benefit.
Prostate cancer screening exams For men aged 50 and older, covered services include the following once every 12 months: • Digital rectal exam. • Prostate Specific Antigen (PSA) test.	There is no coinsurance, copayment, or deductible for an annual digital rectal exam or PSA test.
Prosthetic and orthotic devices and related supplies† Devices (other than dental) that replace all or part of a body part or function. Inside California, these include but aren't limited to testing, fitting, or training in the use of prosthetic and orthotic devices; as well as: colostomy bags and supplies directly related to colostomy care, pacemakers, braces, prosthetic shoes, artificial limbs, and breast prostheses (including a surgical brassiere after a mastectomy). Includes certain supplies	**$0**

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

Covered Service	What you pay
related to prosthetic and orthotic devices, and repair and/or replacement of prosthetic and orthotic devices. Also includes some coverage following cataract removal or cataract surgery – go to "**Vision care**" later in this table for more detail. We also cover these items not covered by Medicare: • Certain surgical boots following surgery when provided during an outpatient visit. • Vacuum erection device for sexual dysfunction. • Certain skin sealants, protectants, moisturizers, ointments that are medically necessary wound care. • Covered special footwear when custom made for foot disfigurement due to disease, injury, or developmental disability.	
Pulmonary rehabilitation services Comprehensive programs of pulmonary rehabilitation are covered for members who have moderate to very severe chronic obstructive pulmonary disease (COPD) and an order for pulmonary rehabilitation from the doctor treating the chronic respiratory disease.	**$10 per day**
Residential substance use disorder and mental health treatment† We cover the following services when the services are provided in a licensed residential treatment facility that provides 24-hour individualized substance use disorder or mental health treatment, the services are generally and customarily provided by a substance use disorder or mental health residential treatment program in	**$0**

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

Covered Service	What you pay
a licensed residential treatment facility, and the services are above the level of custodial care: • Individual and group counseling. • Medical services. • Medication monitoring. • Room and board. • Drugs prescribed by a network provider as part of your plan of care in the residential treatment facility in accord with our drug formulary guidelines if they are administered to you in the facility by medical personnel. • Discharge planning. There's no limit to the number of medically necessary days in our residential treatment program to treat mental health conditions and substance abuse when prescribed by a network provider.	
Screening and counseling to reduce alcohol misuse We cover one alcohol misuse screening for adults (including pregnant women) who misuse alcohol but aren't alcohol dependent. If you screen positive for alcohol misuse, you can get up to 4 brief face-to-face counseling sessions per year (if you're competent and alert during counseling) provided by a qualified primary care doctor or practitioner in a primary care setting.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening and counseling to reduce alcohol misuse preventive benefit.

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

Covered Service	What you pay
Screening for lung cancer with low-dose computed tomography (LDCT) For qualified people, a LDCT is covered every 12 months. Eligible members are people age 50–77 who have no signs or symptoms of lung cancer, but who have a history of tobacco smoking of at least 20 pack-years and who currently smoke or have quit smoking within the last 15 years, who get an order for LDCT during a lung cancer screening counseling and shared decision-making visit that meets the Medicare criteria for such visits and be furnished by a physician or qualified non-physician practitioner. For LDCT lung cancer screenings after the initial LDCT screening: the members must get an order for LDCT lung cancer screening, which may be furnished during any appropriate visit with a physician or qualified non-physician practitioner. If a physician or qualified non-physician practitioner elects to provide a lung cancer screening counseling and shared decision-making visit for later lung cancer screenings with LDCT, the visit must meet the Medicare criteria for such visits.	There is no coinsurance, copayment, or deductible for the Medicare-covered counseling and shared decision-making visit or for the LDCT.
Screening for Hepatitis C Virus infection We cover one Hepatitis C screening if your primary care doctor or other qualified health care provider orders one and you meet one of these conditions: • You're at high risk because you use or have used illicit injection drugs. • You had a blood transfusion before 1992. • You were born between 1945-1965.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for the Hepatitis C Virus.

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

Covered Service	What you pay
If you were born between 1945-1965 and aren't considered high risk, we pay for a screening once. If you're at high risk (for example, you've continued to use illicit injection drugs since your previous negative Hepatitis C screening test), we cover yearly screenings.	
Screening for sexually transmitted infections (STIs) and counseling to prevent STIs We cover sexually transmitted infection (STI) screenings for chlamydia, gonorrhea, syphilis, and Hepatitis B. These screenings are covered for pregnant women and for certain people who are at increased risk for an STI when the tests are ordered by a primary care provider. We cover these tests once every 12 months or at certain times during pregnancy. We also cover up to 2 individual 20- to 30-minute, face-to-face high-intensity behavioral counseling sessions each year for sexually active adults at increased risk for STIs. We only cover these counseling sessions as a preventive service if they are provided by a primary care provider and take place in a primary care setting, such as a doctor's office.	There is no coinsurance, copayment, or deductible for the Medicare-covered screening for STIs and counseling for STIs preventive benefit.
Services to treat kidney disease Covered services include: • Kidney disease education services to teach kidney care and help members make informed decisions about their care.	You pay **$0** per group visit and the following per individual visit: • **$10 per visit**
• Self-dialysis training (includes training for you and anyone helping you with your home dialysis treatments).	**$0**

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

Covered Service	What you pay
• Certain home support services (such as, when necessary, visits by trained dialysis workers to check on your home dialysis, to help in emergencies, and check your dialysis equipment and water supply). • Routine laboratory tests to monitor the effectiveness of dialysis. • One routine office visit per month with the nephrology team. • Vascular and peritoneal access procedures when performed in an outpatient hospital setting if certain criteria are met.	
• Home dialysis equipment and supplies. • Outpatient dialysis treatments (including dialysis treatments when temporarily out of the service area, as explained in Chapter 3, or when your provider for this service is temporarily unavailable or inaccessible).	**$0**
• Nonroutine office visits with the nephrology team.	**$10 per visit**
• Vascular and peritoneal access procedures when performed in a medical office.	**Provider office visits** • **$10 per visit** **Outpatient surgery** You pay the following when it is provided in an outpatient or ambulatory surgery center, or in a hospital operating room, or in any setting and a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort: • **$10 per procedure**

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

Covered Service	What you pay
• Inpatient dialysis treatments (if you're admitted as an inpatient to a hospital for special care).	No additional charge for services received during a hospital stay. Refer to the "Inpatient hospital care" section of this Medical Benefits Chart for the cost-sharing applicable to inpatient stays.
Certain drugs for dialysis are covered under Medicare Part B. For information about coverage for Part B drugs, go to **Medicare Part B drugs** in this table.	
Skilled nursing facility (SNF) care† (For a definition of skilled nursing facility care, go to Chapter 12. Skilled nursing facilities are sometimes called SNFs.) We cover up to 100 days per benefit period of skilled inpatient services in a skilled nursing facility in accord with Medicare guidelines (a prior hospital stay is not required). Covered services include, but aren't limited to: • Semiprivate room (or a private room if medically necessary). • Meals, including special diets. • Skilled nursing services. • Physical therapy, occupational therapy, and speech therapy. • Drugs administered to you as part of your plan of care (this includes substances that are naturally present in the body, such as blood clotting factors). • Blood, including storage and administration. • Medical and surgical supplies ordinarily provided by SNFs. • Laboratory tests ordinarily provided by SNFs. • X-rays and other radiology services ordinarily provided by SNFs.	**$0** A benefit period begins on the first day you go to a Medicare-covered inpatient hospital or skilled nursing facility (SNF). The benefit period ends when you haven't been an inpatient at any hospital or SNF for 60 calendar days in a row.

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

Covered Service	What you pay
• Use of appliances such as wheelchairs ordinarily provided by SNFs. • Physician/Practitioner services. Generally, you get SNF care from network facilities. Under certain conditions listed below, you may be able to pay in-network cost-sharing for a facility that isn't a network provider, if the facility accepts our plan's amounts for payment. • A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides skilled nursing facility care). • A SNF where your spouse or domestic partner is living at the time you leave the hospital.	
Smoking and tobacco use cessation (counseling to stop smoking or tobacco use) Smoking and tobacco use cessation counseling is covered for outpatient and hospitalized patients who meet these criteria: • Use tobacco, regardless of whether they exhibit signs or symptoms of tobacco-related disease. • Are competent and alert during counseling. • A qualified physician or other Medicare-recognized practitioner provides counseling. We cover 2 cessation attempts per year (each attempt may include a maximum of 4 intermediate or intensive sessions, with the patient getting up to 8 sessions per year.)	There is no coinsurance, copayment, or deductible for the Medicare-covered smoking and tobacco use cessation preventive benefits.

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

Covered Service	What you pay
In addition to counseling services, we cover certain FDA-approved nicotine replacement therapies for over-the-counter use. The items must be ordered by a network provider and obtained from a network pharmacy. We'll provide up to a 100-day supply twice during the calendar year.	**$0**
Supervised Exercise Therapy (SET) SET is covered for members who have symptomatic peripheral artery disease (PAD) and a referral for PAD from the physician responsible for PAD treatment. Up to 36 sessions over a 12-week period are covered if the SET program requirements are met. The SET program must: • Consist of sessions lasting 30–60 minutes, comprising a therapeutic exercise-training program for PAD in patients with claudication. • Be conducted in a hospital outpatient setting or a physician's office. • Be delivered by qualified auxiliary personnel necessary to ensure benefits exceed harms, and who are trained in exercise therapy for PAD. • Be under the direct supervision of a physician, physician assistant, or nurse practitioner/clinical nurse specialist who must be trained in both basic and advanced life support techniques. SET may be covered beyond 36 sessions over 12 weeks for an additional 36 sessions over an extended period of time if deemed medically necessary by a health care provider.	**$10 per day**

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

Covered Service	What you pay
Transportation services* We cover transportation to take you to and from a network provider for services covered under this *Evidence of Coverage* when provided by our designated transportation provider. Each stop will count towards one trip. To request non-medical transportation services (rideshare, taxi, or private transportation), call **1-877-930-1477** (TTY users call **711**), Monday through Friday, 5:00 a.m. to 6:00 p.m. You may also create an account with our transportation vendor and schedule rides online at **medicaltrip.net** or via their mobile app. If you need to use non-emergency medical transportation (wheelchair van or gurney van) because you physically or medically aren't able to get your medical appointment by non-medical transportation (rideshare, taxi, or private transportation), call **1-833-226-6760** (TTY users call **711**), Monday through Friday, 9:00 a.m. to 5:00 p.m. Call at least three business days before your appointment or as soon as you can when you have an urgent appointment. Have all of the following when you call: • Your Kaiser Permanente ID card. • The date and time of your medical appointments. • The address of where you need to be picked up and the address of where you're going. • If you will need a return trip. • If someone will be traveling with you (for example, a parent/legal guardian or caregiver).	**$0** for 24 one-way trips (50 miles per trip) per calendar year. For trips greater than 50 miles, you will need an approval from a provider indicating medical necessity to travel to a location beyond this limit.

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

Covered Service	What you pay
Urgently needed services A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area or, even if you're inside our plan's service area, it's unreasonable given your time, place, and circumstances to get this service from network providers. Our plan must cover urgently needed services and only charge you in-network cost sharing. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable. • **Inside our service area:** You must obtain urgent care from network providers, unless our provider network is temporarily unavailable or inaccessible due to an unusual and extraordinary circumstance (for example, major disaster). • **Outside our service area:** You have worldwide urgent care coverage when you travel if you need medical attention right away for an unforeseen illness or injury and you reasonably believed that your health would seriously deteriorate if you delayed treatment until you returned to our service area. Go to Chapter 3, Section 3, for more information.	**Office visits** • **$10 per visit** **Emergency Department visits** • **$50 per visit**

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

Covered Service	What you pay
Vision care Covered services include: • Outpatient physician services for the diagnosis and treatment of diseases and injuries of the eye, including treatment for age-related macular degeneration.	**$10 per visit**
• Original Medicare doesn't cover routine eye exams (eye refractions) for eyeglasses/contacts. However, our plan does cover the following exams: ♦ Routine eye exams (eye refraction exams) to determine the need for vision correction and to provide a prescription for eyeglass lenses.	**$10 per visit**
• Visual field tests.	**$0**
• 🍎 For people who are at high risk of glaucoma, we cover one glaucoma screening each year. People at high risk of glaucoma include people with a family history of glaucoma, people with diabetes, African-Americans who are age 50 and older, and Hispanic Americans who are 65 or older. • For people with diabetes, screening for diabetic retinopathy is covered once per year.	**$0**
• One pair of eyeglasses or contact lenses (including fitting and dispensing) after each cataract surgery that includes insertion of an intraocular lens. If you have 2 separate cataract operations, you can't reserve the benefit after the first surgery and purchase 2 eyeglasses after the second surgery.	**$0** for eyewear in accord with Medicare guidelines. ***Note:** If the eyewear you purchase costs more than what Medicare covers, you pay the difference.

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

Covered Service	What you pay
• Corrective lenses/frames (and replacements) needed after a cataract removal without a lens implant.	
Eyeglasses and contact lenses We provide a single **$175 allowance** toward the purchase price of any or all of the following not more than once every 24 months when a physician or optometrist prescribes an eyeglass lens (for eyeglass lenses and frames) or contact lens (for contact lenses): • Eyeglass lenses when a network provider puts the lenses into a frame ♦ we cover a clear balance lens when only one eye needs correction ♦ we cover tinted lenses when medically necessary to treat macular degeneration or retinitis pigmentosa • Eyeglass frames when a network provider puts two lenses (at least one of which must have refractive value) into the frame • Contact lenses, fitting, and dispensing • We will not provide the allowance if we have provided an allowance toward (or otherwise covered) lenses or frames within the previous 24 months. • The allowance can only be used at the initial point of sale. If you don't use all of your allowance at the initial point of sale, you cannot use it later. • They are standard single vision, lined multifocal, basic progressive multifocal, or lenticular	*If the eyewear you purchase costs more than **$175, you pay the difference.**

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

Covered Service	What you pay
• **Replacement lenses**: If you have a change in prescription of at least .50 diopter in one or both eyes within 12 months of the initial point of sale of an eyeglass lens or contact lens that we provided an allowance toward (or otherwise covered) we'll provide an allowance toward the purchase price of a replacement item of the same type (eyeglass lens, or contact lens, fitting, and dispensing) for the eye that had the .50 diopter change. The allowance toward one of these replacement lenses is $30 for a single vision eyeglass lens or for a contact lens (including fitting and dispensing) and $45 for a multifocal or lenticular eyeglass lens.	If the lens you purchase costs more than the **$30** allowance for single vision or **$45** for multifocal or lenticular eyeglass lens, **you pay the amount that exceeds your allowance**.
• **Special contact lenses:** We cover the following when received from a network facility or network optical sales office: ♦ For aniridia (missing iris), up to two medically necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a network physician/Optometrist. ♦ In accord with Medicare guidelines, corrective lenses (including contact lens fitting and dispensing) and frames (and replacements) for members who are aphakic (for example, who have had a cataract removed but don't have an implanted intraocular lens (IOL) or who have congenital absence of the lens). ♦ For other contact lenses that will provide a significant improvement in your vision not obtainable with eyeglass lenses, we cover either one pair of contact lenses (including fitting and dispensing) or an initial supply of disposable contact lenses	**$0**

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

Covered Service	What you pay
(up to six months, including fitting and dispensing) in any 24 months.	
Welcome to Medicare preventive visit Our plan covers the one-time Welcome to Medicare preventive visit. The visit includes a review of your health, as well as education and counseling about preventive services you need (including certain screenings and shots (or vaccines)), and referrals for other care if needed. **Important:** We cover the Welcome to Medicare preventive visit only within the first 12 months you have Medicare Part B. When you make your appointment, let your doctor's office know you want to schedule your Welcome to Medicare preventive visit.	There is no coinsurance, copayment, or deductible for the "Welcome to Medicare" preventive visit.
Note: Go to Chapter 1, Section 6, and Chapter 11, Section 10 for information about coordination of benefits that applies to all covered services described in this Medical Benefits Chart.	

Section 2.1 – Additional chiropractic and acupuncture coverage*

Kaiser Foundation Health Plan, Inc. contracts with American Specialty Health Plans of California, Inc. ("ASH Plans") to make the network of ASH participating providers available to you.

When you need chiropractic care or acupuncture, you have direct access to more than 3,000 licensed chiropractors and more than 2,900 licensed acupuncturists in California. You can obtain covered services from any ASH participating provider without a referral from a plan physician. Your copayment or coinsurance is due when you receive covered services.

Read the following information so you will know from whom or what group of providers you may receive additional chiropractic and acupuncture services.

ASH Plans contracts with ASH participating providers and other licensed providers to provide the services covered under this section (including laboratory tests, X-rays, and chiropractic supports and appliances). You must receive services covered under this section from an ASH participating provider or another licensed provider with which ASH contracts to provide covered

care, except for services covered under "Emergency and urgent chiropractic and acupuncture services" below and services that aren't available from contracted providers and that are authorized in advance by ASH Plans.

A list of ASH participating providers is available on the ASH Plans website at **ashlink.com/ash/kaisercamedicare** or from the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**). The list of ASH Participating Providers is subject to change at any time, without notice. If you have questions, call the ASH Plans Customer Service Department.

How to obtain services

To obtain services covered under this section, call an ASH participating provider to schedule an initial examination. If additional services are required after the initial examination, verification that the services are medically necessary may be required, as described under "Decision time frames" below. Your ASH participating provider will request any required medical necessity determinations. An ASH Plans clinician in the same or similar specialty as the provider of services under review will determine whether the services are or were medically necessary services.

Decision time frames

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

Your ASH participating provider will be informed of the decision within 24 hours after the decision is made. If the services are authorized, your ASH participating provider will be informed of the scope of the authorized services. If ASH Plans doesn't authorize all of the services, ASH Plans will send you a written decision and explanation, including the rationale for the decision and the criteria used to make the decision, within two business days after the decision is made. The letter will also include information about your appeal rights, which are described in Chapter 9. Any written criteria that ASH Plans uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request. If you have questions or concerns, contact ASH Plans or Kaiser Permanente as described under "Customer Service" in this section.

Covered chiropractic and acupuncture services

We cover the services listed in this section, subject to exclusions described in Chapter 4, Section 3.1, only if all of the following conditions are satisfied:

- You're a member on the date that you receive the services.

- ASH Plans has determined that the services are medically necessary, except for:
  - The initial examination described under "Office visits" in this section.
  - Services covered under "Emergency and urgent chiropractic and acupuncture services" in this section.
- You receive the services from ASH participating providers or other licensed providers with which ASH contracts to provide covered care, except for:
  - Services covered under "Emergency and urgent chiropractic and acupuncture services" in this section.
  - Services that aren't available from ASH participating providers or other licensed providers with which ASH contracts to provide covered care and that are authorized in advance by ASH Plans.

When you receive covered services, you must pay the copayment or coinsurance listed in this section. If you receive services that aren't covered under this section, you may be liable for the full price of those services.

Note: If charges for services are less than the copayment described in this section, you will pay the lesser amount.

The copayment or coinsurance you pay for services covered under this section doesn't apply toward any plan out-of-pocket maximum.

If you have questions about copayments or coinsurance for specific services that you're scheduled to receive or that your provider orders during a visit or procedure, call the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**) weekdays, hours may vary.

Coverage of acupuncture services under this section is different from the coverage of acupuncture services listed in the Medical Benefits Chart. You don't need a referral to get covered services under this section, but covered services and your copayments or coinsurance may differ from those under the Medical Benefits Chart. If you receive acupuncture services for which you have a referral (as described under Chapter 3, Section 2.3), then unless you tell us otherwise, we'll assume that you're using your coverage under the Medical Benefits Chart.

Also, refer to the Medical Benefits Chart for information about the chiropractic services that we cover in accord with Medicare guidelines, which are separate from the services covered under this section.

Office visits

We cover up to a combined total of 20 of the following types of office visits per 12-month period at a **$15 copayment per visit:**

- **Initial chiropractic examination:** An examination performed by an ASH participating provider to determine the nature of your problem (and, if appropriate, to prepare a treatment plan), and to provide medically necessary chiropractic services, which may include an adjustment and adjunctive therapy. We cover an initial examination only if you have not already received covered chiropractic services from an ASH participating provider in the same 12-month period for your musculoskeletal and related disorder.

- **Subsequent chiropractic office visits:** Subsequent ASH participating provider office visits for chiropractic services, that are determined to be medically necessary by an ASH Plans clinician. These subsequent office visits may include an adjustment, adjunctive therapy, and a re-examination to assess the need to continue, extend, or change a treatment plan.
- **Initial acupuncture examination:** An examination performed by an ASH participating provider to determine the nature of your problem (and, if appropriate, to prepare a treatment plan), and to provide medically necessary acupuncture services. We cover an initial examination only if you have not already received covered acupuncture services from an ASH participating provider in the same 12-month period for your musculoskeletal and related disorder, nausea, or pain.
- **Subsequent acupuncture office visits:** Subsequent ASH participating provider office visits for acupuncture services that are determined to be medically necessary by an ASH Plans clinician, which may include a re-examination to assess the need to continue, extend, or change a treatment plan.

Each office visit counts toward any visit limit, if applicable.

Laboratory tests and X-rays

We cover medically necessary laboratory tests and X-rays when prescribed as part of covered chiropractic care described under "Office visits" in this section at **no charge** when an ASH participating provider provides the services or refers you to another licensed provider with which ASH contracts to provide covered services.

Chiropractic supports and appliances

We provide a **$50 allowance per 12-month period** toward the ASH Plans fee schedule price for chiropractic appliances listed in this paragraph when the item is prescribed and provided to you by an ASH Participating Provider as part of covered chiropractic care described under "Office visits" in this section. If the price of the items in the ASH Plans fee schedule exceeds **$50** (the allowance), you will pay the amount in excess of **$50** (and that payment doesn't apply toward the plan out-of-pocket maximum described in Section 1.2). Covered chiropractic appliances are limited to: elbow supports, back supports (thoracic), cervical collars, cervical pillows, heel lifts, hot or cold packs, lumbar braces and supports, lumbar cushions, orthotics, wrist supports, rib belts, home traction units (cervical or lumbar), ankle braces, knee braces, rib supports, and wrist braces.

Second opinions

You may request a second opinion in regard to covered Services by contacting another ASH participating provider. Your visit to another ASH participating provider for a second opinion generally will count toward any visit limit, if applicable. An ASH participating provider may also request a second opinion in regard to covered services by referring you to another ASH participating provider in the same or similar specialty. If you're referred by an ASH participating provider to another ASH participating provider, or you see an ASH participating provider for lab work or an X-ray, your visit to the other ASH participating provider won't count toward any visit limit. An authorization or denial of your request for a second opinion will be provided in an expeditious manner, as appropriate for your condition. If your request for a second opinion is

denied, you will be notified in writing of the reasons for the denial, and of your right to file a grievance as described under "Grievances" in this section.

