KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern California Region

A nonprofit corporation

EOC #4 - Kaiser Permanente Deductible HMO Plan
Evidence of Coverage for
NORTHERN CALIF SOFT DRINK IND

Group ID: 24 Contract: 1 Version: 88 *EOC* Number: 4

January 1, 2022, through December 31, 2022

Member Service Contact Center
24 hours a day, seven days a week (except closed holidays)
1-800-464-4000 (TTY users call **711**)
kp.org

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Cost Share Summary

This "Cost Share Summary" is part of your Evidence of Coverage (*EOC*) and is meant to explain the amount you will pay for covered Services under this plan. It does not provide a full description of your benefits. For a full description of your benefits, including any limitations and exclusions, please read this entire *EOC*, including any amendments, carefully.

Accumulation Period

The Accumulation Period for this plan is January 1 through December 31.

Deductibles and Out-of-Pocket Maximums

For Services that apply to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share for the rest of the Accumulation Period once you have reached the amounts listed below.
For Services that are subject to the Plan Deductible or the Drug Deductible, you must pay Charges for covered Services you receive during the Accumulation Period until you reach the deductible amounts listed below. All payments you make toward your deductibles apply to the Plan Out-of-Pocket Maximum amounts listed below.

Amounts Per Accumulation Period	**Self-Only Coverage** (a Family of one Member)	**Family Coverage** Each Member in a Family of two or more Members	**Family Coverage** Entire Family of two or more Members
Plan Deductible	$200	$200	$400
Drug Deductible	None	None	None
Plan Out-of-Pocket Maximum ("OOPM")	$1,500	$1,500	$3,000

Cost Share Summary Tables by Benefit

How to read the Cost Share summary tables

Each table below explains the Cost Share for a category of benefits. Specific Services related to the benefit are described in the first column of each table. For a detailed description of coverage for a particular benefit, refer to the same benefit heading in the "Benefits" section of this *EOC*.

- **Copayment / Coinsurance**. This column describes the Cost Share you will pay for Services after you have met your Plan Deductible or Drug Deductible, if applicable. (Please see the "Deductibles and Out-of-Pocket Maximums" section above to determine if your plan includes deductibles.) If the Services are not covered in your plan, this column will read "Not covered." If we provide an Allowance that you can use toward the cost of the Services, this column will include the Allowance.
- **Subject to Deductible**. This column explains whether the Cost Share you pay for Services is subject to a Plan Deductible or Drug Deductible. If the Services are subject to a deductible, you will pay Charges for those Services until you have met your deductible. If the Services are subject to a deductible, there will be a "✓" or "D" in this column, depending on which deductible applies ("✓" for Plan Deductible, "D" for Drug Deductible). If the Services do not apply to a deductible, or if your plan does not include a deductible, this column will be blank. For a more detailed explanation of deductibles, refer to "Plan Deductible" and "Drug Deductible" in the "Benefits" section of this *EOC*.
- **Applies to OOPM**. This column explains whether the Cost Share you pay for Services counts toward the Plan Out-of-Pocket Maximum ("OOPM") after you have met any applicable deductible. If the Services count toward the Plan OOPM, there will be a "✓" in this column. If the Services do not count toward the Plan OOPM, this column will be blank. For a more detailed explanation of the Plan OOPM, refer to "Plan Out-of-Pocket Maximum" heading in the "Benefits" section of this *EOC*.

Administered drugs and products

Description of Administered Drugs and Products Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Whole blood, red blood cells, plasma, and platelets	No charge	*.1*	*.1*
Allergy antigens (including administration)	No charge	*.1*	*.1*
Cancer chemotherapy drugs and adjuncts	No charge		*.1*
Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products (“biologics”) derived from tissue, cells, or blood	No charge		*.1*
All other administered drugs and products	No charge		*.1*
Drugs and products administered to you during a home visit	No charge		*.1*

Ambulance Services

Description of Ambulance Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Emergency ambulance Services	$150 per trip	*.1*	*.1*
Nonemergency ambulance and psychiatric transport van Services	$150 per trip	*.1*	*.1*

Behavioral health treatment for autism spectrum disorder

Description of Behavioral Health Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Covered Services	10% Coinsurance up to a maximum of $25 per day		*.1*

Dialysis care

Description of Dialysis Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Equipment and supplies for home hemodialysis and home peritoneal dialysis	No charge	✓	✓

Description of Dialysis Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, evaluation, or treatment	No charge		*I*
Hemodialysis and peritoneal dialysis treatment at a Plan Facility	$25 per visit	*I*	*I*