Emergency and urgent chiropractic and acupuncture services

We cover emergency chiropractic services and urgent chiropractic services provided by an ASH participating provider or a non–participating provider at a **$15 copayment per visit**. We don't cover follow-up or continuing care from a non-participating provider unless ASH Plans has authorized the services in advance. Also, we don't cover services from a non-participating provider that ASH Plans determines aren't emergency chiropractic services or urgent chiropractic services.

Emergency and urgent acupuncture services

We cover emergency acupuncture services and urgent acupuncture services provided by an ASH participating provider or a non–participating provider at a **$15 copayment per visit.** We don't cover follow-up or continuing care from a non–participating provider unless ASH Plans has authorized the services in advance. Also, we don't cover services from a non-participating provider that ASH Plans determines aren't emergency acupuncture services or urgent acupuncture services.

How to file a claim

As soon as possible after receiving emergency chiropractic services or urgent chiropractic services or emergency acupuncture services or urgent acupuncture services, you must file an ASH Plans claim form. To request a claim form or for more information, call ASH Plans toll free at **1-800-678-9133** (TTY users call **711**) or visit the ASH Plans website at **ashlink.com**. You must send the completed claim form to:

ASH Plans
P.O. Box 509002
San Diego, CA 92150-9002

Customer Service

If you have a question or concern regarding the services you received from an ASH participating provider or any other licensed provider with which ASH contracts to provide covered services, you may call the ASH Plans Customer Service Department toll free at **1-800-678-9133** (TTY users call **711**) weekdays, hours may vary, or write ASH Plans at:

ASH Plans
Customer Service Department
P.O. Box 509002
San Diego, CA 92150-9002

Chiropractic and acupuncture grievances

You can file a grievance with Kaiser Permanente regarding any issue. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you're dissatisfied about services you received. You may submit your grievance orally or in writing to Kaiser Permanente as described in Chapter 9.

Section 3 — Services that aren't covered by our plan (exclusions)

This section tells you what services are excluded from Medicare coverage and, therefore, aren't covered by this plan.

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

If you get services that are excluded (not covered), you must pay for them yourself except under the specific conditions listed below. Even if you get the excluded services at an emergency facility, the excluded services are still not covered, and our plan won't pay for them. The only exception is if the service is appealed and decided upon appeal to be a medical service that we should have paid for or covered because of your specific situation. (For information about appealing a decision we have made to not cover a medical service, go to Chapter 9. Section 5.3.)

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Aquatic therapy		Covered when determined to be medically necessary and ordered as part of a physical therapy program.
Care in an intermediate or residential care facility, assisted living facility, or adult foster home		Covered as described in "Residential substance use disorder and mental health treatment" section of the Medical Benefits Chart.
Conception by artificial means, such as in vitro fertilization, zygote intrafallopian transfers, ovum transplants, and gamete intrafallopian transfers (except artificial insemination and related services covered by Medicare)	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Cosmetic surgery or procedures		Covered in cases of an accidental injury or for improvement of the functioning of a malformed body member. Covered for all stages of reconstruction for a breast after a mastectomy, as well as for the unaffected breast to produce a symmetrical appearance.
Custodial care • Custodial care is personal care that doesn't require the continuing attention of trained medical or paramedical personnel, such as care that helps you with activities of daily living, such as bathing or dressing.	**Not covered under any condition**	
Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies		Covered if medically necessary and covered under Original Medicare. We cover gradient compression stockings for lymphedema.

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Elective or voluntary enhancement procedures or services (including weight loss aids, hair growth, sexual performance, athletic performance, cosmetic purposes, anti-aging, and mental performance)		Covered if medically necessary and covered under Original Medicare. We cover drugs when prescribed solely for the purposes of losing weight when medically necessary for the treatment of morbid obesity. We may require members who are prescribed drugs for morbid obesity to be enrolled in a covered comprehensive weight loss program, for a reasonable period of time prior to or concurrent with receiving the prescription drug.
Experimental medical and surgical procedures, equipment, and medications • Experimental procedures and items are those items and procedures determined by our plan and Original Medicare to not be generally accepted by the medical community.		May be covered by Original Medicare under a Medicare-approved clinical research study or by our plan. (Go to Chapter 3, Section 5 for more information on clinical research studies.)
The following eyewear services and items: • Lens protection plan. • Nonprescription products. • Lenses and sunglasses without refractive value, except that this exclusion	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
doesn't apply to a clear balance lens if only one eye needs correction or tinted lenses when medically necessary to treat macular degeneration or retinitis pigmentosa. • Replacement of lost, broken, or damaged lenses or frames. • Eyeglass or contact lens adornment. • Eyewear items that don't require a prescription by law (other than eyeglass frames or a covered balance lens).		
Fees charged for care by your immediate relatives or members of your household.	**Not covered under any condition**	
Full-time nursing care in your home	**Not covered under any condition**	
Homemaker services include basic household help, including light housekeeping or light meal preparation.	**Not covered under any condition**	
Massage therapy	**Not covered under any condition**	
Naturopath services (uses natural or alternative treatments)	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Nonconventional intraocular lenses (IOLs) following cataract surgery (for example, a presbyopia-correcting IOL)		You may request and we may provide insertion of a presbyopia-correcting IOL or astigmatism-correcting IOL following cataract surgery in lieu of a conventional IOL. However, you must pay the difference between Plan Charges for a nonconventional IOL and associated services and Plan Charges for insertion of a conventional IOL following cataract surgery.
Orthopedic shoes or supportive devices for the feet		Shoes that are part of a leg brace and are included in the cost of the brace. Orthopedic or therapeutic shoes for people with diabetic foot disease.
Personal items in your room at a hospital or a skilled nursing facility such as a telephone or a television		Telephones and televisions are provided.
Physical exams and other services (1) required for obtaining or maintaining employment or participation in employee programs, (2) required for insurance or licensing, or (3) on court order or required for parole or probation		Covered if a network physician determines that the services are medically necessary or medically appropriate preventive care.
Private duty nursing	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Private room in a hospital		Covered when medically necessary.
Psychological testing for ability, aptitude, intelligence, or interest	**Not covered under any condition**	
Radial keratotomy, LASIK surgery, and other low-vision aids		One pair of eyeglasses with standard frames (or one set of contact lenses) covered after each cataract surgery that implants an intraocular lens.
Reconstructive surgery that offers only a minimal improvement in appearance or is performed to alter or reshape normal structures of the body in order to improve appearance		We cover reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defect, developmental abnormalities, accidental injury, trauma, infection, tumors, or disease, if a network physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible.
Reversal of sterilization procedures and non-prescription contraceptive supplies	**Not covered under any condition**	
Routine foot care		Some limited coverage provided according to Medicare guidelines (for example, if you have diabetes).

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services considered not reasonable and necessary, according to Original Medicare standards		This exclusion doesn't apply to services or items that aren't covered by Original Medicare but are covered by our plan.
Services provided to veterans in Veterans Affairs (VA) facilities		When emergency services are received at a VA hospital and the VA cost-sharing is more than the cost-sharing under our plan, we'll reimburse veterans for the difference. Members are still responsible for our plan's cost-sharing amounts.
Services related to noncovered services or items		When a service or item is not covered, all services related to the noncovered service or item are excluded, (1) except for services or items we would otherwise cover to treat complications of the noncovered service or item, or (2) unless covered in accord with Medicare guidelines.
Services that are performed safely and effectively by people who don't require licenses or certificates by the state to provide health care services and where the member's condition doesn't require that the services be provided by a licensed health care provider	**Not covered under any condition**	

Services not covered by Medicare	Not covered under any condition	Covered only under specific conditions
Services to reverse voluntary, surgically induced infertility	**Not covered under any condition**	
Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a network provider		Covered as described in the Medical Benefits Chart under "Transportation services" except that transportation won't be provided if the service is not covered under this *Evidence of Coverage*. In addition, non-emergency medical transportation (wheelchair or gurney van) won't be provided if your physical and medical condition allows you to get to your medical appointment by rideshare, taxi, or private transportation.
Travel and lodging expenses		We may pay certain expenses that we preauthorize in accord with our travel and lodging guidelines.

Section 3.1 Chiropractic and acupuncture exclusions

The items and services listed in this "Chiropractic and acupuncture exclusions" section are excluded from coverage, except as covered under the Medical Benefits Chart. These exclusions apply to all services that would otherwise be covered under this *Evidence of Coverage* regardless of whether the services are within the scope of a provider's license or certificate:

- Acupuncture services for conditions other than musculoskeletal and related disorders, nausea, and pain.
- Acupuncture performed with reusable needles.
- Services provided by an acupuncturist that aren't within the scope of licensure for an acupuncturist licensed in California.
- For acupuncture services, adjunctive therapies unless provided during the same course of treatment and in conjunction with acupuncture.

- Services provided by a chiropractor that aren't within the scope of licensure for a chiropractor licensed in California.
- For chiropractic services, adjunctive therapy not associated with spinal, muscle, or joint manipulations.
- Air conditioners, air purifiers, therapeutic mattresses, chiropractic appliances, durable medical equipment, supplies, devices, appliances, and any other item except those listed as covered under Section 2.2.
- Services for asthma or addiction, such as nicotine addiction.
- Hypnotherapy, behavior training, sleep therapy, and weight programs.
- Thermography.
- Experimental or investigational services. If coverage for a service is denied because it is experimental or investigational and you want to appeal the denial, refer to Chapter 9 for information about the appeal process.
- CT scans, MRIs, PET scans, bone scans, nuclear medicine, and any other type of diagnostic imaging or radiology other than X-rays covered under Section 2.2.
- Ambulance and other transportation.
- Education programs, non-medical self-care or self-help, any self-help physical exercise training, and any related diagnostic testing
- Services for pre-employment physicals or vocational rehabilitation.
- Drugs and medicines, including non-legend or proprietary drugs and medicines.
- Services you receive outside the state of California, except for services covered under "Emergency and urgent chiropractic and acupuncture services" in Section 2.2.
- Hospital services, anesthesia, manipulation under anesthesia, and related services.
- Dietary and nutritional supplements, such as vitamins, minerals, herbs, herbal products, injectable supplements, and similar products.
- Massage therapy.
- Maintenance care (services provided to members whose treatment records indicate that they have reached maximum therapeutic benefit).

Chapter 5 — Using plan coverage for Part D drugs

Section 1 — Basic rules for our plan's Part D coverage

Go to the Medical Benefits Chart in Chapter 4 for Medicare Part B drug benefits and hospice drug benefits.

Our plan will generally cover your drugs as long as you follow these rules:

- You must have a provider (a doctor, dentist, or other prescriber) write you a prescription, that's valid under applicable state law.
- Your prescriber must not be on Medicare's Exclusion or Preclusion Lists.
- You generally must use a network pharmacy to fill your prescription. (Go to Section 2 or you can fill your prescription through our plan's mail-order service.)
- Your drug must be on our plan's Drug List (go to Section 3).
- Your drug must be used for a medically accepted indication. A "medically accepted indication" is a use of the drug that is either approved by the FDA or supported by certain references. (Go to Section 3 for more information about a medically accepted indication.)
- Your drug may require approval from our plan based on certain criteria before we agree to cover it. (Go to Section 4 for more information.)

Section 2 — Fill your prescription at a network pharmacy or through our plan's mail-order service

In most cases, your prescriptions are covered *only* if they're filled at our plan's network pharmacies. (Go to Section 2.5 for information about when we cover prescriptions filled at out-of-network pharmacies.)

A network pharmacy is a pharmacy that has a contract with our plan to provide your covered drugs. The term "covered drugs" means all the Part D drugs that are on our plan's Drug List.

Section 2.1 – Network pharmacies

Find a network pharmacy in your area

To find a network pharmacy, go to your *Pharmacy Directory*, visit our website (**kp.org/directory**), and/or call Member Services at **1-800-443-0815** (TTY users call **711**).

You may go to any of our network pharmacies.

If your pharmacy leaves the network

If the pharmacy you use leaves our plan's network, you'll have to find a new pharmacy in the network. To find another pharmacy in your area, get help from Member Services at

1-800-443-0815 (TTY users call **711**) or use the *Pharmacy Directory*. You can also find information on our website at **kp.org/directory**.

Specialized pharmacies

Some prescriptions must be filled at a specialized pharmacy. Specialized pharmacies include:

- Pharmacies that supply drugs for home infusion therapy.
- Pharmacies that supply drugs for residents of a long-term care (LTC) facility. Usually, a LTC facility (such as a nursing home) has its own pharmacy. If you have difficulty getting Part D drugs in an LTC facility, call Member Services at **1-800-443-0815** (TTY users call **711**).
- Pharmacies that serve the Indian Health Service / Tribal / Urban Indian Health Program (not available in Puerto Rico). Except in emergencies, only Native Americans or Alaska Natives have access to these pharmacies in our network. I/T/U pharmacies must be within our service area.
- Pharmacies that dispense drugs restricted by the FDA to certain locations or that require special handling, provider coordination, or education on their use. To locate a specialized pharmacy, go to your *Pharmacy Directory* (**kp.org/directory**) or call Member Services at **1-800-443-0815** (TTY users call **711**).

Section 2.2 – Our plan's mail-order service

For certain kinds of drugs, you can use our plan's network mail-order service. Generally, the drugs provided through mail-order are drugs you take on a regular basis, for a chronic or long-term medical condition. These drugs are marked as **mail-order drugs** in our Drug List.

Our plan's mail-order service allows you to order **up to a 100-day supply**.

To get information about filling your prescriptions by mail, visit your local network pharmacy or our website at **kp.org/refill**. You can conveniently order your prescription refills in the following ways:

- Register and order online securely at **kp.org/refill**.
- Call the number listed on your prescription plan and follow the prompts (be sure to select the mail delivery option when prompted).
- Or, call the number below:
  - *Northern California members* call **1-888-218-6245** (TTY users call **711**), Monday through Friday, 8 a.m. to 8 p.m., Saturday 8 a.m. to 6 p.m. and Sunday 9 a.m. to 6 p.m.
  - *Southern California members* call **1-866-206-2983** (TTY users call **711**), Monday through Friday, 7 a.m. to 7 p.m.
- Mail your prescription or refill request on a mail-order form available at any Kaiser Permanente network pharmacy.

When you order refills for home delivery online, by phone, or in writing, you must pay your cost-sharing when you place your order (there are no shipping charges for regular USPS mail delivery). If you prefer, you may designate a network pharmacy where you want to pick up and pay for your prescription. Contact a network pharmacy if you have a question about whether

your prescription can be mailed or see our Drug List for information about the drugs that can be mailed.

Usually, a mail-order pharmacy order will be delivered to you in no more than 5 days. If your mail-order prescription is delayed, call the number listed above or on your prescription bottle's label for assistance. Also, if you cannot wait for your prescription to arrive from our mail-order pharmacy, you can get an urgent supply by calling your local network retail pharmacy listed in your *Pharmacy Directory* or at **kp.org/directory**. Be aware that you may pay more if you get a 100-day supply from a network retail pharmacy instead of from our mail-order pharmacy.

Refills on mail-order prescriptions. For refills, contact your pharmacy at least 5 days before your current prescription will run out to make sure your next order is shipped to you in time.

Section 2.3 – How to get a long-term supply of drugs

When you get a long-term supply of drugs, your cost sharing may be lower. Our plan offers 2 ways to get a long-term supply (also called an extended supply) of maintenance drugs on our plan's Drug List. (Maintenance drugs are drugs that you take on a regular basis, for a chronic or long-term medical condition.)

- Some retail pharmacies in our network allow you to get a long-term supply of maintenance drugs. Your *Pharmacy Directory* (**kp.org/directory**) tells you which pharmacies in our network can give you a long-term supply of maintenance drugs. You can also call Member Services at **1-800-443-0815** (TTY users call **711**) for more information.
- You can also get maintenance drugs through our mail-order program. Go to Section 2.3, for more information.

Section 2.4 – Using a pharmacy that's not in our plan's network

Generally, we cover drugs filled at an out-of-network pharmacy only when you aren't able to use a network pharmacy. **Check first with Member Services** at **1-800-443-0815** (TTY users call **711**) to see if there's a network pharmacy nearby.

We cover prescriptions filled at an out-of-network pharmacy only in these circumstances:

- If you're traveling within the United States and its territories but outside the service area and you become ill or run out of your covered Part D prescription drugs, we'll cover prescriptions that are filled at an out-of-network pharmacy in limited, nonroutine circumstances according to our Medicare Part D formulary guidelines.
- If you need a Medicare Part D prescription drug in conjunction with covered out-of-network emergency care or out-of-area urgent care, we'll cover up to a 30-day supply from an out-of-network pharmacy. **Note:** Prescription drugs prescribed and provided outside of the United States and its territories as part of covered emergency or urgent care are covered up to a 30-day supply in a 30-day period. These drugs aren't covered under Medicare Part D; therefore, payments for these drugs don't count toward reaching the catastrophic coverage stage.
- If you're unable to obtain a covered drug in a timely manner within our service area because there's no network pharmacy within a reasonable driving distance that provides 24-hour

service. We may not cover your prescription if a reasonable person could have purchased the drug at a network pharmacy during normal business hours.

- If you're trying to fill a prescription for a drug that is not regularly stocked at an accessible network pharmacy or available through our mail-order pharmacy (including high-cost drugs).
- If you're not able to get your prescriptions from a network pharmacy during a disaster.

If you must use an out-of-network pharmacy, you'll generally have to pay the full cost (rather than your normal cost share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost. (Go to Chapter 7, Section 2 for information on how to ask our plan to pay you back.) You may be required to pay the difference between what you pay for the drug at the out-of-network pharmacy and the cost we would cover at an in-network pharmacy.

Section 3 — Your drugs need to be on our plan's Drug List

Section 3.1 – The Drug List tells which Part D drugs are covered

Our plan has a *List of Covered Drugs* (formulary). In this *Evidence of Coverage*, **we call it the Drug List**.

The drugs on this list are selected by our plan with the help of doctors and pharmacists. The list meets Medicare's requirements and has been approved by Medicare. The Drug List only shows drugs covered under Medicare Part D.

We generally cover a drug on our plan's Drug List as long as you follow the other coverage rules explained in this chapter and use of the drug is for a medically accepted indication. A medically accepted indication is a use of the drug that is *either*:

- Approved by the FDA for the diagnosis or condition for which it's being prescribed, or
- Supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System.

Certain drugs may be covered for some medical conditions but are considered non-formulary for other medical conditions. These drugs will be identified on our Drug List and on **www.Medicare.gov**, along with the specific medical conditions that they cover.

The Drug List includes brand name drugs, generic drugs, and biological products (which may include biosimilars).

A brand-name drug is a prescription drug sold under a trademarked name owned by the drug manufacturer. Biological products are drugs that are more complex than typical drugs. On the Drug List, when we refer to drugs, this could mean a drug or a biological product.

A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. Biological products have alternatives called biosimilars. Generally, generics and biosimilars work just as well as the brand-name drug or original biological product and usually cost less. There are generic drug substitutes available for many brand-name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at

the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand name drugs.

Go to Chapter 12 for definitions of types of drugs that may be on the Drug List.

Drugs that aren't on the Drug List

Our plan doesn't cover all prescription drugs.

- In some cases, the law doesn't allow any Medicare plan to cover certain types of drugs. (For more information, go to Section 7.)
- In other cases, we decided not to include a particular drug on the Drug List.
- In some cases, you may be able to get a drug that's not on the Drug List. (For more information, go to Chapter 9.)

Section 3.2 – Three cost-sharing tiers for drugs on the Drug List

Every drug on our plan's Drug List is in one of three cost-sharing tiers:

- Cost-sharing for generic drugs in Tiers 1-2.
- Cost-sharing for brand-name drugs and specialty-tier drugs in Tiers 3-5.
- Cost-sharing for injectable Part D vaccines in Tier 6 (this tier includes only brand-name drugs).

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List. The amount you pay for drugs in each cost-sharing tier is shown in Chapter 6.

Section 3.3 – How to find out if a specific drug is on the Drug List

To find out if a drug is on our Drug List, you have these options:

- Check the most recent Drug List we provided electronically.
- Visit our plan's website (**kp.org/seniorrx**). The Drug List (*2026 Comprehensive Formulary*) on the website is always the most current.
- Call Member Services at **1-800-443-0815** (TTY users call **711**) to find out if a particular drug is on our plan's Drug List (*2026 Comprehensive Formulary*) or ask for a copy of the list.
- Use our plan's "Real-Time Benefit Tool" (**kp.org/seniorrx**) to search for drugs on the Drug List to get an estimate of what you'll pay and see if there are alternative drugs on the Drug List that could treat the same condition. You can also call Member Services at **1-800-443-0815** (TTY users call **711**).

Section 4 — Drugs with restrictions on coverage

Section 4.1 – Why some drugs have restrictions

For certain prescription drugs, special rules restrict how and when our plan covers them. A team of doctors and pharmacists developed these rules to encourage you and your provider to use

drugs in the most effective way. To find out if any of these restrictions apply to a drug you take or want to take, check the Drug List.

If a safe, lower-cost drug will work just as well medically as a higher-cost drug, our plan's rules are designed to encourage you and your provider to use that lower-cost option.

Note that sometimes a drug may appear more than once on our Drug List. This is because the same drugs can differ based on the strength, amount, or form of the drug prescribed by your health care provider, and different restrictions or cost-sharing may apply to the different versions of the drug (for example, 10 mg versus 100 mg; one per day versus 2 per day; tablet versus liquid).

Section 4.2 – Types of restrictions

If there's a restriction for your drug, it usually means that you or your provider have to take extra steps for us to cover the drug. Call Member Services at **1-800-443-0815** (TTY users call **711**) to learn what you or your provider can do to get coverage for the drug. **If you want us to waive the restriction for you, you need to use the coverage decision process and ask us to make an exception**. We may or may not agree to waive the restriction for you. (Go to Chapter 9.)

Getting plan approval in advance

For certain drugs, you or your provider need to get approval from our plan based on specific criteria before we agree to cover the drug for you. This is called **prior authorization**. This is put in place to ensure medication safety and help guide appropriate use of certain drugs. If you don't get this approval, your drug might not be covered by our plan. Our plan’s prior authorization criteria can be obtained by calling Member Services at **1-800-443-0815** (TTY users call **711**).

Trying a different drug first

This requirement encourages you to try less costly but usually just as effective drugs before our plan covers another drug. For example, if Drug A and Drug B treat the same medical condition, our plan may require you to try Drug A first. If Drug A doesn't work for you, our plan will then cover Drug B. This requirement to try a different drug first is called **step therapy.** Our plan's step therapy criteria can be obtained by calling Member Services at **1-800-443-0815** (TTY users call **711**).

Quantity limits

For certain drugs, we limit how much of a drug you can get each time you fill your prescription. For example, if it's normally considered safe to take only one pill per day for a certain drug, we may limit coverage for your prescription to no more than one pill per day.

Section 5 — What you can do if one of your drugs isn't covered the way you'd like

There are situations where a prescription drug you take, or that you and your provider think you should take that isn't on our Drug List has restrictions. For example:

- The drug might not be covered at all. Or a generic version of the drug may be covered but the brand-name version you want to take isn't covered.
- The drug is covered, but there are extra rules or restrictions on coverage.
- The drug is covered, but in a cost-sharing tier that makes your cost-sharing more expensive than you think it should be.

If your drug is in a cost-sharing tier that makes your cost more expensive than you think it should be, go to Section 5.1 to learn what you can do.

If your drug isn't on the Drug List or is restricted, here are options for what you can do:

- You may be able to get a temporary supply of the drug.
- You can change to another drug.
- You can ask for an **exception** and ask our plan to cover the drug or remove restrictions from the drug.

You may be able to get a temporary supply

Under certain circumstances, our plan must provide a temporary supply of a drug you're already taking. This temporary supply gives you time to talk with your provider about the change.

To be eligible for a temporary supply, the drug you take **must no longer be on the Drug List OR is now restricted in some way**.

- **If you're a new member**, we'll cover a temporary supply of your drug during the first 90 days of your membership in our plan.
- **If you were in our plan last year**, we'll cover a temporary supply of your drug during the first 90 days of the calendar year.
  - This temporary supply will be for a maximum of a 30-day supply. If your prescription is written for fewer days, we'll allow multiple fills to provide up to a maximum of a 30-day supply of medication. The prescription must be filled at a network pharmacy. (Note that a long-term care pharmacy may provide the drug in smaller amounts at a time to prevent waste.)
- **For members who've been in our plan for more than 90 days and live in a long-term care facility and need a supply right away:** We'll cover one 31-day emergency supply of a particular drug, or less if your prescription is written for fewer days. This is in addition to the above temporary supply.
- **For current members with level of care changes:** If you enter into or are discharged from a hospital, skilled nursing facility, or long-term care facility to a different care setting or home, this is what is known as a level of care change. When your level of care changes, you may

require an additional fill of your medication. We'll generally cover up to a one-month supply of your Part D drugs during this level of care transition period even if the drug is not on our Drug List.

For questions about a temporary supply, call Member Services at **1-800-443-0815** (TTY users call **711**).

During the time when you're using a temporary supply of a drug, you should talk with your provider to decide what to do when your temporary supply runs out. You have 2 options:

Option 1. You can change to another drug

Talk with your provider about whether a different drug covered by our plan may work just as well for you. Call Member Services at **1-800-443-0815** (TTY users call **711**) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

Option 2. You can ask for an exception

You and your provider can ask our plan to make an exception and cover the drug in the way you'd like it covered. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception. For example, you can ask our plan to cover a drug even though it is not on our plan's Drug List. Or you can ask our plan to make an exception and cover the drug without restrictions.

If you and your provider want to ask for an exception, go to Chapter 9, Section 6.4 to learn what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Section 5.1 – What to do if your drug is in a cost-sharing tier you think is too high

If your drug is in a cost-sharing tier you think is too high, here are things you can do:

You can change to another drug

If your drug is in a cost-sharing tier you think is too high, talk to your provider. There may be a different drug in a lower cost-sharing tier that might work just as well for you. Call Member Services at **1-800-443-0815** (TTY users call **711**) to ask for a list of covered drugs that treat the same medical condition. This list can help your provider find a covered drug that might work for you.

You can ask for an exception

You and your provider can ask our plan to make an exception in the cost-sharing tier for the drug so that you pay less for it. If your provider says you have medical reasons that justify asking us for an exception, your provider can help you ask for an exception to the rule.

If you and your provider want to ask for an exception, go to Chapter 9, Section 6.4 for what to do. It explains the procedures and deadlines set by Medicare to make sure your request is handled promptly and fairly.

Specialty drugs aren't eligible for this type of exception. We don't lower the cost-sharing amount for drugs in this tier.

Section 6 — Our Drug List can change during the year

Most changes in drug coverage happen at the beginning of each year (January 1). However, during the year, our plan can make some changes to the Drug List. For example, our plan might:

- **Add or remove drugs from the Drug List.**
- **Move a drug to a higher or lower cost-sharing tier.**
- **Add or remove a restriction on coverage for a drug.**
- **Replace a brand-name drug with a generic version of the drug.**

We must follow Medicare requirements before we change our plan's Drug List.

Information on changes to drug coverage

When changes to the Drug List occur, we post information on our website about those changes. We also update our online Drug List regularly. Sometimes you'll get direct notice if changes are made to a drug that you take.

Changes to drug coverage that affect you during this plan year

- **Adding new drugs to the Drug List and <u>immediately</u> removing or making changes to a like drug on the Drug List.**
  - When adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
  - We'll make these immediate changes only if we add a new generic version of a brand name or add certain new biosimilar versions of an original biological product that was already on the Drug List.
  - We may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made.
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List.**
  - When adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions.
  - We'll make these changes only if we add a new generic version of a brand-name drug or add certain new biosimilar versions of an original biological product that was already on the Drug List.

- ♦ We'll tell you at least 30 days before we make the change or tell you about the change and cover a 30-day fill of the version of the drug you're taking.

- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market.**
  - ♦ Sometimes a drug can be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you take that drug, we'll tell you after we make the change.
- **Making other changes to drugs on the Drug List.**
  - ♦ We may make other changes once the year has started that affect drugs you're taking. For example, based on FDA boxed warnings or new clinical guidelines recognized by Medicare.
  - ♦ We'll tell you at least 30 days before we make these changes or tell you about the change and cover an additional 30-day fill of the drug you're taking.

If we make changes to any of the drugs you take, talk with your prescriber about the options that would work best for you, including changing to a different drug to treat your condition, or asking for a coverage decision to satisfy any new restrictions on the drug you take. You or your prescriber can ask us for an exception to continue covering the drug or version of the drug you take. For more information on how to ask for a coverage decision, including an exception, go to Chapter 9.

Changes to the Drug List that don't affect you during this plan year

We may make certain changes to the Drug List that aren't described above. In these cases, the change won't apply to you if you're taking the drug when the change is made; however, these changes will likely affect you starting January 1 of the next plan year if you stay in the same plan.

In general, changes that won't affect you during the current plan year are:

- We move your drug into a higher cost-sharing tier.
- We put a new restriction on the use of your drug.
- We remove your drug from the Drug List.

If any of these changes happen for a drug you take (except for market withdrawal, a generic drug replacing a brand-name drug, or other change noted in the sections above), the change won't affect your use or what you pay as your share of the cost until January 1 of the next year.

We won't tell you about these types of changes directly during the current plan year. You'll need to check the Drug List for the next plan year (when the list is available during the open enrollment period) to see if there are any changes to drugs you take that will impact you during the next plan year.

Section 7 — Types of drugs we don't cover

Some kinds of prescription drugs are excluded. This means Medicare doesn't pay for these drugs.

If you get drugs that are excluded (except for certain excluded drugs covered under our enhanced drug coverage), you must pay for them yourself. If you appeal and the requested drug is found not to be excluded under Part D, we'll pay for or cover it. (For information about appealing a decision, go to Chapter 9.)

Here are 3 general rules about drugs that Medicare drug plans won't cover under Part D:

- Our plan's Part D drug coverage can't cover a drug that would be covered under Medicare Part A or Part B.
- Our plan can't cover a drug purchased outside the United States or its territories.
- Our plan can't cover *off-label* use of a drug when the use isn't supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information System. *Off-label* use is any use of the drug other than those indicated on a drug’s label as approved by the FDA.

In addition, by law, the following categories of drugs aren't covered by Medicare drug plans, but may be covered as described under the "Non-Medicare prescription drugs, supplies, and supplements" section in the Medical Benefits Chart:

- Non-prescription drugs (also called over-the-counter drugs).
- Drugs used to promote fertility.
- Drugs used for the relief of cough or cold symptoms.
- Drugs used for cosmetic purposes or to promote hair growth.
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations.
- Drugs used for the treatment of sexual or erectile dysfunction.
- Drugs used for treatment of anorexia, weight loss, or weight gain.
- Outpatient drugs for which the manufacturer requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale.

We offer additional coverage of some prescription drugs (enhanced drug coverage) not normally covered in a Medicare prescription drug plan. Go to the "Non-Medicare prescription drugs, supplies, and supplements" section in the Medical Benefits Chart for details, including any limitations. The amount you pay for these drugs doesn’t count towards qualifying you for the Catastrophic Coverage Stage. (The Catastrophic Coverage Stage is described in Chapter 6, Section 6.

If you get Extra Help from Medicare to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. (Go to our plan's Drug List or call Member Services at **1-800-443-0815** (TTY users call **711**) for more information.) If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in Chapter 2, Section 6.)

Section 8 — How to fill a prescription

To fill your prescription, provide our plan membership information (which can be found on your membership card) at the network pharmacy you choose. The network pharmacy will automatically bill our plan for *our* share of your drug cost. You need to pay the pharmacy *your* share of the cost when you pick up your prescription.

If you don't have our plan membership information with you, you or the pharmacy can call our plan to get the information, or you can ask the pharmacy to look up our plan enrollment information.

If the pharmacy can't get the necessary information, **you may have to pay the full cost of the prescription when you pick it up**. You can then **ask us to reimburse you** for our share. Go to Chapter 7, Section 2 for information about how to ask our plan for reimbursement.

Section 9 — Part D drug coverage in special situations

Section 9.1 – In a hospital or a skilled nursing facility for a stay covered by our plan

If you're admitted to a hospital or to a skilled nursing facility for a stay covered by our plan, we'll generally cover the cost of your prescription drugs during your stay. Once you leave the hospital or skilled nursing facility, our plan will cover your prescription drugs as long as the drugs meet all our rules for coverage described in this chapter.

Section 9.2 – As a resident in a long-term care (LTC) facility

Usually, a long-term care (LTC) facility (such as a nursing home) has its own pharmacy or uses a pharmacy that supplies drugs for all its residents. If you're a resident of an LTC facility, you may get your prescription drugs through the facility's pharmacy or the one it uses, as long as it's part of our network.

Check your *Pharmacy Directory* (**kp.org/directory**) to find out if your LTC facility's pharmacy or the one it uses is part of our network. If it isn't, or if you need more information or help, call Member Services at **1-800-443-0815** (TTY users call **711**). If you're in an LTC facility, we must ensure that you're able to routinely get your Part D benefits through our network of LTC pharmacies.

If you're a resident in an LTC facility and need a drug that's not on our Drug List or restricted in some way, go to Section 5 for information about getting a temporary or emergency supply.

Section 9.3 – Special note about creditable coverage

Each year you will receive a notice that tells you if your drug coverage for the next calendar year is creditable.

If the coverage from the group plan is creditable, it means that our plan has drug coverage that is expected to pay, on average, at least as much as Medicare's standard drug coverage.

Keep any notices about creditable coverage because you may need these notices later to show that you maintained creditable coverage. If you didn't get a creditable coverage notice, ask for a copy from your employer or retiree plan's benefits administrator or the employer or union.

Section 9.4 – If you're in a Medicare-certified hospice

Except for Part B Only plan members whose hospice care is covered by our plan, hospice and our plan don't cover the same drug at the same time. If you're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea, drugs laxatives, pain medication or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in getting these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover your drugs as explained in this document. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, bring documentation to the pharmacy to verify your revocation or discharge.

Section 10 — Programs on drug safety and managing medications

We conduct drug use reviews to help make sure our members get safe and appropriate care.

We do a review each time you fill a prescription. We also review our records on a regular basis. During these reviews, we look for potential problems like:

- Possible medication errors.
- Drugs that may not be necessary because you take another similar drug to treat the same condition.
- Drugs that may not be safe or appropriate because of your age or gender.
- Certain combinations of drugs that could harm you if taken at the same time.
- Prescriptions for drugs that have ingredients you're allergic to.
- Possible errors in the amount (dosage) of a drug you take.
- Unsafe amounts of opioid pain medications.

If we see a possible problem in your use of medications, we'll work with your provider to correct the problem.

Section 10.1 – Drug Management Program (DMP) to help members safely use opioid medications

We have a program that helps make sure members safely use prescription opioids and other frequently abused medications. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several prescribers or pharmacies, or if you had a recent opioid overdose, we may talk to your prescribers to make sure your use of opioid medications is appropriate and medically necessary. Working with your prescribers, if we decide your use of prescription opioid or benzodiazepine medications may not be safe, we may limit how you can get those medications. If we place you in our DMP, the limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain pharmacy(ies).
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from a certain prescriber(s).
- Limiting the amount of opioid or benzodiazepine medications we'll cover for you.

If we plan on limiting how you get these medications or how much you can get, we'll send you a letter in advance. The letter will tell you if we'll limit coverage of these drugs for you, or if you'll be required to get the prescriptions for these drugs only from a specific prescriber or pharmacy. You'll have an opportunity to tell us which prescribers or pharmacies you prefer to use, and about any other information you think is important for us to know. After you've had the opportunity to respond, if we decide to limit your coverage for these medications, we'll send you another letter confirming the limitation. If you think we made a mistake or you disagree with our decision or with the limitation, you and your prescriber have the right to appeal. If you appeal, we'll review your case and give you a new decision. If we continue to deny any part of your request about the limitations that apply to your access to medications, we'll automatically send your case to an independent reviewer outside of our plan. Go to Chapter 9 for information about how to ask for an appeal.

You won't be placed in our DMP if you have certain medical conditions, such as cancer-related pain or sickle cell disease, you're getting hospice, palliative, or end-of-life care, or live in a long-term care facility.

Section 10.2 – Medication Therapy Management (MTM) program to help members manage medications

We have a program that can help our members with complex health needs. Our program is called a Medication Therapy Management (MTM) program. This program is voluntary and free. A team of pharmacists and doctors developed the program for us to help make sure our members get the most benefit from the drugs they take.

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about

your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will get information on the safe disposal of prescription medications that are controlled substances.

It's a good idea to talk to your doctor about your recommended to-do list and medication list. Bring the summary with you to your visit or anytime you talk with your doctors, pharmacists, and other health care providers. Keep your medication list up-to-date and with you (for example, with your ID) in case you go to the hospital or emergency room.

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call Member Services at **1-800-443-0815** (TTY users call **711**).

Chapter 6 — What you pay for Part D drugs

Section 1 — What you pay for Part D drugs

If you're in a program that helps pay for your drugs, **some information in this** *Evidence of Coverage* **about the costs for Part D prescription drugs does not apply to you.** We sent you a separate insert, called the *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs* (also known as the *Low-Income Subsidy Rider* or the *LIS Rider*), which tells you about your drug coverage. If you don't have this insert, call Member Services at **1-800-443-0815** (TTY users call **711**) and ask for the *LIS Rider*.

Section 1.1 – Use this chapter together with other materials that explain your drug coverage

We use "drug" in this chapter to mean a Part D prescription drug. Not all drugs are Part D drugs. Some drugs are covered under Medicare Part A or Part B and other drugs are excluded from Medicare coverage by law.

To understand the payment information, you need to know what drugs are covered, where to fill your prescriptions, and what rules to follow when you get your covered drugs. Chapter 5 explains these rules. When you use our plan's "Real-Time Benefit Tool" to look up drug coverage (**kp.org/seniorrx**), the cost you see shows an estimate of the out-of-pocket costs you're expected to pay. You can also get information provided by the "Real-Time Benefit Tool" by calling Member Services at **1-800-443-0815** (TTY users call **711**).

Section 1.2 – Types of out-of-pocket costs you may pay for covered drugs

There are 3 different types of out-of-pocket costs for covered Part D drugs that you may be asked to pay:

- **Deductible** is the amount you pay for drugs before our plan starts to pay our share.
- **Copayment** is a fixed amount you pay each time you fill a prescription.
- **Coinsurance** is a percentage of the total cost you pay each time you fill a prescription.

Section 1.3 – How Medicare calculates your out-of-pocket costs

Medicare has rules about what counts and what doesn't count toward your out-of-pocket costs. Here are the rules we must follow to keep track of your out-of-pocket costs.

These payments <u>are included</u> in your out-of-pocket costs

Your out-of-pocket costs **include** the payments listed below (as long as they are for covered Part D drugs, and you followed the rules for drug coverage explained in Chapter 5):

- The amount you pay for drugs when you're in the Initial Coverage Stage.

- Any payments you made during this calendar year as a member of a different Medicare drug plan before you joined our plan.
- Any payments for your drugs made by family or friends.
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, and most charities.

Moving to the Catastrophic Coverage Stage:

When you (or those paying on your behalf) have spent a total of **$2,100** in out-of-pocket costs within the calendar year, you move from the Initial Coverage Stage to the Catastrophic Coverage Stage.

These payments aren't included in your out-of-pocket costs

Your out-of-pocket costs **don't include** any of these types of payments:

- Your portion of the plan premium, if any.
- Drugs you buy outside the United States and its territories.
- Drugs that aren't covered by our plan.
- Drugs you get at an out-of-network pharmacy that don't meet our plan's requirements for out-of-network coverage.
- Prescription drugs and vaccines covered by Part A or Part B.
- Payments you make toward drugs covered under our additional coverage but not normally covered in a Medicare Drug Plan.
- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA).
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation).
- Payments made by drug manufacturers under the Manufacturer Discount Program.

Reminder: If any other organization like the ones listed above pays part or all your out-of-pocket costs for drugs, you're required to tell our plan by calling Member Services at **1-800-443-0815** (TTY users call **711**).

Tracking your out-of-pocket total costs

- The *Part D Explanation of Benefits* (EOB) you get includes the current total of your out-of-pocket costs. When this amount reaches **$2,100**, the *Part D EOB* will tell you that you left the Initial Coverage Stage and moved to the Catastrophic Coverage Stage.
- **Make sure we have the information we need**. Go to Section 3.1 to learn what you can do to help make sure our records of what you spent are complete and up-to-date.

Section 2 — Drug payment stages for Senior Advantage members

There are **3 drug payment stages** for your drug coverage under our plan. How much you pay for each prescription depends on what stage you're in when you get a prescription filled or refilled. Details of each stage are explained in this chapter. The stages are:

Stage 1: Yearly Deductible Stage

Stage 2: Initial Coverage Stage

Stage 3: Catastrophic Coverage Stage

Section 3 — Your *Part D Explanation of Benefits (EOB)* explains which payment stage you're in

Our plan keeps track of your prescription drug costs and the payments you make when you get prescriptions at the pharmacy. This way, we can tell you when you move from one drug payment stage to the next. We track 2 types of costs:

- **Out-of-Pocket Costs:** this is how much you paid. This includes what you paid when you get a covered Part D drug, any payments for your drugs made by family or friends, and any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, charities, and most State Pharmaceutical Assistance Programs (SPAPs).
- **Total Drug Costs:** this is the total of all payments made for your covered Part D drugs. It includes what our plan paid, what you paid, and what other programs or organizations paid for your covered Part D drugs.

If you filled one or more prescriptions through our plan during the previous month, we'll send you a *Part D EOB*. The *Part D EOB* includes:

- **Information for that month.** This report gives payment details about prescriptions you filled during the previous month. It shows the total drug costs, what our plan paid, and what you and others paid on your behalf.
- **Totals for the year since January 1.** This shows the total drug costs and total payments for your drugs since the year began.
- **Drug price information.** This displays the total drug price, and information about changes in price from first fill for each prescription claim of the same quantity.
- **Available lower-cost alternative prescriptions.** This shows information about other available drugs with lower cost-sharing for each prescription claim, if applicable.

Section 3.1 – Help us keep our information about your drug payments up to date

To keep track of your drug costs and the payments you make for drugs, we use records we get from pharmacies. Here's how you can help us keep your information correct and up to date:

- **Show your membership card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay.
- **Make sure we have the information we need.** There are times you may pay for the entire cost of a prescription drug. In these cases, we won't automatically get the information we need to keep track of your out-of-pocket costs. To help us keep track of your out-of-pocket costs, give us copies of your receipts. **Examples of when you should give us copies of your drug receipts**:
  - When you purchase a covered drug at a network pharmacy at a special price or use a discount card that's not part of our plan's benefit.
  - When you pay a copayment for drugs provided under a drug manufacturer patient assistance program.
  - Any time you buy covered drugs at out-of-network pharmacies or pay the full price for a covered drug under special circumstances.
  - If you're billed for a covered drug, you can ask our plan to pay our share of the cost. For instructions on how to do this, go to Chapter 7, Section 2.
- **Send us information about the payments others make for you.** Payments made by certain other people and organizations also count toward your out-of-pocket costs. For example, payments made by an AIDS drug assistance program (ADAP), the Indian Health Service, and charities count toward your out-of-pocket costs. Keep a record of these payments and send them to us so we can track your costs.
- **Check the written report we send you.** When you get the *Part D EOB*, look it over to be sure the information is complete and correct. If you think something is missing or you have questions, call Member Services at **1-800-443-0815** (TTY users call **711**). You can also choose to view your *Part D EOB* online instead of by mail. Visit **kp.org/goinggreen** and sign on to learn more about choosing to view your *Part D EOB* securely online. Be sure to keep these reports.

Section 4 — There's no deductible for Senior Advantage

There is no deductible for Senior Advantage. You begin in the Initial Coverage Stage when you fill your first prescription of the year. Go to Section 5 for information about your coverage in the Initial Coverage Stage.

Section 5 — The Initial Coverage Stage

Section 5.1 – What you pay for a drug depends on the drug and where you fill your prescription

During the Initial Coverage Stage, our plan pays its share of the cost of your covered drugs, and you pay your share (your copayment or coinsurance amount). Your share of the cost will vary depending on the drug and where you fill your prescription.

Our plan has three cost-sharing tiers

Every drug on our plan's Drug List is in one of three cost-sharing tiers:

- Cost-sharing for generic drugs in Tiers 1-2.
- Cost-sharing for brand-name drugs and specialty-tier drugs in Tiers 3-5.
- Cost-sharing for injectable Part D vaccines in Tier 6 (this tier includes only brand-name drugs).

To find out which cost-sharing tier your drug is in, look it up in our plan's Drug List.