Durable Medical Equipment ("DME") for home use

Description of DME Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Blood glucose monitors for diabetes blood testing and their supplies	10% Coinsurance		*I*
Peak flow meters	10% Coinsurance		*I*
Insulin pumps and supplies to operate the pump	10% Coinsurance		*I*
Other Base DME Items as described in this *EOC*	10% Coinsurance		*I*
Supplemental DME items as described in this *EOC*	10% Coinsurance		
Retail-grade breast pumps	No charge		*I*
Hospital-grade breast pumps	No charge		*I*

Emergency and Urgent Care visits

Description of Emergency and Urgent Care Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Emergency Department visits	10% Coinsurance		*I*
Urgent Care visits	$25 per visit		*I*

Note: If you are admitted to the hospital as an inpatient from the Emergency Department, the Emergency Department visits Cost Share above does not apply. Instead, the Services you received in the Emergency Department, including any observation stay, if applicable, will be considered part of your inpatient hospital stay. For the Cost Share for inpatient care, refer to "Hospital inpatient care" in this "Cost Share Summary." The Emergency Department Cost Share does apply if you are admitted for observation but are not admitted as an inpatient.

Family planning Services

Description of Family Planning Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Family planning counseling	No charge		/
Injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices (“IUDs”) and office visits related to their insertion, removal, and management when provided to prevent pregnancy	No charge		/
Female sterilization procedures if performed in an outpatient or ambulatory surgery center or in a hospital operating room	No charge		/
All other female sterilization procedures	No charge		/
Male sterilization procedures if performed in an outpatient or ambulatory surgery center or in a hospital operating room	10% Coinsurance	/	/
All other male sterilization procedures	$25 per visit		/
Termination of pregnancy	10% Coinsurance	/	/

Fertility Services

Diagnosis and treatment of infertility

Description of Diagnosis and Treatment of Infertility Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Office visits	50% Coinsurance		
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	50% Coinsurance		
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	50% Coinsurance		
Outpatient imaging	50% Coinsurance		
Outpatient laboratory	50% Coinsurance		

Description of Diagnosis and Treatment of Infertility Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Outpatient diagnostic Services	50% Coinsurance		
Outpatient administered drugs	50% Coinsurance		
Hospital inpatient care (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	50% Coinsurance		

Artificial insemination

Description of Artificial Insemination Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Office visits	50% Coinsurance		
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when performed in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	50% Coinsurance		
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	50% Coinsurance		
Outpatient imaging	50% Coinsurance		
Outpatient laboratory	50% Coinsurance		
Outpatient diagnostic Services	50% Coinsurance		
Outpatient administered drugs	50% Coinsurance		
Hospital inpatient care (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services)	50% Coinsurance		

Assisted reproductive technology ("ART") Services

Description of ART Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Assisted reproductive technology ("ART") Services such as invitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), or zygote intrafallopian transfer ("ZIFT")	Not covered		

Health education

Description of Health Education Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Covered health education programs, which may include programs provided online and counseling over the phone	No charge		/
Individual counseling during an office visit related to smoking cessation	No charge		/
Individual counseling during an office visit related to diabetes management	No charge		/
Other covered individual counseling when the office visit is solely for health education	No charge		/
Covered health education materials	No charge		/

Hearing Services

Description of Hearing Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hearing exams with an audiologist to determine the need for hearing correction	$25 per visit		/
Physician Specialist Visits to diagnose and treat hearing problems	$25 per visit		/
Hearing aids, including, fitting, counseling, adjustment, cleaning, and inspection	Not covered		

Home health care

Description of Home Health Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Home health care Services (100 visits per Accumulation Period)	No charge		/

Hospice care

Description of Hospice Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Hospice Services	No charge		*.1*

Hospital inpatient care

Description of Hospital Inpatient Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient hospital stays	10% Coinsurance	*.1*	*.1*

Injury to teeth

Description of Injury to Teeth Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Accidental injury to teeth	Not covered		

Mental health Services

Description of Mental Health Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient mental health hospital stays	10% Coinsurance	*.1*	*.1*
Individual mental health evaluation and treatment	$25 per visit		*.1*
Group mental health treatment	$12 per visit		*.1*
Partial hospitalization	10% Coinsurance	*.1*	*.1*
Other intensive psychiatric treatment programs	10% Coinsurance	*.1*	*.1*
Residential mental health treatment Services	10% Coinsurance	*.1*	*.1*