Your pharmacy choices

How much you pay for a drug depends on whether you get the drug from:

- A network retail pharmacy.
- A pharmacy that isn't in our plan's network. We cover prescriptions filled at out-of-network pharmacies in only limited situations. Go to Chapter 5, Section 2.5 to find out when we'll cover a prescription filled at an out-of-network pharmacy.
- Our plan's mail-order pharmacy.

For more information about these pharmacy choices and filling your prescriptions, go to Chapter 5 and our plan's *Pharmacy Directory* (**kp.org/directory**).

Section 5.2 – Your costs for a *one-month* supply of a covered drug

During the Initial Coverage Stage, your share of the cost of a covered drug will be either a copayment or coinsurance.

The amount of the copayment or coinsurance depends on the cost-sharing tier.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your costs for a *one-month* supply of a covered Part D drug

Tier	Retail cost-sharing (in-network)	Mail-order cost-sharing	Long-term care (LTC) cost-sharing	Out-of-network cost-sharing (Coverage is limited to certain situations; go to Chapter 5 for details)
	(up to a 30-day supply)		(up to a 31-day supply)	(up to a 30-day supply)
Generic drugs (Tiers 1-2)	**$5**			
Brand-name and Specialty drugs (Tiers 3-5)	**$20**			
Injectable Part D vaccines (Tier 6)	**$0**	Mail-order isn't available.	**$0**	

Go to Section 7 for more information on cost-sharing for Part D vaccines.

Section 5.3 – If your doctor prescribes less than a full month's supply, you may not have to pay the cost of the entire month's supply

Typically, the amount you pay for a drug covers a full month's supply. There may be times when you or your doctor would like you to have less than a month's supply of a drug (for example, when you're trying a medication for the first time). You can also ask your doctor to prescribe, and your pharmacist to dispense, less than a full month's supply, if this will help you better plan refill dates.

If you get less than a full month's supply of certain drugs, you won't have to pay for the full month's supply.

- If you're responsible for coinsurance, you pay a percentage of the total cost of the drug. Since the coinsurance is based on the total cost of the drug, your cost will be lower since the total cost for the drug will be lower.
- If you're responsible for a copayment for the drug, you only pay for the number of days of the drug that you get instead of a whole month. We calculate the amount you pay per day for your drug (the daily cost-sharing rate) and multiply it by the number of days of the drug you get.

Section 5.4 – Your costs for a *long-term* (up to a 100-day) supply of a covered Part D drug

For some drugs, you can get a long-term supply (also called an extended supply). A long-term supply is up to a 100-day supply.

Sometimes the cost of the drug is lower than your copayment. In these cases, you pay the lower price for the drug instead of the copayment.

Your costs for a *long-term* (up to a 100-day) supply of a covered Part D drug

Tier	Retail cost-sharing (in-network)		Mail-order cost-sharing
	31-60 day supply	61-100 day supply	31-100 day supply
Generic drugs (Tiers 1-2)	**$10**	**$15**	**$10**
Brand-name and Specialty drugs (Tiers 3-5)	**$40**	**$60**	**$40**
Injectable Part D vaccines (Tier 6)	**A long-term supply isn't available.**		

Section 5.5 – You stay in the Initial Coverage Stage until your out-of-pocket costs for the year reach $2,100

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach **$2,100**. You then move to the Catastrophic Coverage Stage.

We offer additional coverage on some prescription drugs that aren't normally covered in a Medicare Prescription Drug Plan. Payments made for these drugs won’t count towards your total out-of-pocket costs.

The *Part D EOB* you get will help you keep track of how much you, our plan, and any third parties have spent on your behalf during the year. Not all members will reach the **$2,100** out-of-pocket limit in a year.

We'll let you know if you reach this amount. Go to Section 1.3 for more information on how Medicare calculates your out-of-pocket costs.

Section 6 — The Catastrophic Coverage Stage

In the Catastrophic Coverage Stage, you pay nothing for covered Part D drugs. You enter the Catastrophic Coverage Stage when your out-of-pocket costs reach the **$2,100** limit for the calendar year. Once you're in the Catastrophic Coverage Stage, you'll stay in this payment stage until the end of the calendar year.

During this payment stage, you pay nothing for your covered Part D drugs.

Section 7 — What you pay for Part D vaccines

Important message about what you pay for vaccines – Some vaccines are considered medical benefits and are covered under Part B. Other vaccines are considered Part D drugs. You can find these vaccines listed in our plan's Drug List. Our plan covers most adult Part D vaccines at no cost to you. Go to our plan's Drug List or call Member Services at **1-800-443-0815** (TTY users call **711**) for coverage and cost-sharing details about specific vaccines.

There are 2 parts to our coverage of Part D vaccines:

- The first part is the cost of **the vaccine itself**.
- The second part is for the cost of **giving you the vaccine**. (This is sometimes called the administration of the vaccine.)

Your costs for a Part D vaccine depend on 3 things:

1. **Whether the vaccine is recommended for adults by an organization called the Advisory Committee on Immunization Practices (ACIP).**
   - ♦ Most adult Part D vaccines are recommended by ACIP and cost you nothing.
2. **Where you get the vaccine.**
   - ♦ The vaccine itself may be dispensed by a pharmacy or provided by the doctor's office.
3. **Who gives you the vaccine.**
   - ♦ A pharmacist or another provider may give the vaccine in the pharmacy. Or a provider may give it in the doctor's office.

What you pay at the time you get the Part D vaccine can vary depending on the circumstances and what **drug payment stage** you're in.

- When you get a vaccine, you may have to pay the entire cost for both the vaccine itself and the cost for the provider to give you the vaccine. You can ask our plan to pay you back for our share of the cost. For most adult Part D vaccines, this means you'll be reimbursed the entire cost you paid.
- Other times, when you get a vaccine, you pay only your share of the cost under your Part D benefit. For most adult Part D vaccines, you pay nothing.

Below are 3 examples of ways you might get a Part D vaccine.

Situation 1: You get the Part D vaccine at the network pharmacy. (Whether you have this choice depends on where you live. Some states don't allow pharmacies to give certain vaccines.)

- For most adult Part D vaccines, you pay nothing.
- For other Part D vaccines, you pay the pharmacy your copayment for the vaccine itself, which includes the cost of giving you the vaccine.
- Our plan will pay the remainder of the costs.

Situation 2: You get the Part D vaccine at your doctor's office.

- When you get the vaccine, you may have to pay the entire cost of the vaccine itself and the cost for the provider to give it to you.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid. For other Part D vaccines, you'll be reimbursed the amount you paid less any copayment for the vaccine (including administration).

Situation 3: You buy the Part D vaccine itself at the network pharmacy and take it to your doctor's office where they give you the vaccine.

- For most adult Part D vaccines, you pay nothing for the vaccine itself.
- For other Part D vaccines, you pay the pharmacy your copayment for the vaccine itself.
- When your doctor gives you the vaccine, you may have to pay the entire cost for this service.
- You can then ask our plan to pay our share of the cost by using the procedures described in Chapter 7.
- For most adult Part D vaccines, you'll be reimbursed the full amount you paid.

IMPORTANT NOTE: There's no charge for covered Part D vaccines and their administration. However, there may be an office visit charge if administered during a provider office visit.

Chapter 7 — Asking us to pay our share of a bill for covered medical services or drugs

Section 1 — Situations when you should ask us to pay our share for covered services or drugs

Sometimes when you get medical care or a prescription drug, you may need to pay the full cost. Other times, you may find you pay more than you expected under the coverage rules of our plan, or you may get a bill from a provider. In these cases, you can ask our plan to pay you back (reimburse you). It's your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or drugs covered by our plan. There may be deadlines that you must meet to get paid back. Go to Section 2 of this chapter.

There may also be times when you get a bill from a provider for the full cost of medical care you got or for more than your share of cost sharing. First, try to resolve the bill with the provider. If that doesn't work, send the bill to us instead of paying it. We'll look at the bill and decide whether the services should be covered. If we decide they should be covered, we'll pay the provider directly. If we decide not to pay it, we'll notify the provider. You should never pay more than plan-allowed cost sharing. If this provider is contracted, you still have the right to treatment.

Examples of situations in which you may need to ask our plan to pay you back or to pay a bill you got:

1. **When you got emergency or urgently needed medical care from a provider who's not in our plan's network**

   Outside the service area, you can get emergency or urgently needed services from any provider, whether or not the provider is a part of our network. In these cases,

   - You're only responsible for paying your share of the cost for emergency or urgently needed services. Emergency providers are legally required to provide emergency care.
   - If you pay the entire amount yourself at the time you get the care, ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you made.
   - You may get a bill from the provider asking for payment you think you don't owe. Send us this bill, along with documentation of any payments you already made.
     - ♦ If the provider is owed anything, we'll pay the provider directly.
     - ♦ If you already paid more than your share of the cost of the service, we'll determine how much you owed and pay you back for our share of the cost.

2. **When a network provider sends you a bill you think you shouldn't pay**

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

- You only have to pay your cost-sharing amount when you get covered services. We don't allow providers to add additional separate charges, called balance billing. This protection (that you never pay more than your cost-sharing amount) applies even if we pay the provider less than the provider charges for a service and even if there's a dispute and we don't pay certain provider charges.
- Whenever you get a bill from a network provider you think is more than you should pay, send us the bill. We'll contact the provider directly and resolve the billing problem.
- If you already paid a bill to a network provider, but feel you paid too much, send us the bill along with documentation of any payment you made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan.

3. If you're retroactively enrolled in our plan

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

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

4. When you use an out-of-network pharmacy to fill a prescription

If you go to an out-of-network pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover out of network pharmacies in limited circumstances. Go to Chapter 5, Section 2.5 to learn about these circumstances. We may not pay you back the difference between what you paid for the drug at the out-of-network pharmacy and the amount we'd pay at an in-network pharmacy.

5. When you pay the full cost for a prescription because you don't have our plan membership card with you

If you don't have our plan membership card with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can't 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. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

6. When you pay the full cost for a prescription in other situations

You may pay the full cost of the prescription because you find the drug isn't covered for some reason.

- For example, the drug may not be on our plan's Drug List, or it could have a requirement or restriction 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 to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

When you send us a request for payment, we'll review your request and decide whether the service or drug should be covered. This is called making a **coverage decision**. If we decide it should be covered, we'll pay for our share of the cost for the service or drug. If we deny your request for payment, you can appeal our decision. Chapter 9 has information about how to make an appeal.

Section 2 — How to ask us to pay you back or pay a bill you got

You can ask us to pay you back by sending us a request in writing. If you send a request in writing, send your bill and documentation of any payment you have made. It's a good idea to make a copy of your bill and receipts for your records. **You must submit your claim to us within 12 months (for Part C medical claims) and within 36 months (for Part D drug claims)** of the date you got the service, item, or drug.

To make sure you're giving us all the information we need to make a decision, you can fill out our claim form to make your request for payment. You don't have to use the form, but it'll help us process the information faster. You can file a claim to request payment by:

- Completing and submitting our electronic form at **kp.org** and upload supporting documentation.
- Either download a copy of the form from our website (**kp.org**) or call Member Services and ask them to send you the form. Mail the completed form to our Claims Department address listed below.
- If you're unable to get the form, you can file your request for payment by sending us the following information to our Claims Department address listed below:
  - A statement with the following information:
    - Your name (member/patient name) and medical/health record number.
    - The date you received the services.
    - Where you received the services.
    - Who provided the services.
    - Why you think we should pay for the services.
    - Your signature and date signed. (If you want someone other than yourself to make the request, we'll also need a completed "Appointment of Representative" form, which is available at **kp.org**.)

- A copy of the bill, your medical record(s) for these services and your receipt if you paid for the services.

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

Northern California members:
Kaiser Permanente
Claims Department
P.O. Box 12923
Oakland, CA 94604-2923

Southern California members:
Kaiser Permanente
Claims Department
P.O. Box 7004
Downey, CA 90242-7004

To request payment of a Part D drug that was prescribed by a network provider and obtained from a network pharmacy, write to the address below. For all other Part D requests, send your request to the address above.

Kaiser Permanente
Medicare Part D Unit
P.O. Box 1809
Pleasanton, CA 94566

Section 3 — We'll consider your request for payment and say yes or no

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

- If we decide the medical care or drug is covered and you followed all the rules, we'll pay for our share of the cost. Our share of the cost might not be the full amount you paid (for example, if you got a drug at an out-of-network pharmacy or if the cash price you paid for a drug is higher than our negotiated price). If you already paid for the service or drug, we'll mail your reimbursement of our share of the cost to you. If you haven't paid for the service or drug yet, we'll mail the payment directly to the provider.
- If we decide the medical care or drug is *not* covered, or you did *not* follow all the rules, we won't pay for our share of the cost. We'll send you a letter explaining the reasons why we aren't sending the payment and your right to appeal that decision.

Section 3.1 – If we tell you that we won't pay for all or part of the medical care or drug, you can make an appeal

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment. The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to Chapter 9.

Chapter 8 — Your rights and responsibilities

Section 1 — Our plan must honor your rights and cultural sensitivities

Section 1.1 – We must provide information in a way that works for you and consistent with your cultural sensitivities (in languages other than English, large font, braille, audio file, or data CD

Our plan is required to ensure that all services, both clinical and non-clinical, are provided in a culturally competent manner and are accessible to all enrollees, including those with limited English proficiency, limited reading skills, hearing incapacity, or those with diverse cultural and ethnic backgrounds. Examples of how our plan can meet these accessibility requirements include but aren't limited to, provision of translator services, interpreter services, teletypewriters, or TTY (text telephone or teletypewriter phone) connection.

Our plan has free interpreter services available to answer questions from non-English-speaking members. This document is available in Spanish by calling Member Services. We can also give you information in large font, braille, audio, or data CD at no cost if you need it. We're required to give you information about our plan's benefits in a format that's accessible and appropriate for you. To get information from us in a way that works for you, call Member Services at **1-800-443-0815** (TTY users call **711**).

Our plan is required to give female enrollees the option of direct access to a women's health specialist within the network for women's routine and preventive health care services.

If providers in our plan's network for a specialty aren't available, it's our plan's responsibility to locate specialty providers outside the network who will provide you with the necessary care. In this case, you'll only pay in-network cost-sharing. If you find yourself in a situation where there are no specialists in our plan's network that cover a service you need, call our plan for information on where to go to get this service at in-network cost-sharing.

If you have any trouble getting information from our plan in a format that's accessible and appropriate for you, seeing a women's health specialist or finding a network specialist, call to file a grievance with Member Services. You can also file a complaint with Medicare by calling **1-800-MEDICARE (1-800-633-4227)** or directly with the Office for Civil Rights **1-800-368-1019** or TTY users call **1-800-537-7697**.

Sección 1.1– Debemos proporcionar la información de un modo adecuado para usted y conforme a su sensibilidad cultural (en idiomas distintos al inglés, en braille, en letra grande, o en CD)

Nuestro plan está obligado a garantizar que todos los servicios, tanto clínicos como no clínicos, se proporcionen de una manera culturalmente competente y que sean accesibles para todas las personas inscritas, incluidas las que tienen un dominio limitado del inglés, capacidades limitadas para leer, una incapacidad auditiva o diversos antecedentes culturales y étnicos. Algunos ejemplos de cómo nuestro plan puede cumplir estos requisitos de accesibilidad incluyen, entre

otros, proporcionar servicios de traducción, servicios de interpretación, de teletipo o TTY (teléfono de texto o teletipo).

Nuestro plan tiene servicios de interpretación disponibles para responder las preguntas de los miembros que no hablan inglés. Este documento está disponible en español o chino llamando a Servicio a los Miembros. También podemos darle información en letra grande, braille o en CD sin costo si la necesita. 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 información de una forma que se adapte a sus necesidades, llame a Servicio a los Miembros.

Nuestro plan está obligado a ofrecer a las mujeres inscritas la opción de acceder directamente a un especialista en salud femenina dentro de la red para los servicios de atención médica preventiva y de rutina para la mujer.

Si los proveedores de nuestra red para una especialidad no están disponibles, es nuestra responsabilidad buscar proveedores fuera de la red que le proporcionen la atención necesaria. En este caso, usted solo pagará el costo compartido dentro de la red. Si se encuentra en una situación en la que no hay especialistas dentro de nuestra red que cubran el servicio que necesita, llámenos para recibir información sobre a dónde acudir para obtener este servicio con un costo compartido dentro de la red.

Si tiene algún problema para obtener información de nuestro plan en un formato que sea accesible y adecuado para usted, para ver a un especialista en salud femenina o para encontrar un especialista de la red, llame a Servicio a los Miembros para presentar una queja. También puede presentar una queja ante Medicare, llamando al 1-800-MEDICARE (1-800-633-4227) o directamente en la Oficina de Derechos Civiles al 1-800-368-1019 o TTY 1-800-537-7697.

Section 1.2 – We must ensure you get timely access to covered services and drugs

You have the right to choose a primary care provider (PCP) in our plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist) without a referral, as well as other providers described in Chapter 3, Section 2.2.

You have the right to get appointments and covered services from our plan's 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 you aren't getting your medical care or Part D drugs within a reasonable amount of time, Chapter 9 tells what you can do.

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

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

- Your personal health information includes the personal information you gave us when you enrolled in this plan as well as your medical records and other medical and health information.
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a *Notice of Privacy Practice*, that tells 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.
- Except for the circumstances noted below, if we intend to 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 or someone you have given legal power to make decisions for you first*.
- There are certain exceptions that don't require us to get your written permission first. These exceptions are allowed or required by law.
  - We're required to release health information to government agencies that are checking on quality of care.
  - Because you're a member of our plan through Medicare, we're required to give Medicare your health information, including information about your Part D drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations; typically, this requires that information that uniquely identifies you not be shared.
- Your health information is shared with your group only with your authorization or as otherwise permitted by law.

You can see the information in your records and know how it's 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're 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'll 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 aren't routine.

If you have questions or concerns about the privacy of your personal health information, call Member Services at **1-800-443-0815** (TTY users call **711**).

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

As a member of our plan, you have the right to get several kinds of information from us.

If you want any of the following kinds of information, call Member Services at **1-800-443-0815** (TTY users call **711**):

- **Information about our plan.** This includes, for example, information about our plan's financial condition.
- **Information about our network providers and pharmacies.** You have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network.
- **Information about your coverage and the rules you must follow when using your coverage.** Chapters 3 and 4 provide information regarding medical services. Chapters 5 and 6 provide information about Part D drug coverage.
- **Information about why something is not covered and what you can do about it.** Chapter 9 provides information on asking for a written explanation on why a medical service or Part D drug isn't covered, or if your coverage is restricted. Chapter 9 also provides information on asking us to change a decision, also called an appeal.

Section 1.5 – You have the right to know your treatment options and participate in decisions about your care

You have the right to get full information from your doctors and other health care providers. 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 your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're 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. If you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result.

You have the right to give instructions about what's to be done if you can't 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're in this situation. This means, *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.

Legal documents you can use to give directions in advance of these situations are called **advance directives**. Documents like a **living will** and **power of attorney for health care** are examples of advance directives.

How to set up an advance directive to give instructions:

- **Get a form.** You can get an advance directive form from your lawyer, a social worker, or some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also call Member Services at **1-800-443-0815** (TTY users call **711**) to ask for the forms.
- **Fill out the form and sign it.** No matter where you get this form, it's a legal document. Consider having a lawyer help you prepare it.
- **Give copies of the form to the right people.** Give a copy of the form to your doctor and to the person you name on the form who can make decisions for you if you can't. You may want to give copies to close friends or family members. Keep a copy at home.

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

- The hospital will ask whether you signed an advance directive form and whether you have it with you.
- If you didn't sign an advance directive form, the hospital has forms available and will ask if you want to sign one.

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

If your instructions aren't followed

If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the Quality Improvement Organization listed in Chapter 2, Section 4.

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

If you have any problems, concerns or complaints and need to ask for coverage, or make an appeal, Chapter 9 of this document tells what you can do. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—**we're required to treat you fairly**.

Section 1.7 – If you believe you're being treated unfairly, or your rights aren't being respected

If you believe you've been treated unfairly, or your rights haven't been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, 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.

If you believe you've been treated unfairly or your rights haven't been respected, *and* it's *not* about discrimination, you can get help dealing with the problem you're having from these places:

- **Call Member Services** at **1-800-443-0815** (TTY users call **711**).
- **Call your local SHIP** at **1-800-434-0222**.
- **Call Medicare** at **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**).

Section 1.8 – How to get more information about your rights

Get more information about your rights from these places:

- **Call Member Services** at **1-800-443-0815** (TTY users call **711**).
- **Call your local SHIP** at **1-800-434-0222**.
- **Contact Medicare**
  - Visit **www.Medicare.gov** to read the publication *Medicare Rights & Protections* (available at **www.Medicare.gov/publications/11534-medicare-rights-and-protections.pdf**).
  - Call **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**).

Section 1.9 – Information about new technology assessments

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

Section 1.10 – You can make suggestions about rights and responsibilities

As a member of our plan, you have the right to make recommendations about the rights and responsibilities included in this chapter. Please call Member Services at **1-800-443-0815** (TTY users call **711**) with any suggestions.

Section 2 — Your responsibilities as a member of our plan

Things you need to do as a member of our plan are listed below. For questions, call Member Services at **1-800-443-0815** (TTY users call **711**).

- **Get familiar with your covered services and the rules you must follow to get these covered services.** Use this *Evidence of Coverage* to learn what's covered and the rules you need to follow to get covered services.
  - Chapters 3 and 4 give details about medical services.
  - Chapters 5 and 6 give details about Part D drug coverage.
- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us.** Chapter 1 tells you about coordinating these benefits.
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get 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 get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on.
  - Make sure your doctors know all the drugs you're taking, including over-the-counter drugs, vitamins, and supplements.
  - If you have questions, be sure to ask and get an answer you can understand.
- **Be considerate.** We expect 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're responsible for these payments:
  - You must continue to pay a premium for your Medicare Part B to stay a member of our plan.
  - For most of your medical services or drugs covered by our plan, you must pay your share of the cost when you get the service or drug.
  - If you're required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to stay a member of our plan.
- **If you move *within* our plan service area, we need to know** so we can keep your membership record up to date and know how to contact you.
- **If you move *outside* our plan service area, you can't stay a member of our plan**.
- **If you move, tell Social Security (or the Railroad Retirement Board).**

Chapter 9 — If you have a problem or complaint (coverage decisions, appeals, complaints)

Section 1 — What to do if you have a problem or concern

This chapter explains 2 types of processes for handling problems and concerns:

- For some problems, you need to use the **process for coverage decisions and appeals**.
- For other problems, you need to use the **process for making complaints** (also called grievances).

Both processes have been approved by Medicare. Each process has a set of rules, procedures, and deadlines that must be followed by us and by you.

The information in this chapter will help you identify the right process to use and what to do.

Section 1.1 – Legal terms

There are legal terms for some of the rules, procedures, and types of deadlines explained in this chapter. Many of these terms are unfamiliar to most people. To make things easier, this chapter uses more familiar words in place of some legal terms.

However, it's sometimes important to know the correct legal terms. To help you know which terms to use to get the right help or information, we include these legal terms when we give details for handling specific situations.

Section 2 — Where to get more information and personalized help

We're always available to help you. Even if you have a complaint about our treatment of you, we're obligated to honor your right to complain. You should always call Member Services at **1-800-443-0815** (TTY users call **711**) for help. In some situations, you may also want help or guidance from someone who isn't connected with us. Two organizations that can help you are:

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. 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're having. They can also answer questions, give you more information, and offer guidance on what to do.

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

Medicare

You can also contact Medicare for help.

- Call **1-800-MEDICARE** (**1-800-633-4227**), 24 hours a day, 7 days a week. TTY users call **1-877-486-2048**.
- Visit **www.Medicare.gov**.

Section 3 — Which process to use for your problem

Is your problem or concern about your benefits or coverage?

This includes problems about whether medical care (medical items, services and/or Part B drugs) are covered or not, the way they are covered, and problems related to payment for medical care.

Yes.

- Go to **Section 4, A guide to coverage decisions and appeals.**

No.

- Go to **Section 10, How to make a complaint about quality of care, waiting times, customer service, or other concerns.**

COVERAGE DECISIONS AND APPEALS

Section 4 — A guide to coverage decisions and appeals

Coverage decisions and appeals deal with problems about your benefits and coverage for your medical care (services, items and Part B drugs, including payment). To keep things simple, we generally refer to medical items, services and Medicare Part B drugs as **medical care**. You use the coverage decision and appeals process for issues such as whether something is covered or not and the way in which something is covered.

Asking for coverage decisions before you get services

If you want to know if we'll cover medical care before you get it, you can ask us to make a coverage decision for you. A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your medical care. For example, if our plan network doctor refers you to a medical specialist not inside the network, this referral is considered a favorable coverage decision unless either you or your network doctor can show that you got a standard denial notice for this medical specialist, or the *Evidence of Coverage* makes it clear that the referred service is never covered under any condition. You or your doctor can also contact us and ask for a coverage decision if your doctor is unsure whether we'll cover a particular medical service or refuses to provide medical care you think you need.

In limited circumstances a request for a coverage decision will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a coverage decision, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

We make a coverage decision whenever we decide what's covered for you and how much we pay. In some cases, we might decide medical care isn't covered or is no longer covered for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

When you appeal a decision for the first time, this is called a Level 1 appeal. In this appeal, we review the coverage decision we made to check to see if we properly followed the rules. When we complete the review, we give you our decision.

In limited circumstances a request for a Level 1 appeal will be dismissed, which means we won't review the request. Examples of when a request will be dismissed include if the request is incomplete, if someone makes the request on your behalf but isn't legally authorized to do so or if you ask for your request to be withdrawn. If we dismiss a request for a Level 1 appeal, we'll send a notice explaining why the request was dismissed and how to ask for a review of the dismissal.

If we say no to all or part of your Level 1 appeal for medical care, your appeal will automatically go to a Level 2 appeal conducted by an independent review organization not connected to us.

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal.
- Go to **Section 5.4** for more information about Level 2 appeals for medical care.
- Part D appeals are discussed further in Section 6.

If you aren't satisfied with the decision at the Level 2 appeal, you may be able to continue through additional levels of appeal (this chapter explains the Level 3, 4, and 5 appeals processes).

Section 4.1 – Get help asking for a coverage decision or making an appeal

Here are resources if you decide to ask for any kind of coverage decision or appeal a decision:

- **Call Member Services** at **1-800-443-0815** (TTY users call **711**).
- **Get free help** from your State Health Insurance Assistance Program.

1-800-443-0815 (TTY 711), 7 days a week, 8 a.m. to 8 p.m.

- **Your doctor can make a request for you.** If your doctor helps with an appeal past Level 2, they need to be appointed as your representative. Call Member Services at **1-800-443-0815** (TTY users call **711**) and ask for the *Appointment of Representative* form. (The form is also available at **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **kp.org**.
  - For medical care or Part B drugs, your doctor can ask for 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.
  - For Part D drugs, your doctor or other prescriber can ask for a coverage decision or a Level 1 appeal on your behalf. If your Level 1 appeal is denied, your doctor or prescriber can ask for a Level 2 appeal.
- **You can ask someone to act on your behalf.** You can name another person to act for you as your representative to ask for a coverage decision or make an appeal.
  - If you want a friend, relative, or other person to be your representative, call Member Services at **1-800-443-0815** (TTY users call **711**) and ask for the *Appointment of Representative* form. (The form is also available at **www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf** or on our website at **kp.org**.) This form gives that person permission to act on your behalf. It must be signed by you and by the person you want to act on your behalf. You must give us a copy of the signed form.
  - We can accept an appeal request from a representative without the form, but we can't complete our review until we get it. If we don't get the form before our deadline for making a decision on your appeal, your appeal request will be dismissed. If this happens, we'll send you a written notice explaining your right to ask the independent review organization to review our decision to dismiss your appeal.
- **You also have the right to hire a lawyer.** You can contact your own lawyer or get the name of a lawyer from your local bar association or other referral service. There are groups that will give you free legal services if you qualify. However, **you aren't required to hire a lawyer** to ask for any kind of coverage decision or appeal a decision.

Section 4.2 – Rules and deadlines for different situations

There are 4 different situations that involve coverage decisions and appeals. Each situation has different rules and deadlines. We give the details for each of these situations:

- **Section 5:** Medical care: How to ask for a coverage decision or make an appeal.
- **Section 6:** Part D drugs: How to ask for a coverage decision or make an appeal.
- **Section 7:** How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon.
- **Section 8:** How to ask us to keep covering certain medical services if you think your coverage is ending too soon (*Applies only to these services*: home health care, skilled nursing facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services).

If you're not sure which information applies to you, call Member Services at **1-800-443-0815** (TTY users call **711**). You can also get help or information from your SHIP.

Section 5 — Medical care: How to ask for a coverage decision or make an appeal

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

Your benefits for medical care are described in Chapter 4 in the Medical Benefits Chart. In some cases, different rules apply to a request for a Part B drug. In those cases, we'll explain how the rules for Part B drugs are different from the rules for medical items and services.

This section tells what you can do if you're in any of the 5 following situations:

1. You aren't getting certain medical care you want, and you believe this is covered by our plan. **Ask for a coverage decision. Section 5.2.**
2. Our plan won't approve the medical care your doctor or other medical provider wants to give you, and you believe this care is covered by our plan. **Ask for a coverage decision. Section 5.2.**
3. You got medical care that you believe should be covered by our plan, but we said we won't pay for this care. **Make an appeal. Section 5.3.**
4. You got and paid for medical care that you believe should be covered by our plan, and you want to ask our plan to reimburse you for this care. **Send us the bill. Section 5.5.**
5. You're told that coverage for certain medical care you've been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health. **Make an appeal. Section 5.3.**

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, go to Sections 7 and 8. Special rules apply to these types of care.

Section 5.2 – How to ask for a coverage decision

Legal Terms	A coverage decision that involves your medical care is called an **organization determination.** A fast coverage decision is called an **expedited determination**.

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

A standard coverage decision is usually made within 7 calendar days when the medical item or service is subject to our prior authorization rules, 14 calendar days for all other medical items and services, or 72 hours for Part B drugs. A fast coverage decision is generally made within 72 hours, for medical services, or 24 hours for Part B drugs. To get a fast coverage decision, you must meet 2 requirements:

- You may *only ask* for coverage for medical items and/or services (not requests for payment for items and/or services you already got).
- 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 regain function.

If your doctor tells us that your health requires a fast coverage decision, we'll 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'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

- Explains that we'll use the standard deadlines.
- Explains if your doctor asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
- Explains that you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for.

Step 2: Ask our plan to make a coverage decision or fast coverage decision.

- Start by calling, writing, or faxing our plan 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. Chapter 2 has contact information.

Step 3: We consider your request for medical care coverage and give you our answer.

For standard coverage decisions we use the standard deadlines.

This means we'll give you an answer within 7 calendar days after we get your request for a medical item or service that is subject to our prior authorization rules. If your requested medical item or service is not subject to our prior authorization rules, we'll give you an answer within 14 calendar days after we get your request. If your request is for a Part B drug, we'll give you an answer within 72 hours after we get your request.

- **However**, if you ask for more time, or if we need 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 take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to Section 10 for information on complaints.)

For fast coverage decisions we use an expedited timeframe.

A fast coverage decision means we'll answer within 72 hours if your request is for a medical item or service. If your request is for a Part B drug, we'll answer within 24 hours.

- **However**, if you ask for more time, or if we need 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 take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
- If you believe we *shouldn't* take extra days, you can file a *fast complaint*. (Go to Section 10 for information on complaints.) We'll call you as soon as we make the decision.
- If our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no.

Step 4: If we say no to your request for coverage for medical care, you can appeal.

- If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the medical care coverage you want. If you make an appeal, it means you're going on to Level 1 of the appeals process.

Section 5.3 – How to make a Level 1 appeal

Legal Terms	An appeal to our plan about a medical care coverage decision is called a plan **reconsideration.** A fast appeal is also called an **expedited reconsideration.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 30 calendar days or 7 calendar days for Part B drugs. A fast appeal is generally made within 72 hours.

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 5.2.

Step 2: Ask our plan for an appeal or a fast appeal

- **If you're asking for a standard appeal, submit your standard appeal in writing**. Chapter 2 has contact information.
- **If you're asking for a fast appeal, make your appeal in writing or call us**. Chapter 2 has contact information.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the 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 may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information regarding your medical decision**. **You and your doctor may add more information to support your appeal**. We're allowed to charge a fee for copying and sending this information to you.

Step 3: We consider your appeal and we give you our answer.

- When our plan is reviewing your appeal, we take a careful look at all the information. We check to see if we followed all the rules when we said no to your request.
- We'll gather more information if needed and may contact you or your doctor.

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to.
  - If you ask for more time, or if we need 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 take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug.
  - If we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal.

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we receive your appeal. We'll give you our decision sooner if your health condition requires us to.
  - If you ask for more time, or if we need 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 take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug.
  - If you believe we *shouldn't* take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to Section 10 of this chapter for information on complaints.)
  - If we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. Section 5.4 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage 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 Part B drug.
- **If our plan says no to part or all of your appeal**, we'll automatically send your appeal to the independent review organization for a Level 2 appeal.

Section 5.4 – The Level 2 appeal process

Legal Term	The formal name for the independent review organization is the **Independent Review Entity.** It's sometimes called the **IRE.**

The **independent review organization is an independent organization hired by Medicare**. It isn't connected with us and isn't a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: The independent review organization reviews your appeal.

- We'll 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're 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 the information about your appeal.

If you had a fast appeal at Level 1, you'll also have a fast appeal at Level 2

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal.
- 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 Part B drug.

If you had a standard appeal at Level 1, you'll also have a standard appeal at Level 2

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal.
- 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 Part B drug.

Step 2: The independent review organization gives you its answer.

The independent review organization will tell you its decision in writing and explain the reasons for it.

- **If the independent 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 get the decision from the independent review

organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization.

- **If the independent review organization says yes to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug **within 72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests** we have **24 hours** from the date we get the decision from the independent review organization.
- **If this organization says no to part or all of your appeal**, it means it agrees with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:
  - Explains the decision.
  - Lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process.
  - Tells you how to file a Level 3 appeal.

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal the details on 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. Section 9 explains the Level 3, 4, and 5 appeals processes.

Section 5.5 – If you're asking us to pay for our share of a bill you got for medical care

Chapter 7 describes when you may need to ask for reimbursement or to pay a bill you got from a provider. It also tells how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork asking for reimbursement, you're asking for a coverage decision. To make this decision, we'll check to see if the medical care you paid for is covered. We'll also check to see if you followed the rules for using your coverage for medical care.

- **If we say yes to your request:** If the medical care is covered and you followed the rules, we'll send you the payment for our share of the cost typically within 30 calendar days, but no later than 60 calendar days after we get your request. If you haven't paid for the medical care, we'll send the payment directly to the provider.
- **If we say no to your request:** If the medical care is *not* covered, or you did *not* follow all the rules, we won't send payment. Instead, we'll send you a letter that says we won't pay for the medical care and the reasons why.

If you don't agree with our decision to turn you down, **you can make an appeal**. If you make an appeal, it means you're 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 in Section 5.3. For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast appeal.
- If the independent review organization decides we should pay, we must send you or the provider the payment 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 asked for to you or the provider within 60 calendar days.

Section 6 — Part D drugs: How to ask for a coverage decision or make an appeal

Section 6.1 – 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 include coverage for many prescription drugs. To be covered, the drug must be used for a medically accepted indication. (Go to Chapter 5 for more information about a medically accepted indication.) For details about Part D drugs, rules, restrictions, and costs go to Chapters 5 and 6. **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. We also use the term Drug List instead of *List of Covered Drugs* or *formulary*.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it.
- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision.

Part D coverage decisions and appeals

Legal Term	An initial coverage decision about your Part D drugs is called a **coverage determination.**

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your drugs. This section tells what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that's not on our plan's Drug List. **Ask for an exception. Section 6.2**.

- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **Ask for an exception. Section 6.2**.
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception. Section 6.2**.
- Asking to get pre-approval for a drug. **Ask for a coverage decision. Section 6.2**.
- Pay for a prescription drug you already bought. **Ask us to pay you back. Section 6.4**.

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

This section tells you both how to ask for coverage decisions and how to ask for an appeal.

Section 6.2 – Asking for an exception

Legal Terms	Asking for coverage of a drug that's not on the Drug List is a **formulary exception.** Asking for removal of a restriction on coverage for a drug is a **formulary exception.**

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **exception.** An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are 2 examples of exceptions that you or your doctor or other prescriber can ask us to make:

- **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, the cost-sharing amount will vary depending on your plan. You can't ask for an exception to the cost-sharing amount we require you to pay for the drug.
- **Removing a restriction for a covered drug.** Chapter 5 describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the cost-sharing amount we require you to pay for the drug.

Section 6.3 – Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

Our Drug List typically 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're asking for and wouldn't cause more side effects or other health problems, we generally won't approve your request for an exception. If you ask us for a tiering exception, we generally won't 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 an exception, our approval usually is valid until the end of our 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, you can ask for another review by making an appeal.

Section 6.4 – How to sk for a coverage decision, including an exception

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

Step 1: Decide if you need a standard coverage decision or a fast coverage decision.

Standard coverage decisions are made within **72 hours** after we get your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we get your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. **To get a fast coverage decision, you must meet 2 requirements**:

- You must be asking for a drug you didn't get yet. (You can't ask for a fast coverage decision to be paid back for a drug you have already bought.)
- 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'll automatically give you a fast coverage decision**.
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision**. If we don't approve a fast coverage decision, we'll send you a letter that:
  - Explains that we'll use the standard deadlines.
  - Explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision.
  - Tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your complaint within 24 hours of receipt.

Step 2: Ask for a standard coverage decision or a fast coverage decision.

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the *CMS Model Coverage Determination Request Form*, which is available on our website (**kp.org**). Chapter 2 has contact information. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

You, your doctor (or other prescriber), or your representative can do this. You can also have a lawyer act on your behalf. Section 4 tells how you can give written permission to someone else to act as your representative.

- **If you're asking for an exception, provide the supporting statement** which is the medical reasons for the exception. 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.

Step 3: We consider your request and give you our answer.

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we get your request.
  - For exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must generally give you our answer **within 72 hours** after we get your request.
  - For exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it'll be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we must **provide the coverage** we agreed to **within 72 hours** after we get your request or doctor's statement supporting your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll 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 get your request.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within 14 calendar days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your coverage request, you can make an appeal.

If we say no, you have the right to ask us to reconsider this decision by making an appeal. This means asking again to get the drug coverage you want. If you make an appeal, it means you're going to Level 1 of the appeals process.

Section 6.5 – How to make a Level 1 appeal

Legal Terms	An appeal to our plan about a Part D drug coverage decision is called a plan **redetermination.** A fast appeal is called an **expedited redetermination.**

Step 1: Decide if you need a standard appeal or a fast appeal.

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal.

- If you're appealing a decision, we made about a drug you didn't get yet, you and your doctor or other prescriber will need to decide if you need a fast appeal.
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in Section 6.4.

Step 2: You, your representative, doctor, or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal.

- **For standard appeals, submit a written request**. Chapter 2 has contact information.
- **For fast appeals either submit your appeal in writing or call us at 1-800-443-0815**. Chapter 2 has contact information.
- **We must accept any written request**, including a request submitted on the *CMS Model Redetermination Request Form*, which is available on our website (**kp.org**). Include your name, contact information, and information about your claim to help us process your request.
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the 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 may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal.
- **You can ask for a copy of the information in your appeal and add more information**. You and your doctor may add more information to support your appeal. We're allowed to charge a fee for copying and sending this information to you.

Step 3: We consider your appeal and give you our answer.

- When we review your appeal, we take another careful look at all 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

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal.** We'll give you our answer sooner if your health requires us to.
  - If we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 72 hours after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so.
  - If we don't give you a decision within 7 calendar days, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. Section 6.6 explains the Level 2 appeal process.
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision.

Deadlines for a standard appeal about payment for a drug you already bought

- We must give you our answer **within 14 calendar days** after we get your request.
  - If we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization.
- **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within **30 calendar** days after we get your request.
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal.

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal.

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process.

Section 6.6 – How to make a Level 2 appeal

Legal Term	The formal name for the independent review organization is the **Independent Review Entity**. It is sometimes called the **IRE**.

The independent review organization is an independent organization hired by Medicare. It is not connected with us and is not a government agency. This organization decides whether the decision we made is correct or if it should be changed. Medicare oversees its work.

Step 1: 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 on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.
  - **You must make your appeal request within 65 calendar days** from the date on the written notice.
- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE.
- We'll send the information about your appeal to the independent review organization. This information is called your **case file. You have the right to ask us for a copy of your case file**. We're 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 reviews your appeal.

Reviewers at the independent review organization will take a careful look at all the information about your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal.
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request.

Deadlines for standard appeal

- For standard appeals, the independent 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 didn't get yet. If you're asking us to pay you back for a drug you already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request.

Step 3: The independent review organization gives you its answer.

For fast appeals:

- **If the independent review organization says yes to part or all of what you asked for**, we must provide the drug coverage that was approved by the independent review organization **within 24 hours** after we get the decision from the independent review organization.

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage**, we must **provide the drug coverage** that was approved by the independent review organization **within 72 hours** after we get the decision from the independent review organization.
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we're required to **send payment to you within 30 calendar days** after we get the decision from the independent review organization.

What if the independent review organization says no to your appeal?

If this organization says no to **part or all of** your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It's also called **turning down your appeal**.) In this case, the independent review organization will send you a letter that:

- Explains the decision.
- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final.
- Tells you the dollar value that must be in dispute to continue with the appeals process.

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further.

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal).
- If you want to go on to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 7 — How to ask us to cover a longer inpatient hospital stay if you think you're being discharged too soon

When you're admitted to a hospital, you have the right to get all covered hospital services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll 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 is decided, your doctor or the hospital staff will tell you.

- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay, and your request will be considered.

Section 7.1 – During your inpatient hospital stay, you'll get a written notice from Medicare that tells you about your rights

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights*. Everyone with Medicare gets a copy of this notice. If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services at **1-800-443-0815** (TTY users call **711**) or **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**).

- **Read this notice carefully and ask questions if you don't understand it**. It tells you:
  - Your right to get 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.
  - Where to report any concerns you have about the quality of your hospital care.
  - Your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date, so we'll cover your hospital care for a longer time.
- **You'll be asked to sign the written notice to show that you got it and understand your rights**.
  - You or someone who is acting on your behalf will be asked to sign the notice.
  - Signing the notice shows *only* that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date.
- **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it.
  - If you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged.
  - To look at a copy of this notice in advance, call Member Services at **1-800-443-0815** (TTY users call **711)** or **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**. You can also get the notice online at **www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im**.

Section 7.2 – How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, 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.**

- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at **1-800-443-0815** (TTY users call **711**). Or call your State Health Insurance Assistance Program, (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

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. The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly.

How can you contact this organization?
The written notice you got (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

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.**
  - **If you meet this deadline**, you can stay in the hospital *after* your discharge date *without paying for it* while you wait to get the decision from the Quality Improvement Organization.
  - **If you don't meet this deadline, contact us**. If you decide to stay in the hospital after your planned discharge date, *you may have to pay the costs* for hospital care you get after your planned discharge date.
- Once you ask for an immediate review of your hospital discharge, the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives 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.
- You can get a sample of the **Detailed Notice of Discharge** by calling Member Services at **1-800-443-0815** (TTY users call **711)** or **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**. Or you can get a sample notice online at **www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im**.

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

- Health professionals at the Quality Improvement Organization (the reviewers) 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 can if you want.

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

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

What happens if the answer is yes?

- If the independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary**.
- You'll have to keep paying your share of the costs (such as deductibles or copayments if these apply). In addition, there may be limitations on your covered hospital services.

What happens if the answer is no?

- If the independent review organization says *no*, they're 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 independent review organization says *no* to your appeal and you decide to stay in the hospital, **you may have to pay the full cost** of hospital care you get 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 said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you are going on to *Level 2* of the appeals process.

Section 7.3 – How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision 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.

Step 1: 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 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 the information about your appeal.

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you its decision.

If the independent review organization says yes:

- **We must reimburse you** for our share of the costs of hospital care you got 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 independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal. This is called upholding the decision.
- The notice you get will tell you in writing what you can do if you want to continue with the review process.

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 in this chapter tells more about Levels 3, 4, and 5 of the appeals process.

Section 8 — How to ask us to keep covering certain medical services if you think your coverage is ending too soon

When you're getting covered **home health services, skilled nursing care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care*.

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

Section 8.1 – We'll tell you in advance when your coverage will be ending

Legal Term	**Notice of Medicare Non-Coverage**. It tells you how you can ask for a **fast-track appeal**. Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

- **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
  - The date when we'll stop covering the care for you.
  - How to ask for a fast-track appeal to ask us to keep covering your care for a longer period of time.
- **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got**. Signing the notice shows *only* that you have got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care.