Office visits

Description of Office Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits that are not described elsewhere in this “Cost Share Summary”	$25 per visit		*.1*

Description of Office Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Physician Specialist Visits that are not described elsewhere in this "Cost Share Summary"	$25 per visit		/
Group appointments that are not described elsewhere in this "Cost Share Summary"	$12 per visit		/
Acupuncture Services	$25 per visit		/

Ostomy and urological supplies

Description of Ostomy and Urological Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Ostomy and urological supplies as described in this *EOC*	No charge		/

Outpatient imaging, laboratory, and other diagnostic and treatment Services

Description of Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans	10% Coinsurance up to a maximum of $50 per procedure	/	/
Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds	$10 per encounter		/
Nuclear medicine	$10 per encounter		/
Routine retinal photography screenings	No charge		/
Routine laboratory tests to monitor the effectiveness of dialysis	No charge		/
All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available)	$10 per encounter		/
Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs and EEGs)	$10 per encounter		/
Radiation therapy	No charge	/	/

Description of Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Ultraviolet light treatments (including ultraviolet light therapy equipment as described in this *EOC*)	No charge		I,

Outpatient prescription drugs, supplies, and supplements

If the "Cost Share at a Plan Pharmacy" column in this section provides Cost Share for a 30-day supply and your Plan Physician prescribes more than this, you may be able to obtain more than a 30-day supply at one time up to the day supply limit for that drug. Applicable Cost Share will apply. For example, two 30-day copayments may be due when picking up a 60-day prescription, three copayments may be due when picking up a 100-day prescription at the pharmacy.

Most items

Description of Most Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on the generic, brand, and specialty tiers	Not covered	Not covered		

Base drugs, supplies, and supplements

Description of Base Drugs, Supplies and Supplements	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Hematopoietic agents for dialysis	No charge for up to a 30-day supply	Not available		I,
Elemental dietary enteral formula when used as a primary therapy for regional enteritis	No charge for up to a 30-day supply	Not available		I,
All other items on the generic tier (Tier 1) as described in this *EOC*	$15 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		I,
All other items on the brand tier (Tier 2) as described in this *EOC*	$15 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		I,
All other items on the specialty tier (Tier 4) as described in this *EOC*	$15 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		I,

Anticancer drugs and certain critical adjuncts following a diagnosis of cancer

Description of Anticancer Drugs and Certain Critical Adjuncts	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Oral anticancer drugs on the generic tier (Tier 1)	$15 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		/
Oral anticancer drugs on the brand tier (Tier 2)	$15 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		/
Oral anticancer drugs on the specialty tier (Tier 4)	$15 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		/
Non-oral anticancer drugs on the generic tier (Tier 1)	$15 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		/
Non-oral anticancer drugs on the brand tier (Tier 2)	$15 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		/
Non-oral anticancer drugs on the specialty tier (Tier 4)	$15 for up to a 30-day supply	Availability for mail order varies by item. Talk to your local pharmacy		/

Home infusion drugs

Description of Home Infusion Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Home infusion drugs	No charge for up to a 30-day supply	Not available		/
Supplies necessary for administration of home infusion drugs	No charge	No charge		/

Home infusion drugs are self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion, such as an intravenous or intraspinal-infusion.

Diabetes supplies and amino acid–modified products

Description of Diabetes Supplies and Amino Acid-Modified Products	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria)	No charge for up to a 30-day supply	Not available		*1*
Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing	No charge for up to a 100-day supply	Not available		*1*
Insulin-administration devices: pen delivery devices, disposable needles and syringes, and visual aids required to ensure proper dosage (except eyewear)	$15 for up to a 100-day supply	Availability for mail order varies by item. Talk to your local pharmacy		*1*

For drugs related to the treatment of diabetes (for example, insulin), and for continuous insulin delivery devices that use disposable items such as patches or pods, refer to the "Most items" table above. For insulin pumps, refer to the "Durable Medical Equipment ("DME") for home use" table above.