Section 8.2 – 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'll 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.**
- **Meet the deadlines.**
- **Ask for help if you need it.** If you have questions or need help, call Member Services at **1-800-443-0815** (TTY users call **711**). Or call your State Health Insurance Assistance Program (SHIP) for personalized help. SHIP contact information is available in Chapter 2, Section 3.

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate. The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a fast-track appeal. You must act quickly.

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in Chapter 2.

Act quickly:

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the *Notice of Medicare Non-Coverage*. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in Chapter 2.

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

Legal Term	**Detailed Explanation of Non-Coverage.** Notice that gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the *reviewers*) 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 can if you want.
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them.
- By the end of the day the reviewers tell us of your appeal, you'll get the *Detailed Explanation of Non-Coverage* from us that explains in detail our reasons for ending our coverage for your services.

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

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it's medically necessary**.
- You'll have to keep paying your share of the costs (such as deductibles or copayments if these apply). There may be limitations on your covered services.

What happens if the reviewers say no?

- If the reviewers say *no*, then **your coverage will end on the date we told you**.
- 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, **you'll 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.

- 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 a Level 2 appeal.

Section 8.3 – How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision 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.

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

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

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

What happens if the independent review organization says yes?

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

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal.
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go 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'll need to decide whether you want to take your appeal further.

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision.
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. Section 9 tells more about Levels 3, 4, and 5 of the appeals process.

Section 9 — Taking your appeal to Levels 3, 4, and 5

Section 9.1 – Appeal Levels 3, 4 and 5 for Medical Service Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you 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 can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

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.** Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal.
  - If we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision.
  - If we decide to appeal the decision, we'll 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 medical care 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 the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 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.** Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5.

- ♦ If we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision.
- ♦ If we decide to appeal the decision, we'll 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 don't want to accept the decision, you may 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 to a Level 5 appeal and how to continue with a Level 5 appeal.

Level 5 appeal

A judge at the **Federal District Court** will review your appeal.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

Section 9.2 – Appeal Levels 3, 4, and 5 for Part D Drug Requests

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the value of the drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

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.** 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 get the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - ♦ If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - ♦ If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 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**. 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 get the decision.
- **If the answer is no, the appeals process *may* or *may not* be over.**
  - If you decide to accept the decision that turns down your appeal, the appeals process is over.
  - If you don't want to accept the decision, you may 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 will tell you whether the rules allow you to go on to a Level 5 appeal. It will also tell you who 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.

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court.

MAKING COMPLAINTS

Section 10 — How to make a complaint about quality of care, waiting times, customer service, or other concerns

Section 10.1 – What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems about quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process.

Complaint	Example
Quality of your medical care	• Are you unhappy with the quality of the care you got (including care in the hospital)?
Respecting your privacy	• Did someone not respect your right to privacy or share confidential information?
Disrespect, poor customer service, or other negative behaviors	• Has someone been rude or disrespectful to you? • Are you unhappy with our Member Services? • Do you feel you're being encouraged to leave our plan?

Complaint	Example
Waiting times	• Are you having trouble getting an appointment, or waiting too long to get it? • Have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by our Member Services or other staff at our plan? ♦ Examples include waiting too long on the phone, in the waiting or exam room, or getting a prescription.
Cleanliness	• Are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
Information you get from us	• Did we fail to give you a required notice? • Is our written information hard to understand?
Timeliness (These types of complaints are all about the timeliness of our actions related to coverage decisions and appeals)	If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples: • You asked us for a fast coverage decision or a fast appeal, and we said no; you can make a complaint. • You believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint. • You believe we aren't meeting deadlines for covering or reimbursing you for certain medical items or services or drugs that were approved; you can make a complaint. • You believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint.

Section 10.2 – How to make a complaint

Legal Terms	• A **complaint** is also called a **grievance.** • **Making a complaint** is called **filing a grievance**. • **Using the process for complaints** is called **using the process for filing a grievance**. • A **fast complaint** is called an **expedited grievance**.

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

- **Calling Member Services** at **1-800-443-0815** (TTY users call **711**) **is usually the first step**. If there's anything else you need to do, Member Services will let you know.

- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us.** If you put your complaint in writing, we'll respond to your complaint in writing. We'll 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'll try to resolve your complaint over the phone**. If we can't 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're dissatisfied with the services you received. Go to Chapter 2 for whom you should contact if you have a complaint.
  - You must submit your grievance to us (orally or in writing) within 60 calendar days of the event or incident. We must address your grievance as quickly as your health requires, but no later than 30 calendar days after receiving your complaint. We may extend the time frame to make our decision by up to 14 calendar days if you ask for an extension, or if we justify a need for additional information and the delay is in your best interest.
  - You can file a fast grievance about our decision not to expedite a coverage decision or appeal for medical care or items, or if we extend the time we need to make a decision about a coverage decision or appeal for medical care or items. We must respond to your fast grievance **within 24 hours**.
- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about.

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

- **If possible, we'll 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.
- **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'll tell you in writing.
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**.
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you.

Section 10.3 – You can also make complaints about quality of care to the Quality Improvement Organization

When your complaint is about *quality of care*, you have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization**. 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. Chapter 2 has contact information.

Or

kp.org

- **You can make your complaint to both the Quality Improvement Organization and us at the same time**.

Section 10.4 – You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to **www.medicare.gov/my/Medicare-complaint**. You can also call **1-800-MEDICARE** (**1-800-633-4227**). TTY/TDD users call **1-877-486-2048**.

Section 11 — CalPERS appeal procedure following disposition of Medicare's grievance process

If you're not satisfied with the resolution of your complaint through the grievance process described above in Section 10.1, including services not subject to the Medicare appeals process, you may have additional dispute resolution options, depending on the nature of the complaint.

Section 11.1 – Eligibility issues

Issues of eligibility must be referred directly to CalPERS at:

CalPERS
Health Account Management Division
Attn: Enrollment Administration
P.O. Box 942715
Sacramento, CA 94229-2715

Fax: (916)795-1277, or telephone the CalPERS Customer Service and Outreach Division toll free at **888 CalPERS** (or **888-225-7377**)

Section 11.2 – CalPERS Administrative Review process

If you remain dissatisfied with the determination, you may request an Administrative Review.

The request for an Administrative Review must be submitted in writing to CalPERS within thirty (30) days from the date of our grievance denial letter. Upon satisfactory showing of good cause, CalPERS may grant additional time to file a request for an Administrative Review, not to exceed 30 days.

The request must be mailed to:

Health Benefit Compliance and Appeals Unit
Health Appeals Coordinator
P.O. Box 1953
Sacramento, CA 95812-1953

If you're planning to submit information we may have regarding your dispute with your request for Administrative Review, note that we may require you to sign an authorization form to release this information. In addition, if CalPERS determines that additional information is needed after

we submit the information we have regarding your dispute, CalPERS may ask you sign an Authorization to Release Health Information (ARHI) form.

If you have additional medical records from Providers or scientific studies that you believe are relevant to CalPERS review, those records should be included with the written request. You should send copies of documents, not originals, as CalPERS will retain the documents for its files. You're responsible for the cost of copying and mailing medical records required for the Administrative Review. Providing supporting information to CalPERS is voluntary. However, failure to provide such information may delay or preclude CalPERS in providing a final Administrative Review determination.

CalPERS cannot review claims of medical malpractice (i.e. quality of care, quality of service disputes, or claims subject to a Medicare appeals process).

CalPERS will attempt to provide a written determination of its Administrative Review within 60 days from the date all pertinent information is received by CalPERS. For claims involving urgent care, CalPERS will make a decision as soon as possible, taking into account the medical exigencies, but no later than three (3) business days from the date all pertinent information is received by CalPERS.

Section 11.3 – CalPERS Administrative Hearing process

You must complete the CalPERS Administrative Review process prior to being offered the opportunity for an Administrative Hearing. Only claims involving covered benefits are eligible for an Administrative Hearing.

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

You must request an Administrative Hearing in writing within 30 days of the date of the Administrative Review determination. Upon satisfactorily showing good cause, CalPERS may grant additional time to file a request for an Administrative Hearing, not to exceed 30 days.

The request for an Administrative Hearing must set forth the facts and the law upon which the request is based. The request should include any additional arguments and evidence favorable to a member's case not previously submitted for Administrative Review.

If CalPERS accepts the request for an Administrative Hearing, it shall be conducted in accordance with the Administrative Procedure Act (Government Code section 11500 et seq.). An Administrative Hearing is a formal legal proceeding held before an Administrative Law Judge (ALJ); you may, but aren't required to, be represented by an attorney. After taking testimony and receiving evidence, the ALJ will issue a Proposed Decision. The CalPERS Board of Administration (Board) will vote regarding whether to adopt the Proposed Decision as its own decision at an open (public) meeting. The Board’s final decision will be provided in writing to you within two weeks of the Board's open meeting.

Section 11.4 – CalPERS appeals beyond Administrative Review and Administrative Hearing

If you're dissatisfied with the Board's decision, you may petition the Board for reconsideration of its decision, or may appeal to the Superior Court.

You may not begin civil legal remedies until after exhausting these administrative procedures.

Summary of Process and Rights of Members under the Administrative Procedure Act

- **Right to records, generally.** You may, at your own expense, obtain copies of all non-medical and non-privileged medical records from us and/or CalPERS, as applicable.
- **Records subject to attorney-client privilege.** Communication between an attorney and a client, whether oral or in writing, won't be disclosed under any circumstances.
- **Attorney Representation.** At any stage of the appeal proceedings, you may be represented by an attorney. If you choose to be represented by an attorney, you must do so at your own expense. Neither CalPERS nor Health Plan will provide an attorney or reimburse you for the cost of an attorney even if you prevail on appeal.
- **Right to experts and consultants.** At any stage of the proceedings, you may present information through the opinion of an expert, such as a physician. If you choose to retain an expert to assist in presentation of a claim, it must be at your own expense. Neither CalPERS nor Health Plan will reimburse you for the costs of experts, consultants or evaluations.

Service of Legal Process
Legal process or service upon CalPERS must be served in person at:

CalPERS Legal Office
Lincoln Plaza North
400 "Q" Street
Sacramento, CA 95814

Section 12 — Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted the Medicare grievance process:

- 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.

Chapter 10 — Ending membership in our plan

Section 1 — Ending your Senior Advantage membership in our plan

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

- You might leave our plan because you decide you *want* to leave. Sections 2 and 3 give information on ending your membership voluntarily.
  - ♦ You can disenroll from Medicare Part B or from Senior Advantage at any time.
- There are also limited situations where we're required to end your membership. Section 5 tells you about situations when we must end your membership.

If you're leaving our plan, our plan must continue to provide your medical care and prescription drugs and you'll continue to pay your cost share until your membership ends.

Section 1.1 – 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.

Section 2 — When can you end your Senior Advantage membership in our plan?

Section 2.1 – You can end your Senior Advantage membership at any time

You may terminate (disenroll from) your Senior Advantage membership at any time.

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

Section 2.2 – Get more information about when you can end your Senior Advantage membership

If you have questions about ending your Senior Advantage membership you can:

- Contact your group administrator.
- Call **Medicare** at **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**).

Section 3 — How to end your Senior Advantage membership

Check with the CalPERS Health Account Management Division at **888 CalPERS** (or **888-225-7377**) before you disenroll from Senior Advantage. Disenrolling from Senior Advantage so you can return to Original Medicare or at any time other than CalPERS open enrollment period may result in loss of CalPERS-sponsored health coverage.

If you request disenrollment during your group's open enrollment, your disenrollment effective date is determined by the date your written request is received by us and the date your group coverage ends. The effective date won't 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.

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

You may request disenrollment by:

- Calling toll free **1-800-MEDICARE (1-800-633-4227)**, 24 hours a day, 7 days a week. TTY users call **1-877-486-2048**.
- Sending written notice to the following address:

  Kaiser Permanente
  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're able to enroll in their plan. Your new plan will tell you the date when your membership in that plan begins and your Senior Advantage membership will end on that same day (your disenrollment date).

The Centers for Medicare & Medicaid Services will let us know if you enroll in another Medicare health plan, so you won't need to send us a disenrollment request.

Original Medicare

If you request disenrollment from Senior Advantage and you don't 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 won't 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 don't enroll in a separate Medicare Part D prescription drug plan, Medicare may enroll you in a drug plan, unless you opt out of automatic enrollment.

Note: If you disenroll from Medicare drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may have to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

Section 4 — Until your Senior Advantage membership ends, you must keep getting your medical items, services, and drugs through our plan

Until your Senior Advantage membership ends, and your new Medicare coverage starts, you must continue to get your medical services, items, and prescription drugs through our plan.

- **Continue to use our network providers to get medical care.**
- **Continue to use our network pharmacies or mail order to get your prescriptions filled.**
- **If you're hospitalized on the day your membership ends, your hospital stay will be covered by our plan until you're discharged** (even if you're discharged after your new health coverage starts).

You will be billed as a non-member for any services you receive after your membership terminates. Health Plan and plan providers have no further liability or responsibility under this *Evidence of Coverage* after your membership terminates.

Section 5 — We must end your Senior Advantage membership in certain situations

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

- If you no longer have Medicare Part B.
- If you move out of our service area.
- If you're away from our service area for more than 6 months.
  - If you move or take a long trip, call Member Services at **1-800-443-0815** (TTY users call **711**) to find out if the place you're moving or traveling to is in our plan's area.
  - If you've been a member of our plan continuously before January 1999 *and* you were living outside of our service area before January 1999, you're still eligible as long as you haven't moved since before January 1999. However, if you move to another location outside our service area, you'll be disenrolled from our plan.
- If you're no longer a United States citizen or lawfully present in the United States.

- If you're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our plan and you'll lose 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. Contact your Group's Health Benefits Officer (or, if you're retired, the CalPERS Health Account Management Division) for information.

We'll ask CalPERS to approve termination of your membership in accord with Section 22841 of the California Government Code, if you commit one of the following acts:

- If you become incarcerated (go to prison).
- If you lie or withhold information about other insurance you have that provides prescription drug coverage.
- If you intentionally give us incorrect information when you're enrolling in our plan, and that information affects your eligibility for our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you continuously behave in a way that's disruptive and makes it difficult for us to provide medical care for you and other members of our plan. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
- If you let someone else use your membership card to get medical care. (We can't make you leave our plan for this reason unless we get permission from Medicare first.)
    - ♦ If we end your membership because of this reason, Medicare may have your case investigated by the Inspector General.

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

If we terminate your membership for any of the reasons stated above:

- You won't be allowed to enroll in our 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.
- We'll 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 Chapter 7. We'll deduct any amounts you owe health plan or plan providers from any payment we make to you.

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'll 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.

Termination of contract with 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 we'll 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. Contact the CalPERS Health Account Management Division for information.

Where can you get more information?

If you have questions or want more information on when we can end your membership call Member Services at **1-800-443-0815** (TTY users call **711**).

Section 5.1 – We can't ask you to leave our plan for any health-related reason

Our plan isn't allowed to ask you to leave our plan for any health-related reason.

What should you do if this happens?
If you feel you're being asked to leave our plan because of a health-related reason, call Medicare at **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**).

Section 5.2 – You have the right to make a complaint if we end your Senior Advantage membership in our plan

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

Section 6 — Continuation of membership

If your membership under this Senior Advantage *Evidence of Coverage* 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 *Evidence of Coverage* 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, 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.

Section 6.1 – Continuation of group coverage

COBRA

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

If your group is subject to COBRA and you're eligible for COBRA coverage, in order to enroll, you must submit a COBRA election form to your group within the COBRA election period. Ask your Health Benefits Officer (or, if you're retired, the CalPERS Health Account Management Division) 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 Section 6.2, 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.

Section 6.2 – Conversion from group membership to an individual plan

After your group notifies us to terminate your group membership, we'll 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 in Chapter 1, Section 2.5. Individual plan coverage begins when your group coverage ends. The premiums and coverage under our individual plan are different from those under this *Evidence of Coverage* and will include Medicare Part D prescription drug coverage.

However, if you're 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).

Chapter 11 — Legal notices

Section 1 — Notice about governing law

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

Section 2 — Notice about nondiscrimination

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

If you want more information or have concerns about discrimination or unfair treatment, 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 your local Office for Civil Rights. You can also review information from the Department of Health and Human Services' Office for Civil Rights at **www.HHS.gov/ocr/index.html**.

If you have a disability and need help with access to care, call Member Services at **1-800-443-0815** (TTY users call **711**). If you have a complaint, such as a problem with wheelchair access, Member Services can help.

Section 3 — Notice about Medicare Secondary Payer subrogation rights

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

Section 4 — Administration of this Evidence of Coverage

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

Section 5 — Amendment of Agreement

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

Section 6 — Applications and statements

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

Section 7 — Assignment

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

Section 8 — Attorney and advocate fees and expenses

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

Section 9 — Claims review authority

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

Section 10 — Coordination of benefits

As described in Chapter 1, Section 6, "How other insurance works with our plan," if you have other insurance, you are required to use your other coverage in combination with your coverage as a Senior Advantage plan member to pay for the care you receive. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you. You will get your covered care as usual from network providers, and the other coverage you have will simply help pay for the care you receive.

If your other coverage is the primary payer, it will often settle its share of payment directly with us, and you will not have to be involved. However, if payment owed to us by a primary payer is sent directly to you, you are required by Medicare law to give this primary payment to us. For more information about primary payments in third party liability situations, go to Section 16, and for primary payments in workers' compensation cases, go to Section 18.

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

Section 11 — Employer responsibility

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

Section 12 — Evidence of Coverage binding on members

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

Section 13 — Government agency responsibility

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

Section 14 — Member nonliability

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

Section 15 — No waiver

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

Section 16 — Notices

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

Note: When we tell your group about changes to this *Evidence of Coverage* 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. The Subscriber is also responsible for notifying Group of any change in contact information.

Section 17 — Overpayment recovery

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

Section 18 — Third party liability

As stated in Chapter 1, Section 6, 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 "Third party liability" section does not affect your obligation to pay cost-sharing for these services.

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

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain against a third party that results in any settlement proceeds or judgment, from other types of coverage that include but are not limited to: liability,

uninsured motorist, underinsured motorist, personal umbrella, workers' 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. If you reimburse us without the need for legal action, we will allow a procurement cost discount. If we have to pursue legal action to enforce its interest, there will be no procurement discount.

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:

The Rawlings Company
One Eden Parkway
P.O. Box 2000
LaGrange, KY 40031-2000
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.

Section 19 — U.S. Department of Veterans Affairs

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

Section 20 — Workers' compensation or employer's liability benefits

As stated in Chapter 1, Section 10, workers' compensation usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue primary payments under workers' compensation or employer's liability law. You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered services even

if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered services from the following sources:

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

Section 21 — Surrogacy

In situations where a member receives monetary compensation to act as a surrogate, our plan will seek reimbursement of all Plan Charges for covered services the member receives that are associated with conception, pregnancy and/or delivery of the child. A surrogate arrangement is one in which a woman agrees to become pregnant and to surrender the baby to another person or persons who intend to raise the child.

Section 22 — Binding arbitration

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

Scope of arbitration

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

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *Evidence of Coverage* or a member Party's relationship to Kaiser Foundation Health Plan, Inc. (Health Plan), including any claim for medical or hospital malpractice (a claim that medical services 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 *Evidence of Coverage* 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 (go to Chapter 9 for Medicare appeal information).
- 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 him or her arises from a member's relationship to one or more Kaiser Permanente Parties.

"Kaiser Permanente Parties" include:

- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals.
- 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 Member Services.

Initiating arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and telephone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include 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:

Northern California members:
Kaiser Foundation Health Plan, Inc.
Legal Department, Professional & Public Liability
1 Kaiser Plaza, 19th Floor
Oakland, CA 94612

Southern California members:
Kaiser Foundation Health Plan, Inc.
Legal Department, Professional & Public Liability
373 E. Walnut Street
Pasadena, CA 91188

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

Filing fee

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

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

Number of arbitrators

The number of arbitrators may affect the Claimants' responsibility for paying the neutral arbitrator's fees and expenses (go to 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 noneconomic losses, and the right to have an award for future damages conformed to periodic payments, shall apply to any claims for professional negligence or any other claims as permitted or required by law.

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

Chapter 12 — Definitions of important words

Acupuncture Services – The stimulation of certain points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions and appropriate adjunctive therapies, such as hot/cold packs, infrared heat, or acupressure, when provided during the same course of treatment and in conjunction with acupuncture and when provided by an acupuncturist for the treatment of your Musculoskeletal and Related Disorder, nausea (such as nausea related to chemotherapy, post-surgery nausea, or nausea related to pregnancy), or joint pain (such as lower back, shoulder, or hip joint pain), and headaches.

Allowance – A specified credit amount that you can use toward the cost of an item. If the cost of the item(s) or service(s) you select exceeds the allowance, you will pay the amount in excess of the allowance, which does not apply to the maximum out-of-pocket amount.

Ambulatory Surgical Center – An Ambulatory Surgical Center is an entity that operates exclusively for the purpose of furnishing outpatient surgical services to patients not requiring hospitalization and whose expected stay in the center doesn't exceed 24 hours.

Appeal – An appeal is something you do if you disagree with our decision to deny a request for coverage of health care services or prescription drugs or payment for services or drugs you already got. You may also make an appeal if you disagree with our decision to stop services that you're getting.

ASH Participating Provider – One of the following types of providers:

- An acupuncturist who is licensed to provide acupuncture services in California and who has a contract with ASH Plans to provide medically necessary acupuncture services to you.
- A chiropractor who is licensed to provide chiropractic services in California and who has a contract with ASH Plans to provide medically necessary chiropractic services to you.

ASH Plans – American Specialty Health Plans of California, Inc., a California corporation.

Balance Billing – When a provider (such as a doctor or hospital) bills a patient more than our plan's allowed cost-sharing amount. As a member of our plan, you only have to pay our plan's cost-sharing amounts when you get services covered by our plan. We don't allow providers to **balance bill** or otherwise charge you more than the amount of cost-sharing our plan says you must pay.

Benefit Period – The way that both our plan and Original Medicare measures your use of skilled nursing facility (SNF) services. A benefit period begins the day you go into a skilled nursing facility. The benefit period ends when you haven't gotten any skilled care in a SNF for 60 days in a row. If you go into a skilled nursing facility after one benefit period has ended, a new benefit period begins. There is no limit to the number of benefit periods.

Biological Product – A prescription drug that is made from natural and living sources like animal cells, plant cells, bacteria, or yeast. Biological products are more complex than other drugs and can't be copied exactly, so alternative forms are called biosimilars. (go to "**Original Biological Product**" and "**Biosimilar**").

Biosimilar – A biological product that's very similar, but not identical, to the original biological product. Biosimilars are as safe and effective as the original biological product. Some biosimilars may be substituted for the original biological product at the pharmacy without needing a new prescription (go to "**Interchangeable Biosimilar**").

Brand-Name Drug – A prescription drug that is manufactured and sold by the pharmaceutical company that originally researched and developed the drug. Brand-name drugs have the same active-ingredient formula as the generic version of the drug. However, generic drugs are manufactured and sold by other drug manufacturers and are generally not available until after the patent on the brand-name drug has expired.

Catastrophic Coverage Stage – The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent **$2,100** for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs.

Centers for Medicare & Medicaid Services (CMS) – The federal agency that administers Medicare.

Charges – "Charges" means the following:

- For Services provided by Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members.
- For Services for which a provider (other than Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider.
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a member for the item if a member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan).
- For all other Services, the payments that Kaiser Permanente makes for the Services or, if Kaiser Permanente subtracts your copayment or coinsurance from its payment, the amount Kaiser Permanente would have paid if it did not subtract your copayment or coinsurance.

Chiropractic Services – Chiropractic services include spinal and extremity manipulation and adjunctive therapies such as ultrasound, therapeutic exercise, or electrical muscle stimulation, when provided during the same course of treatment and in conjunction with chiropractic manipulative services, and other services provided or prescribed by a chiropractor (including laboratory tests, X-rays, and chiropractic supports and appliances) for the treatment of your musculoskeletal and related disorder.

Coinsurance – An amount you may be required to pay, expressed as a percentage (for example, 20%) of Plan Charges as your share of the cost for services or prescription drugs.

Complaint – The formal name for making a complaint is **filing a grievance**. The complaint process is used *only* for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Outpatient Rehabilitation Facility (CORF) – A facility that mainly provides rehabilitation services after an illness or injury, including physical therapy, social or psychological services, respiratory therapy, occupational therapy and speech-language pathology services, and home environment evaluation services.

Coordination of Benefits (COB) – Coordination of Benefits is a provision used to establish the order in which claims are paid when you have other insurance. If you have Medicare and other health insurance or coverage, each type of coverage is called a payer. When there's more than one payer, there are coordination of benefits rules that decide which one pays first. The primary payer pays what it owes on your bills first, and then sends the rest to the secondary payer to pay. If payment owed to us is sent directly to you, you're required under Medicare law to give the payment to us. In some cases, there may also be a third payer. Go to Chapter 1, Section 6, and Chapter 11, Section 8 for more information.

Copayment (or copay) – An amount you may be required to pay as your share of the cost for a medical service or supply, like a doctor's visit, hospital outpatient visit, or a prescription drug. A copayment is a set amount (for example $10), rather than a percentage.

Cost-Sharing – Cost-sharing refers to amounts that a member has to pay when services or drugs are gotten. Cost-sharing includes any combination of the following 3 types of payments: 1) any deductible amount a plan may impose before services or drugs are covered; 2) any fixed copayment amount that a plan requires when a specific service or drug is gotten; or 3) any coinsurance amount, a percentage of the total amount paid for a service or drug that a plan requires when a specific service or drug is gotten. **Note:** In some cases, you may not pay all applicable cost-sharing at the time you receive the services, and we'll send you a bill later for the cost-sharing. For example, if you receive nonpreventive care during a scheduled preventive care visit, we may bill you later for the cost-sharing applicable to the nonpreventive care. For items ordered in advance, you pay the cost-sharing in effect on the order date (although we'll not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the cost-sharing when the item is ordered. For outpatient prescription drugs, the order date is the date that the pharmacy processes the order after receiving all of the information they need to fill the prescription.

Cost-Sharing Tier – Every drug on the list of covered drugs is in one of three cost-sharing tiers.

Coverage Determination – A decision about whether a drug prescribed for you is covered by our plan and the amount, if any, you're required to pay for the prescription. In general, if you bring your prescription to a pharmacy and the pharmacy tells you the prescription isn't covered under our plan, that isn't a coverage determination. You need to call or write to our plan to ask for a formal decision about the coverage. Coverage determinations are called **coverage decisions** in this document.

Covered Drugs – The term we use to mean all the prescription drugs covered by our plan.

Covered Services – The term we use to mean all the health care services and supplies that are covered by our plan.

Creditable Prescription Drug Coverage – Prescription drug coverage (for example, from an employer or union) that is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage. People who have this kind of coverage when they become eligible for Medicare can generally keep that coverage without paying a penalty, if they decide to enroll in Medicare prescription drug coverage later.

Custodial Care – Custodial care is personal care provided in a nursing home, hospice, or other facility setting when you don't need skilled medical care or skilled nursing care. Custodial care, provided by people who don't have professional skills or training, includes help with activities of daily living like bathing, dressing, eating, getting in or out of a bed or chair, moving around, and using the bathroom. It may also include the kind of health-related care that most people do themselves, like using eye drops. Medicare doesn't pay for custodial care.

Daily Cost-Sharing Rate – A daily cost-sharing rate may apply when your doctor prescribes less than a full month's supply of certain drugs for you and you're required to pay a copayment. A daily cost-sharing rate is the copayment divided by the number of days in a month's supply. Here is an example: If your copayment for a one-month supply of a drug is $30, and a one-month's supply in our plan is 30 days, then your daily cost-sharing rate is $1 per day.

Deductible – The amount you must pay for health care or prescriptions before our plan pays.

Dependent – A Member who meets the eligibility requirements as a Dependent (eligibility requirements can be obtained through the CalPERS website at **www.calpers.ca.gov**, or by calling CalPERS).

Disenroll or Disenrollment – The process of ending your membership in our plan.

Dispensing Fee – A fee charged each time a covered drug is dispensed to pay for the cost of filling a prescription, such as the pharmacist's time to prepare and package the prescription.

Durable Medical Equipment (DME) – Certain medical equipment that is ordered by your doctor for medical reasons. Examples include: walkers, wheelchairs, crutches, powered mattress systems, diabetic supplies, IV infusion pumps, speech-generating devices, oxygen equipment, nebulizers, or hospital beds ordered by a provider for use in the home.

Emergency – A medical emergency is when you, or any other prudent layperson with an average knowledge of health and medicine, believe that you have medical symptoms that require immediate medical attention to prevent loss of life (and, if you're a pregnant woman, loss of an unborn child), loss of a limb, or loss of function of a limb, or loss of or serious impairment to a bodily function. The medical symptoms may be an illness, injury, severe pain, or a medical condition that is quickly getting worse.

Emergency Acupuncture Services – Covered acupuncture services provided for the treatment of a musculoskeletal and related disorder, nausea, or pain, which manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could expect the absence of immediate acupuncture services to result in serious jeopardy to your health or body functions or organs.

Emergency Care – Covered services that are: 1) provided by a provider qualified to furnish emergency services; and 2) needed to treat, evaluate, or stabilize an emergency medical condition.

Emergency Chiropractic Services – Covered chiropractic services provided for the treatment of a musculoskeletal and related disorder which manifests itself by acute symptoms of sufficient severity (including severe pain) such that you could expect the absence of immediate chiropractic services to result in serious jeopardy to your health or body functions or organs.

Emergency Medical Condition – A medical or mental health condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, with an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in:

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

Evidence of Coverage (EOC) and Disclosure Information – This document, along with your enrollment form and any other attachments, or riders which explains your coverage, what we must do, your rights, and what you have to do as a member of our plan.

Exception – A type of coverage decision that, if approved, allows you to get a drug that isn't on our formulary (a formulary exception), or get a non-preferred drug at a lower cost-sharing level (a tiering exception). You may also ask for an exception if our plan requires you to try another drug before getting the drug you're asking for, if our plan requires a prior authorization for a drug and you want us to waive the criteria restriction, or if our plan limits the quantity or dosage of the drug you're asking for (a formulary exception).

Excluded Drug – A drug that is not a covered Part D drug, as defined under 42 U.S.C. Section 1395w-102(e).

Extra Help – A Medicare program to help people with limited income and resources pay Medicare prescription drug program costs, such as premiums, deductibles, and coinsurance.

Family – A subscriber and all of their dependents.

Generic Drug – A prescription drug that's approved by the FDA as having the same active ingredient(s) as the brand-name drug. Generally, a generic drug works the same as a brand-name drug and usually costs less.

Grievance – A type of complaint you make about our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This doesn't involve coverage or payment disputes.

Group – California Public Employees Retirement System (CalPERS).

Health Plan – Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. This **EOC** sometimes refers to Health Plan as "we" or "us."

Home Health Aide – A person who provides services that don't need the skills of a licensed nurse or therapist, such as help with personal care (e.g., bathing, using the toilet, dressing, or carrying out the prescribed exercises).

Home Health Care – Skilled nursing care and certain other health care services that you get in your home for the treatment of an illness or injury. Covered services are listed in the Medical Benefits Chart in Chapter 4. We cover home health care in accord with Medicare guidelines. Home health care can include services from a home health aide if the services are part of the home health plan of care for your illness or injury. They aren't covered unless you're also getting a covered skilled service. Home health services don't include the services of housekeepers, food service arrangements, or full-time nursing care at home.

Home Region – The region where you enrolled (either the Northern California region or the Southern California region).

Hospice – A benefit that provides special treatment for a member who has been medically certified as terminally ill, meaning having a life expectancy of 6 months or less. Our plan must provide you with a list of hospices in your geographic area. If you elect hospice and continue to pay premiums, you're still a member of our plan. You can still get all medically necessary services as well as the supplemental benefits we offer.

Hospital Inpatient Stay – A hospital stay when you have been formally admitted to the hospital for skilled medical services. Even if you stay in the hospital overnight, you might still be considered an outpatient.

Income Related Monthly Adjustment Amount (IRMAA) – If your modified adjusted gross income as reported on your IRS tax return from two years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people won't pay a higher premium.

Initial Coverage Stage – This is the stage before your out-of-pocket costs for the year have reached the out-of-pocket threshold amount.

Initial Enrollment Period – When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part A and Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

Inpatient Hospital Care – Health care that you get during an inpatient stay in an acute care general hospital.

Interchangeable Biosimilar – A biosimilar that may be used as a substitute for an original biosimilar product at the pharmacy without needing a new prescription because it meets additional requirements about the potential for automatic substitution. Automatic substitution at the pharmacy is subject to state law.

Kaiser Foundation Health Plan (Health Plan) – Kaiser Foundation Health Plan, Inc., Northern and Southern California Regions, is a nonprofit corporation and a Medicare Advantage organization. This *Evidence of Coverage* sometimes refers to Health Plan as "we" or "us" and it applies to Senior Advantage members enrolled in our Northern and Southern California region's service areas, which are described in Chapter 1, Section 2.3.

Kaiser Foundation Hospital – A network hospital owned and operated by Kaiser Foundation Hospitals.

Kaiser Permanente – Health Plan, Medical Group, and Kaiser Foundation Hospitals.

Kaiser Permanente Region (Region) – A Kaiser Foundation Health Plan organization that conducts a direct-service health care program. When you're outside our service area, you can get medically necessary health care and ongoing care for chronic conditions from designated providers in another Kaiser Permanente Region's service area. For more information, refer to Chapter 3, Section 2.2.

List of Covered Drugs (formulary or Drug List) – A list of prescription drugs covered by our plan.

Long-Term Care Hospital – A Medicare-certified acute-care hospital that typically provide Medicare covered services such as comprehensive rehabilitation, respiratory therapy, head trauma treatment, and pain management. They aren't long-term care facilities such as convalescent or assisted living facilities.

Low-Income Subsidy (LIS) – Go to **Extra Help**.

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Maximum Fair Price – The price Medicare negotiated for a selected drug.

Maximum Out-of-Pocket Amount – The most that you pay out-of-pocket during the calendar year for in-network covered Part A and Part B services. Amounts you pay for our plan premiums, Medicare Part A and Part B premiums, and Part D prescription drugs don't count toward the maximum out-of-pocket amount.

Medicaid (or Medical Assistance) – A joint federal and state program that helps with medical costs for some people with low incomes and limited resources. State Medicaid programs vary, but most health care costs are covered if you qualify for both Medicare and Medicaid.

Medical Care or Services – Health care services or items. Some examples of health care items include durable medical equipment, eyeglasses, and drugs covered by Medicare Part A or Part B, but not drugs covered under Medicare Part D.

Medical Group – It is the network of plan providers that our plan contracts with to provide covered services to you. The name of our medical groups are The Permanente Medical Group Inc., a for-profit professional corporation and the Southern California Permanente Medical Group, a for-profit professional partnership.

Medically Accepted Indication – A use of a drug that is either approved by the FDA or supported by certain references, such as the American Hospital Formulary Service Drug Information and the Micromedex DRUGDEX Information system.

Medically Necessary – Services, supplies, or drugs that are needed for the prevention, diagnosis, or treatment of your medical condition and meet accepted standards of medical practice.

Medicare – The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with End-Stage Renal Disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

Medicare Advantage (MA) Plan – Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A and Part B benefits. A Medicare Advantage Plan can be (i) an HMO, (ii) a PPO, (iii) a Private Fee-for-Service (PFFS) plan, or (iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage.**

Medicare-Covered Services – Services covered by Medicare Part A and Part B. All Medicare health plans must cover all the services that are covered by Medicare Part A and B. The term Medicare-Covered Services doesn't include the extra benefits, such as vision or hearing, that a Medicare Advantage plan may offer.

Medicare Health Plan – A Medicare health plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in our plan. This term includes all Medicare Advantage Plans, Medicare Cost Plans, Special Needs Plans, Demonstration/ Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medicare Prescription Drug Coverage (Medicare Part D) – Insurance to help pay for outpatient prescription drugs, vaccines, biologicals, and some supplies not covered by Medicare Part A or Part B.

Medication Therapy Management (MTM) program – A Medicare Part D program for complex health needs provided to people who meet certain requirements or are in a Drug Management Program. MTM services usually include a discussion with a pharmacist or health care provider to review medications.

Medigap (Medicare Supplement Insurance) Policy – Medicare supplement insurance sold by private insurance companies to fill gaps in Original Medicare. Medigap policies only work with Original Medicare. (A Medicare Advantage Plan is not a Medigap policy.)

Member (Member of our Plan, or Plan Member) – A person with Medicare who is eligible to get covered services, who has enrolled in our plan, and whose enrollment has been confirmed by the Centers for Medicare & Medicaid Services (CMS).

Member Services – A department within our plan responsible for answering your questions about your membership, benefits, grievances, and appeals.

Musculoskeletal and Related Disorders – Conditions with signs and symptoms related to the nervous, muscular, and/or skeletal systems. Musculoskeletal and related disorders are conditions typically categorized as structural, degenerative, or inflammatory disorders; or biomechanical dysfunction of the joints of the body and/or related components of the muscle or skeletal systems (muscles, tendons, fascia, nerves, ligaments/capsules, discs, and synovial structures) and related manifestations or conditions.

Network Pharmacy – A pharmacy that contracts with our plan where members of our plan can get their prescription drug benefits. In most cases, your prescriptions are covered only if they are filled at one of our network pharmacies.

Network Physician – Any licensed physician who is a partner or employee of Medical Group, or any licensed physician who contracts to provide services to our members (but not including physicians who contract only to provide referral services).

Network Provider –Provider is the general term for doctors, other health care professionals (including, but not limited to, physician assistants, nurse practitioners, and nurses), hospitals, and other health care facilities that are licensed or certified by Medicare and by the state to provide health care services. **Network providers** have an agreement with our plan to accept our payment as payment in full, and in some cases, to coordinate as well as provide covered services to members of our plan. Network providers are also called **plan providers**.

Organization Determination – A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or services. Organization determinations are called coverage decisions in this document.

Original Biological Product – A biological product that has been approved by the FDA and serves as the comparison for manufacturers making a biosimilar version. It is also called a reference product.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare) – Original Medicare is offered by the government, and not a private health plan like Medicare Advantage plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-Network Pharmacy – A pharmacy that doesn't have a contract with our plan to coordinate or provide covered drugs to members of our plan. Most drugs you get from out-of-network pharmacies aren't covered by our plan unless certain conditions apply.

Out-of-Network Provider or Out-of-Network Facility – A provider or facility that doesn't have a contract with our plan to coordinate or provide covered services to members of our plan. Out-of-network providers are providers that aren't employed, owned, or operated by our plan.

Out-of-Pocket Costs – Go to the definition for cost-sharing above. A member's cost-sharing requirement to pay for a portion of services or drugs gotten is also referred to as the member's out-of-pocket cost requirement.

Out-of-Pocket Threshold – The maximum amount you pay out of pocket for Part D drugs.

PACE Plan – A PACE (Program of All-Inclusive Care for the Elderly) plan combines medical, social, and long-term services and supports (LTSS) for frail people to help people stay independent and living in their community (instead of moving to a nursing home) as long as possible. People enrolled in PACE plans get both their Medicare and Medicaid benefits through our plan.

Part C – Go to **Medicare Advantage (MA) Plan.**

Part D – The voluntary Medicare Prescription Drug Benefit Program.

Part D Drugs – Drugs that can be covered under Part D. We may or may not offer all Part D drugs. Certain categories of drugs have been excluded as covered Part D drugs by Congress. Certain categories of Part D drugs must be covered by every plan.

Part D Late Enrollment Penalty – An amount added to your monthly plan premium for Medicare drug coverage if you go without creditable coverage (coverage that's expected to pay, on average, at least as much as standard Medicare prescription drug coverage) for a continuous period of 63 days or more after you're first eligible to join a Part D plan.

Plan – Kaiser Permanente Senior Advantage.

Plan Charges – Plan Charges means the following:

- For services provided by Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for services provided to members.
- For services for which a provider (other than Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider.
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a member for the item if a member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs; the direct and indirect costs of providing Kaiser Permanente pharmacy services to members; and the pharmacy program's contribution to the net revenue requirements of Health Plan).
- For all other services, the payments that Kaiser Permanente makes for the services or, if Kaiser Permanente subtracts cost-sharing from its payment, the amount Kaiser Permanente would have paid if it did not subtract cost-sharing.

Post-Stabilization Care – Medically necessary services related to your emergency medical condition that you receive after your treating physician determines that this condition is clinically stable. You're considered clinically stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards, that you're safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

Preferred Provider Organization (PPO) Plan – A Preferred Provider Organization plan is a Medicare Advantage Plan that has a network of contracted providers that have agreed to treat plan members for a specified payment amount. A PPO plan must cover all plan benefits whether they're received from network or out-of-network providers. Member cost-sharing will generally be higher when plan benefits are gotten from out-of-network providers. PPO plans have an annual limit on your out-of-pocket costs for services gotten from network (preferred) providers and a higher limit on your total combined out-of-pocket costs for services from both in-network (preferred) and out-of-network (non-preferred) providers.

Premium – The periodic payment to Medicare, an insurance company, or a health care plan for health or prescription drug coverage.

Preventive services – Health care to prevent illness or detect illness at an early stage, when treatment is likely to work best (for example, preventive services include Pap tests, flu shots, and screening mammograms).

Primary Care Provider (PCP) – The doctor or other provider you see first for most health problems. In many Medicare health plans, you must see your primary care provider before you see any other health care provider.

Prior Authorization – Approval in advance to get services and/or certain drugs. Covered services that need prior authorization are marked in the Medical Benefits Chart in Chapter 4 and described in Chapter 3, Section 2.3. Covered drugs that need prior authorization are marked in the formulary and our criteria are posted on our website.

Prosthetics and Orthotics – Medical devices including, but not limited to, arm, back and neck braces; artificial limbs; artificial eyes; and devices needed to replace an internal body part or function, including ostomy and urological supplies and enteral and parenteral nutrition therapy.

Quality Improvement Organization (QIO) – A group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients.

"Real-Time Benefit Tool" – A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

Referral – A written order from your primary care doctor for you to visit a specialist or get certain medical services. Without a referral, our plan may not pay for services from a specialist.

Rehabilitation Services – These services include inpatient rehabilitation care, physical therapy (outpatient), speech and language therapy, and occupational therapy.

Selected Drug – A drug covered under Part D for which Medicare negotiated a Maximum Fair Price.

Service Area – A geographic area where you must live to join a particular health plan. For plans that limit which doctors and hospitals you may use, it's also generally the area where you can get routine (non-emergency) services. Our plan must disenroll you if you permanently move out of our plan's service area.

Services – Health care services or items ("health care" includes both physical health care and mental health care).

Skilled Nursing Facility (SNF) Care – Skilled nursing care and rehabilitation services provided on a continuous, daily basis, in a skilled nursing facility. Examples of care include physical therapy or intravenous injections that can only be given by a registered nurse or doctor.

Specialty-Tier Drugs – Very high-cost drugs approved by the FDA that are on our formulary.

Subscriber – A member who is eligible for membership on his or her own behalf and not by virtue of dependent status.

Supplemental Security Income (SSI) – A monthly benefit paid by Social Security to people with limited income and resources who are disabled, blind, or age 65 and older. SSI benefits aren't the same as Social Security benefits.

Urgent Chiropractic or Acupuncture Services – Chiropractic or acupuncture services that meet all of the following requirements:

- They are necessary to prevent serious deterioration of your health resulting from an unforeseen illness, injury, or complication of an existing condition, including pregnancy.
- They cannot be delayed until you return to the service area.

Urgently Needed Services –A plan-covered service requiring immediate medical attention that's not an emergency is an urgently needed service if either you're temporarily outside our plan's service area, or it's unreasonable given your time, place, and circumstances to get this service from network providers. Examples of urgently needed services are unforeseen medical illnesses and injuries, or unexpected flare-ups of existing conditions. Medically necessary routine provider visits (like annual checkups) aren't considered urgently needed even if you're outside our plan's service area or our plan network is temporarily unavailable.

KAISER PERMANENTE®

Kaiser Permanente Senior Advantage Member Services

	Member Services — Contact Information
Call	**1-800-443-0815** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m. Member Services **1-800-443-0815** (TTY users call **711**) also has free language interpreter services available for non-English speakers.
TTY	**711** Calls to this number are free. 7 days a week, 8 a.m. to 8 p.m.
Write	Your local Member Services office (see the *Provider Directory* for locations).
Website	**kp.org**

State Health Insurance Assistance Program

A State Health Insurance Assistance Program (SHIP) is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare. Go to Chapter 2, Section 3, for SHIP contact information.

PRA Disclosure Statement

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1051. If you have comments or suggestions for improving this form, write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850.

Nondiscrimination Notice

In this document, “we”, “us”, or “our” means Kaiser Permanente (Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., and the Southern California Medical Group). This notice is available on our website at **kp.org**.

Discrimination is against the law. We follow state and federal civil rights laws.

We do not discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- 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 our Member Services department at the numbers below. The call is free. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week.
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week.
- All others: **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week.