Contraceptive drugs and devices

Description of Contraceptive Drugs and Devices	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
The following hormonal contraceptive items for women on the generic tier (Tier 1) when prescribed by a Plan Provider: • Rings • Patches • Oral contraceptives	No charge for up to a 365-day supply	No charge for up to a 365-day supply Rings are not available for mail order		*1*
The following contraceptive items for women on the generic tier (Tier 1) when prescribed by a Plan Provider: • Female condoms • Spermicide • Sponges	No charge for up to a 100-day supply	Not available		*1*
The following hormonal contraceptive items for women on the brand tier (Tier 2) when prescribed by a Plan Provider: • Rings • Patches • Oral contraceptives	No charge for up to a 365-day supply	No charge for up to a 365-day supply Rings are not available for mail order		*1*

Description of Contraceptive Drugs and Devices	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
The following contraceptive items for women on the brand tier (Tier 2) when prescribed by a Plan Provider: • Female condoms • Spermicide • Sponges	No charge for up to a 100-day supply	Not available		✓
Emergency contraception	No charge	Not available		✓
Diaphragms and cervical caps	No charge	Not available		✓

Certain preventive items

Description of Certain Preventive Items	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Items on our Preventive Services list on our website at **kp.org/prevention** when prescribed by a Plan Provider	No charge for up to a 100-day supply	Not available		✓

Fertility and sexual dysfunction drugs

Description of Fertility and Sexual Dysfunction Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Drugs on the generic tier (Tier 1) prescribed to treat infertility or in connection with covered artificial insemination Services	Not covered	Not covered		
Drugs on the brand and specialty tiers (Tier 2 and Tier 4) prescribed to treat infertility or in connection with covered artificial insemination Services	Not covered	Not covered		
Drugs on the generic tier (Tier 1) prescribed in connection with covered assisted reproductive technology ("ART") Services	Not covered	Not covered		
Drugs on the brand and specialty tiers (Tier 2 and Tier 4) prescribed in connection with covered assisted reproductive technology ("ART") Services	Not covered	Not covered		

Description of Fertility and Sexual Dysfunction Drugs	Cost Share at a Plan Pharmacy	Cost Share by Mail	Subject to Deductible	Applies to OOPM
Drugs on the generic tier (Tier 1) prescribed for sexual dysfunction disorders	Not covered	Not covered		
Drugs on the brand and specialty tiers (Tier 2 and Tier 4) prescribed for sexual dysfunction disorders	Not covered	Not covered		

Outpatient surgery and outpatient procedures

Description of Outpatient Surgery and Outpatient Procedure Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Outpatient surgery and outpatient procedures (including imaging and diagnostic Services) when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or minimize discomfort	10% Coinsurance	/	/
Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above	$25 per procedure		/

Preventive Services

Description of Preventive Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine physical exams, including well-woman and preventive exams for Members age 2 and older	No charge		/
Well-child preventive exams for Members through age 23 months	No charge		/
Normal series of regularly scheduled preventive prenatal care exams after confirmation of pregnancy	No charge		/
First postpartum follow-up consultation and exam	No charge		/
Immunizations (including the vaccine) administered to you in a Plan Medical Office	No charge		/
Tuberculosis skin tests	No charge		/

Description of Preventive Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Screening and counseling Services when provided during a routine physical exam or a well-child preventive exam, such as obesity counseling, routine vision and hearing screenings, alcohol and substance abuse screenings, health education, depression screening, and developmental screenings to diagnose and assess potential developmental delays	No charge		*.1*
Screening colonoscopies	No charge		*.1*
Screening flexible sigmoidoscopies	No charge		*.1*
Routine imaging screenings such as mammograms	No charge		*.1*
Bone density CT scans	No charge		*.1*
Bone density DEXA scans	No charge		*.1*
Routine laboratory tests and screenings, such as cancer screening tests, sexually transmitted infection ("STI") tests, cholesterol screening tests, and glucose tolerance tests	No charge		*.1*
Other laboratory screening tests, such as fecal occult blood tests and hepatitis B screening tests	No charge		*.1*

Prosthetic and orthotic devices

Description of Prosthetic and Orthotic Device Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Internally implanted prosthetic and orthotic devices as described in this *EOC*	No charge	*.1*	*.1*
External prosthetic and orthotic devices as described in this *EOC*	No charge		*.1*
Supplemental prosthetic and orthotic devices as described in this *EOC*	No charge		*.1*

Rehabilitative and habilitative Services

Description of Rehabilitative and Habilitative Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Individual outpatient physical, occupational, and speech therapy	$25 per visit	*.1*	*.1*
Group outpatient physical, occupational, and speech therapy	$12 per visit	*.1*	*.1*
Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program	$25 per day	*.1*	*.1*

Skilled nursing facility care

Description of Skilled Nursing Facility Care Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Skilled nursing facility Services up to 100 days per benefit period*	10% Coinsurance	*.1*	*.1*

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

Substance use disorder treatment

Description of Substance Use Disorder Treatment Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Inpatient detoxification	10% Coinsurance	*.1*	*.1*
Individual substance use disorder evaluation and treatment	$25 per visit		*.1*
Group substance use disorder treatment	$5 per visit		*.1*
Intensive outpatient and day-treatment programs	10% Coinsurance up to a maximum of $5 per day		*.1*
Residential substance use disorder treatment	10% Coinsurance up to a maximum of $100 per admission	*.1*	*.1*

Telehealth visits

Interactive video visits

Description of Interactive Video Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits	No charge		/
Physician Specialist Visits	No charge		/

Scheduled telephone visits

Description of Scheduled Telephone Visit Services	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Primary Care Visits and Non-Physician Specialist Visits	No charge		/
Physician Specialist Visits	No charge		/

Vision Services for Adult Members

Description of Vision Services for Adult Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	No charge		/
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$25 per visit		/
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$25 per visit		/
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		/
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		/
Low vision devices (including fitting and dispensing)	Not covered		

Vision Services for Pediatric Members

Description of Vision Services for Pediatric Members	Copayment / Coinsurance	Subject to Deductible	Applies to OOPM
Routine eye exams with a Plan Optometrist to determine the need for vision correction and to provide a prescription for eyeglass lenses	No charge		/
Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$25 per visit		/
Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye	$25 per visit		/
Aniridia lenses: up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		/
Aphakia lenses: up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period	No charge		/
Low vision devices (including fitting and dispensing)	Not covered		

Introduction

This *Evidence of Coverage* ("*EOC*") describes the health care coverage of "Kaiser Permanente Deductible HMO Plan" provided under the *Group Agreement* ("*Agreement*") between Kaiser Foundation Health Plan, Inc. ("Health Plan") and the entity with which Health Plan has entered into the *Agreement* (your "Group").

This *EOC* is part of the *Agreement* between Health Plan and your Group. The *Agreement* contains additional terms such as Premiums, when coverage can change, the effective date of coverage, and the effective date of termination. The *Agreement* must be consulted to determine the exact terms of coverage. A copy of the *Agreement* is available from your Group.

Once enrolled in other coverage made available through Health Plan, that other plan's evidence of coverage cannot be cancelled without cancelling coverage under this *EOC*, unless the change is made during open enrollment or a special enrollment period.

For benefits provided under any other program offered by your Group (for example, workers compensation benefits), refer to your Group's materials.

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

It is important to familiarize yourself with your coverage by reading this *EOC* completely, so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please carefully read the sections that apply to you.

About Kaiser Permanente

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOU MAY GET HEALTH CARE.

When you join Kaiser Permanente, you are enrolling in one of two Health Plan Regions in California (either our Northern California Region or Southern California Region), which we call your "Home Region." The coverage information in this *EOC* applies when you obtain care in your Home Region. When you visit the other California Region, you may receive care as described in "Receiving Care Outside of Your Home Region" in the "How to Obtain Services" section.

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

We provide covered Services to Members using Plan Providers located in our Service Area, which is described in the "Definitions" section. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Hospice care as described under "Hospice Care" in the "Benefits" section
- Visiting Member Services as described under "Receiving Care Outside of Your Home Region" in the "How to Obtain Services" section

Term of this *EOC*

This *EOC* is for the period January 1, 2022, through December 31, 2022, unless amended. Your Group can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has expired or been amended.

Definitions

Some terms have special meaning in this *EOC*. When we use a term with special meaning in only one section of this *EOC*, we define it in that section. The terms in this "Definitions" section have special meaning when capitalized and used in any section of this *EOC*.

Accumulation Period: A period of time no greater than 12 consecutive months for purposes of accumulating amounts toward any deductibles (if applicable), out-of-pocket maximums, and benefit limits. For example, the Accumulation Period may be a calendar year or contract year. The Accumulation Period for this *EOC* is from January 1 through December 31.

Allowance: A specified amount that you can use toward the purchase price of an item. If the price of the items you select exceeds the Allowance, you will pay the amount in excess of the Allowance (and that payment will not apply toward any deductible or out-of-pocket maximum).

Ancillary Coverage: Optional benefits such as acupuncture, chiropractic, or dental coverage that may be available to Members enrolled under this *EOC.* If your plan includes Ancillary Coverage, this coverage will be described in an amendment to this *EOC* or a separate agreement from the issuer of the coverage.

Charges: "Charges" means the following:

- For Services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members
- For Services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan)
- For all other Services, the payments that Kaiser Permanente makes for the Services or, if Kaiser Permanente subtracts your Cost Share from its payment, the amount Kaiser Permanente would have paid if it did not subtract your Cost Share

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service under this *EOC.*

Copayment: A specific dollar amount that you must pay when you receive a covered Service under this *EOC.* Note: The dollar amount of the Copayment can be $0 (no charge).

Cost Share: The amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Similarly, if your coverage includes a Drug Deductible, and you receive Services that are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Dependent: A Member who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

Disclosure Form ("DF"): A summary of coverage for prospective Members. For some products, the DF is combined with the evidence of coverage.

Drug Deductible: The amount you must pay under this *EOC* in the Accumulation Period for certain drugs, supplies, and supplements before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Refer to the "Cost Share Summary" section to learn whether your coverage includes a Drug Deductible, the Services that are subject to the Drug Deductible, and the Drug Deductible amount.

Emergency Medical Condition: A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that you reasonably believed that the absence of immediate medical attention would result in any of the following:

- Placing the person's health (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

A mental health condition is an Emergency Medical Condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

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

Emergency Services: All of the following with respect to an Emergency Medical Condition:

- A medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services (such as imaging and

laboratory Services) routinely available to the emergency department to evaluate the Emergency Medical Condition

- Within the capabilities of the staff and facilities available at the hospital, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services you receive are Post Stabilization Care and not Emergency Services)

***EOC*:** This *Evidence of Coverage* document, including any amendments, which describes the health care coverage of "Kaiser Permanente Deductible HMO Plan" under Health Plan's *Agreement* with your Group.

Family: A Subscriber and all of their Dependents.

Group: The entity with which Health Plan has entered into the *Agreement* that includes this *EOC*.

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. Health Plan is a health care service plan licensed to offer health care coverage by the Department of Managed Health Care. This *EOC* sometimes refers to Health Plan as "we" or "us."

Home Region: The Region where you enrolled (either the Northern California Region or the Southern California Region).

Kaiser Permanente: Kaiser Foundation Hospitals (a California nonprofit corporation), Health Plan, and the Medical Group.

Medical Group: The Permanente Medical Group, Inc., a for-profit professional corporation.

Medically Necessary: For Services related to mental health or substance use disorder treatment, a Service is Medically Necessary if it is addressing your specific needs, for the purpose of preventing, diagnosing, or treating an illness, injury, condition, or its symptoms, including minimizing the progression of that illness, injury, condition, or its symptoms, in a manner that is all of the following:

- In accordance with the generally accepted standards of mental health and substance use disorder care
- Clinically appropriate in terms of type, frequency, extent, site, and duration
- Not primarily for the economic benefit of the health care service plan and subscribers or for the convenience of the patient, treating physician, or other health care provider

For all other Services, a Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant).

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

Non-Physician Specialist Visits: Consultations, evaluations, and treatment by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists). For Services described under "Dental and Orthodontic Services" in the "Benefits" section, non-physician specialists include dentists and orthodontists.

Non–Plan Hospital: A hospital other than a Plan Hospital.

Non–Plan Physician: A physician other than a Plan Physician.

Non–Plan Provider: A provider other than a Plan Provider.

Non–Plan Psychiatrist: A psychiatrist who is not a Plan Physician.

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your (or your unborn child's) health resulting from an unforeseen illness, unforeseen injury, or unforeseen complication of an existing condition (including pregnancy) if all of the following are true:

- You are temporarily outside our Service Area
- A reasonable person would have believed that your (or your unborn child's) health would seriously deteriorate if you delayed treatment until you returned to our Service Area

Physician Specialist Visits: Consultations, evaluations, and treatment by physician specialists, including personal Plan Physicians who are not Primary Care Physicians.

Plan Deductible: The amount you must pay under this *EOC* in the Accumulation Period for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that Accumulation Period. Refer to the "Cost Share Summary" section to learn whether your coverage includes a Plan Deductible, the Services that are subject to the Plan Deductible, and the Plan Deductible amount.

Plan Facility: Any facility listed in the Provider Directory on our website at kp.org/facilities. Plan Facilities include Plan Hospitals, Plan Medical Offices, and other facilities that we designate in the directory. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call our Member Service Contact Center.

Plan Hospital: Any hospital listed in the Provider Directory on our website at kp.org/facilities. In the directory, some Plan Hospitals are listed as Kaiser Permanente Medical Centers. The directory is