Upon request, this document can be made available to you in braille, large print, audio, or electronic formats. To obtain a copy in one of these alternative formats, or another format, call our Member Services department and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with us if you believe we have failed to provide these services or unlawfully discriminated in another way. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Call our Member Services department. Phone numbers are listed above.
- **By mail:** Download a form at **kp.org** or call Member Services and ask them to send you a form that you can send back.
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at **kp.org/facilities** for addresses)

- **Online:** Use the online form on our website at **kp.org**

You may also contact the Kaiser Permanente Civil Rights Coordinator directly at the addresses below:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office of Civil Rights *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office of Civil Rights in writing, by phone or by email:

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY **711**)
- **By mail:** Fill out a complaint form or send a letter to:

  Office of Civil Rights
  Department of Health Care Services
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  California Department of Health Care Services Office of Civil Rights Complaint forms are available at: http://www.dhcs.ca.gov/Pages/Language_Access.aspx
- **Online:** Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office of Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office of Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY **711** or **1-800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:
  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201
  U.S. Department of Health and Human Services Office of Civil Rights Complaint forms are available at: https://www.hhs.gov/ocr/office/file/index.html
- **Online:** Visit the **Office of Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf**

Notice of Language Assistance

English: ATTENTION. Language assistance is available at no cost to you. You can ask for interpreter services, including sign language interpreters. You can ask for materials translated into your language or alternative formats, such as braille, audio, or large print. You can also request auxiliary aids and devices at our facilities. Call our Member Services department for help. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week
- All others: **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week

Arabic: تنبيه. المساعدة اللغوية متوفرة بدون تكلفة عليك. يمكنك طلب خدمات الترجمة، بما في ذلك مترجمي لغة الإشارة. يمكنك طلب وثائق مترجمة بلغتك أو بصيغ بديلة مثل طريقة برايل للمكفوفين أو ملف صوتي أو الطباعة بأحرف كبيرة. يمكنك أيضًا طلب وسائل مساعدة وأجهزة مساعدة في مرافقنا. اتصل مع قسم خدمات الأعضاء لدينا للحصول على المساعدة. لا تعمل خدمات الأعضاء في العطلات الرئيسية.

- Medicare، بما في ذلك D-SNP على: **1-800-443-0815** (TTY **711**)، 8 صباحاً إلى 8 مساءً، 7 أيام في الأسبوع
- Medi-Cal: على **1-855-839-7613** (TTY **711**)، 24 ساعة في اليوم، 7 أيام في الأسبوع
- الآخرين جميعاً: **1-800-464-4000** (TTY **711**)، 24 ساعة في اليوم، 7 أيام في الأسبوع

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Լեզվական աջակցությունը հասանելի է ձեզ անվճար: Դուք կարող եք խնդրել բանավոր թարգմանության ծառայություններ, այդ թվում՝ ժեստերի լեզվի թարգմանիչներ: Դուք կարող եք խնդրել ձեր լեզվով թարգմանված նյութեր կամ այլընտրանքային ձևաչափեր, ինչպիսիք են՝ բրայլը, ձայնագրությունը կամ խոշոր տառատեսակը: Դուք կարող եք նաև դիմել օժանդակ աջակցության և սարքերի համար, որոնք առկա են մեր հաստատություններում: Օգնության համար զանգահարեք մեր Անդամների սպասարկման բաժին: Անդամների սպասարկման բաժինը փակ է հիմնական տոն օրերին:

- Medicare, ներառյալ D-SNP՝ **1-800-443-0815** (TTY **711**), 8 a.m.-ից 8 p.m.-ը, շաբաթը 7 օր
- Medi-Cal՝ **1-855-839-7613** (TTY **711**), օրը 24 ժամ, շաբաթը 7 օր
- Մյուս բոլորը՝ **1-800-464-4000** (TTY **711**), օրը 24 ժամ, շաբաթը 7 օր

Chinese：请注意，我们有免费语言协助。您可以要求我们提供口译服务，包括手语翻译员。您可以要求将资料翻译成您所使用的语言或其他格式的版本，如盲文、音频或大字版。您还可以要求使用我们设施中的语言辅助工具和设备。请联系会员服务部以获取帮助。重要节假日期间会员服务不开放。

- Medicare，包括 D-SNP：**1-800-443-0815** (TTY **711**)，每周 7 天，上午 8 点至晚上 8 点
- Medi-Cal：**1-855-839-7613** (TTY 711)，每周 7 天，每天 24 小时
- 所有其他保险计划：**1-800-757-7585** (TTY **711**)，每周 7 天，每天 24 小时

Farsi: توجه. امکان بهره‌مندی از مساعدت زبانی به طور رایگان برای شما وجود دارد. می‌توانید خدمات ترجمه شفاهی را درخواست کنید، از جمله مترجمان زبان اشاره. همچنین می‌توانید مطالب ترجمه‌شده به زبان خودتان یا در قالب‌های جایگزین را درخواست کنید، از جمله خط بریل، فایل صوتی، یا چاپ با حروف درشت. همچنین می‌توانید امکانات و دستگاه‌های کمکی را از مراکز ما درخواست کنید. برای دریافت کمک، با خدمات اعضای ما تماس بگیرید. خدمات اعضاء، در تعطیلات رسمی بسته است.

- Medicare، شامل D-SNP: با شماره **1-800-443-0815** (TTY **711**) از 8 صبح تا 8 عصر، در 7 روز هفته تماس بگیرید
- Medi-Cal: با شماره **1-855-839-7613** (TTY **711**)، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید
- همه موارد دیگر: با شماره **1-800-464-4000** (TTY **711**)، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید

Hindi: ध्यान दें। भाषा सहायता आपके लिए बिना किसी शुल्क के उपलब्ध है। आप दुभाषिया सेवाओं के लिए अनुरोध कर सकते हैं, जिसमें साइन लैंगुवेज के दुभाषिये भी शामिल हैं। आप सामग्रियों को अपनी भाषा या वैकल्पिक प्रारूप, जैसे कि ब्रेल, ऑडियो, या बड़े प्रिंट में अनुवाद करवाने के लिए भी कह सकते हैं। आप हमारे सुविधा-केंद्रों पर सहायक साधनों और उपकरणों का भी अनुरोध कर सकते हैं। सहायता के लिए हमारे सदस्य सेवा विभाग को कॉल करें। सदस्य सेवा विभाग मुख्य छुट्टियों वाले दिन बंद रहता है।

- Medicare, जिसमें D-SNP शामिल है: **1-800-443-0815** (TTY **711**), सुबह 8 बजे से रात 8 बजे तक, सप्ताह के 7 दिन
- Medi-Cal: **1-855-839-7613** (TTY **711**), दिन के चौबीस घंटे, सप्ताह के 7 दिन
- बाकी सभी: **1-800-464-4000** (TTY **711**), दिन के चौबीस घंटे, सप्ताह के 7 दिन

Hmong: FAJ SEEB. Muaj kev pab txhais lus pub dawb rau koj. Koj muaj peev xwm thov kom pab txhais lus, suav nrog kws txhais lus piav tes. Koj muaj peev xwm thov kom muab cov ntaub ntawv no txhais ua koj yam lus los sis ua lwm hom, xws li hom ntawv rau neeg dig muag xuas, tso ua suab lus, los sis luam tawm kom koj. Koj kuj tuaj yeem thov kom muab tej khoom pab dawb thiab tej khoom siv txhawb tau rau ntawm peb cov chaw kuaj mob. Hu mus thov kev pab

rau ntawm peb Lub Chaw Pab Tswv Cuab. Lub chaw pab tswv cuab kaw rau cov hnub so uas tseem ceeb.

- Medicare, suav nrog D-SNP: **1-800-443-0815** (TTY **711**), 8 teev sawv ntxov txog 8 teev tsaus ntuj, 7 hnub hauv ib lub vij
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 teev hauv ib hnub, 7 hnub hauv ib lub vij
- Tag nrho lwm yam: **1-800-464-4000** (TTY **711**), 24 teev hauv ib hnub, 7 hnub hauv ib lub vij

Japanese: ご注意。言語サポートは無料でご利用いただけます。あなたは手話通訳を含む通訳サービスを依頼できます。点字、大型活字、または録音音声など、あなたの言語に翻訳された資料や別のフォーマットの資料を求めることができます。当社の施設では補助器具や機器の要請も承っております。支援が必要な方は、加入者サービス部門にお電話ください。加入者向けサービスは主要な休日では営業しておりません。

- D-SNP を含む Medicare：**1-800-443-0815**（TTY **711**）、午前 8 時から午後 8 時まで、年中無休
- Medi-Cal：**1-855-839-7613**（TTY **711**）、24 時間、年中無休
- その他全て：**1-800-464-4000**（TTY **711**）、24 時間、年中無休

Khmer (Cambodian): យកចិត្តទុកដាក់។ ជំនួយភាសាគឺមានដោយមិនគិតថ្លៃសម្រាប់អ្នក។ អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ រួមទាំងអ្នកបកប្រែភាសាសញ្ញាផងដែរ។ អ្នកអាចស្នើសុំឯកសារដែលត្រូវបានបកប្រែជាភាសារបស់អ្នក ឬទម្រង់ផ្សេងទៀតដូចជាអក្សរស្ដាប សំឡេង ឬអក្សរធំៗ។ អ្នកក៏អាចស្នើសុំជំនួយបន្ថែម និងឧបករណ៍ជំនួយនៅតាមកន្លែងរបស់យើងផងដែរ។ សូមទូរសព្ទទៅផ្នែកសេវាសមាជិករបស់យើងសម្រាប់ជំនួយ។ សេវាសមាជិកត្រូវបានបិទនៅថ្ងៃឈប់សម្រាកសំខាន់ៗ។

- Medicare, រួមទាំង D-SNP: **1-800-443-0815** (TTY **711**) ពីម៉ោង 8 ព្រឹក ដល់ 8 យប់ 7 ថ្ងៃក្នុងមួយសប្ដាហ៍
- Medi-Cal: **1-855-839-7613** (TTY **711**) 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្ដាហ៍
- ផ្សេងៗទៀត៖ **1-800-464-4000** (TTY **711**) 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្ដាហ៍

Korean: 안내 사항. 무료 언어 지원 제공. 수화 통역사를 포함한 통역 서비스를 요청할 수 있습니다. 한국어로 번역된 자료 또는 점자, 오디오 또는 큰 글씨와 같은 대체 형식의 자료를 요청할 수 있습니다. 저희 시설에서 보조 기구와 장치를 요청할 수도 있습니다. 가입자 서비스 부서에 도움을 요청하시기 바랍니다. 주요 공휴일에는 가입자 서비스를 운영하지 않습니다.

- Medicare(D-SNP 포함), 주 7 일 오전 8 시~오후 8 시에 **1-800-443-0815** (TTY **711**) 번으로 문의
- Medi-Cal: **1-855-839-7613** (TTY **711**), 주 7 일, 하루 24 시간
- 기타: **1-800-464-4000** (TTY **711**), 주 7 일, 하루 24 시간

Laotian: ໂປດຊາບ. ມີການຊ່ວຍເຫຼືອດ້ານພາສາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ທ່ານສ າມາດຂໍບໍລິການນາຍພາສາ, ລວມທັງນາຍພາສາມື. ທ່ານ ສາມາດຂໍໃຫ້ແປເອກະສານນີ້ເປັນພາສາຂອງທ່ານ ຫຼື ຮູບ ແບບອື່ນ ເຊັ່ນ ອັກສອນນູນ, ສຽງ, ຫຼື ການພິມຂະໜາດໃ ຫຍ່. ນອກຈາກນັ້ນທ່ານຍັງສາມາດຮ້ອງຂໍເຄື່ອງຊ່ວຍຟັງ ແລະ ອຸປະກອນການຊ່ວຍເຫຼືອໃນສະຖານທີ່ຂອງພວກ ເຮົາ. ໂທຫາພະແນກບໍລິການສະມາຊິກຂອງພວກເຮົາເ ພື່ອຂໍຄວາມຊ່ວຍເຫຼືອ. ພະແນກບໍລິການສະມາຊິກແ ມ່ນປິດໃນວັນພັກທີ່ສໍາຄັນຕ່າງໆ.

- Medicare, ລວມທັງ D-SNP: **1-800-443-0815** (TTY **711**), 8 ໂມງເຊົ້າ ຫາ 8 ໂມງແລງ, 7 ວັນຕໍ່ອາທິດ
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ
- ອື່ນໆ: **1-800-464-4000** (TTY **711**), 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ

Mien: CAU FIM JANGX LONGX OC. Ninh mbuo duqv liepc ziangx tengx faan waac bun meih muangx mv zuqc heuc meih ndorqv nyaanh cingv oc. Meih corc haiv tov taux ninh mbuo tengx lorz faan waac bun meih, caux longc buoz wuv faan waac bun muangx. Meih aengx haih tov taux ninh mbuo dorh nyungc horngh jaa dorngx faan benx meih nyei waac a'fai fiev bieqc da'nyeic diuc daan, fiev benx domh nzangc-pokc bun hluo, bungx waac-qiez bun uangx, a'fai aamx bieqc domh zeiv-linh. Meih corc haih tov longc benx wuotc ginc jaa-dorngx tengx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Mborqv finx lorz taux yie mbuo dinc zangc domh gorn ziux goux baengc mienh nyei dorngx liouh tov heuc ninh mbuo tengx nzie weih. Ziux goux baengc mienh nyei gorn zangc se gec mv zoux gong yiem gingc nyei hnoi-nyieqc oc.

- Medicare, caux D-SNP: **1-800-443-0815** (TTY **711**), yiem 8 dimv lungh ndorm taux 8 dimv lungh muonx, yietc norm leiz baaix zoux gong 7 hnoi
- Medi-Cal: **1-855-839-7613** (TTY **711**), yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi
- Yietc zungv da'nyeic diuc jauv-louc: **1-800-464-4000** (TTY **711**), yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi

Navajo: GIHA. Tséé' naalkáah sidá'ígíí éí doo tł'éé' íił'į' dah sidáa'ígíí. Tł'éé'góó tł'ízí'ígíí éí tséé' naalkáah sidá'ígíí bikáa' dah sidaaígíí, t'á'ii bik'eh dah na'ałkaígíí. T'á'ii éí tł'éé'góó tł'ízí'ígíí bik'eh dah deidiyós, t'á'ii éí bi'éé' bik'eh dah na'ałkaígíí bik'eh dah deidiyós. T'á'ii bik'eh dah na'ałkaígíí bikáa' dah na'ałkaígíí t'áá ałtso bik'eh dah deidiyós. Bi'éé' naalkáah sidá'ígíí bik'eh ha'a'aah. T'á'ii bik'eh dah na'ałkaígíí éí bik'eh dah naazhjaa'ígíí bik'eh dah na'ałkaígíí.

- Medicare, bikáa' dah deidiyós D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. góó 8 p.m., 7 jį t'ááłá'í damóo
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 tł'ohch'oolí t'ááłá'í jį, 7 jį t'ááłá'í damóo
- T'áá ał'ąą: **1-800-464-4000** (TTY **711**), 24 tł'ohch'oolí t'ááłá'í jį, 7 jį t'ááłá'í damóo

Punjabi: ਧਿਆਨ ਦਿਓ। ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸ਼ਿਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦਿੱਤੇ ਜਾਣ ਲਈ ਕਹਿ ਸਕਦੇ ਹੋ, ਜਿਸ ਵਿੱਚ ਸਾਈਨ ਲੈਂਗੁਵੇਜ਼ ਦੇ ਦੁਭਾਸ਼ਿਏ ਵੀ ਸ਼ਾਮਲ ਹਨ। ਤੁਸੀਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ, ਜਾਂ ਕਿਸੇ ਵੈਕਲਪਿਕ ਫਾਰਮੈਟ ਵਿੱਚ ਅਨੁਵਾਦਿਤ ਕਰਨ ਲਈ ਵੀ ਕਹਿ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸਹੂਲਤਾਂ 'ਤੇ ਸਹਾਇਕ ਏਡਜ਼ ਅਤੇ ਉਪਕਰਨਾਂ ਲਈ ਵੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਮਦਦ ਲਈ ਸਾਡੇ ਮੈਂਬਰਾਂ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦੇ ਵਿਭਾਗ ਨੂੰ ਕਾੱਲ ਕਰੋ। ਮੈਂਬਰਾਂ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦਾ ਵਿਭਾਗ ਮੁੱਖ ਛੁਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ।

- Medicare, ਜਿਸ ਵਿੱਚ D-SNP ਵੀ ਸ਼ਾਮਲ ਹੈ: **1-800-443-0815** (TTY **711**), ਸਵੇਰੇ 8 ਵਜੇ ਤੋਂ ਸ਼ਾਮ 8 ਵਜੇ ਤੱਕ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- Medi-Cal: **1-855-839-7613** (TTY **711**), ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- ਬਾਕੀ ਸਾਰੇ: **1-800-464-4000** (TTY **711**), ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ

Russian: ВНИМАНИЕ! Для Вас доступны бесплатные услуги перевода. Вы можете запросить услуги устного перевода, в том числе услуги переводчика языка жестов. Вы также можете запросить материалы, переведенные на ваш язык или в альтернативных форматах, например шрифтом Брайля, крупным шрифтом или в аудиоформате. Вы также можете запросить дополнительные приспособления и вспомогательные устройства в наших учреждениях. Если Вам нужна помощь, позвоните в отдел обслуживания участников. Отдел обслуживания участников не работает в дни государственных праздников.

- Medicare, включая D-SNP: **1-800-443-0815** (TTY **711**), без выходных с 8:00 до 20:00.
- Medi-Cal: **1-855-839-7613** (TTY **711**), круглосуточно без выходных.
- Любые другие поставщики услуг: **1-800-464-4000** (TTY **711**), круглосуточно без выходных.

Spanish: ATENCIÓN. Se ofrece ayuda en otros idiomas sin ningún costo para usted. Puede solicitar servicios de interpretación, incluyendo intérpretes de lengua de señas. Puede solicitar materiales traducidos a su idioma o en formatos alternativos, como braille, audio o letra grande. También puede solicitar ayuda adicional y dispositivos auxiliares en nuestros centros de atención. Llame al Departamento de Servicio a los Miembros para pedir ayuda. Servicio a los Miembros está cerrado los días festivos principales.

- Medicare, incluyendo D-SNP: **1-800-443-0815** (TTY **711**), los 7 días de la semana, de 8 a. m. a 8 p. m., los 7 días de la semana
- Medi-Cal: **1-855-839-7613** (TTY **711**), las 24 horas del día, los 7 días de la semana.
- Todos los otros: **1-800-788-0616** (TTY **711**), las 24 horas del día, los 7 días de la semana.

Tagalog: PAUNAWA. May magagamit na tulong sa wika nang wala kang babayaran. Maaari kang humiling ng mga serbisyo ng interpreter, kasama ang mga interpreter sa sign language. Maaari kang humiling ng mga babasahin na nakasalin-wika sa iyong wika o sa mga alternatibong format, na tulad ng braille, audio, o malalaking titik. Puwede ka ring humiling ng mga karagdagang tulong at device sa aming mga pasilidad. Tawagan ang aming departamento ng Mga Serbisyo sa Miyembro para sa tulong. Ang mga serbisyo sa miyembro ay sarado sa mga pangunahing holiday.

- Medicare, kasama ang D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. hanggang 8 p.m., 7 araw sa isang linggo
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo
- Ang lahat ng iba: **1-800-464-4000** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo

Thai: ส่งถึง มีบริการให้ความช่วยเหลือด้านภาษา แก่ท่านโดยไม่มีค่าใช้จ่าย ท่านสามารถขอรับบริการล่าม รวมถึงล่ามภาษามือได้ ท่านสามารถขอให้แปลเอกสารเป็นภาษาของท่าน หรือในรูปแบบอื่นๆ เช่นอักษรเบรลล์ ไฟล์เสียง หรือตัวอักษรขนาดใหญ่ ท่านสามารถขอรับอุปกรณ์ ช่วยเหลือและอุปกรณ์เสริมได้ ณ สถานที่ให้บริการของเรา โทรติดต่อฝ่ายบริการสมาชิกของเราเพื่อขอความช่วยเหลือได้ ฝ่ายบริการสมาชิกจะปิดทำการในวันหยุดราชการต่างๆ

- Medicare **รวมถึง** D-SNP: **1-800-443-0815** (TTY **711**) 8.00 **น.** ถึง 20.00 **น.** **หรือ** 7 **วันต่อสัปดาห์**
- Medi-Cal: **1-855-839-7613** (TTY **711**) **ตลอด** 24 **ชั่วโมง หรือ** 7 **วันต่อสัปดาห์**
- **อื่นๆ ทั้งหมด: 1-800-464-4000** (TTY **711**) **ตลอด** 24 **ชั่วโมง หรือ** 7 **วันต่อสัปดาห์**

Ukrainian: УВАГА! Послуги перекладача надаються безкоштовно. Ви можете залишити запит на послуги усного перекладу, зокрема мовою жестів. Ви можете зробити запит на отримання матеріалів, перекладених вашою мовою, або в альтернативних форматах, як-от надрукованим шрифтом Брайля чи великим шрифтом, а також у звуковому форматі. Крім того, ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Якщо вам потрібна допомога, зателефонуйте у відділ обслуговування клієнтів. Відділ обслуговування клієнтів зачинений у державні свята.

- Medicare, зокрема D-SNP: **1-800-443-0815** (TTY **711**), з 8:00 до 20:00, без вихідних.
- Medi-Cal: **1-855-839-7613** (TTY **711**), цілодобово, без вихідних.
- Усі інші надавачі послуг: **1-800-464-4000** (TTY **711**), цілодобово, без вихідних.

Vietnamese: LƯU Ý. Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ miễn phí cho quý vị. Quý vị có thể yêu cầu dịch vụ thông dịch, bao gồm cả thông dịch viên ngôn ngữ ký hiệu. Quý vị có thể yêu cầu tài liệu được dịch sang ngôn ngữ của quý vị hay định dạng thay thế, chẳng hạn như chữ nổi braille, băng đĩa thu âm hay bản in khổ chữ lớn. Quý vị cũng có thể yêu cầu các phương tiện và thiết bị phụ trợ tại các cơ sở của chúng tôi. Gọi cho ban Dịch Vụ Hội Viên của chúng tôi để được trợ giúp. Ban dịch vụ hội viên không làm việc vào những ngày lễ lớn.

- Medicare, bao gồm cả D-SNP: **1-800-443-0815** (TTY **711**), 8 giờ sáng đến 8 giờ tối, 7 ngày trong tuần
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần
- Mọi chương trình khác: **1-800-464-4000** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần.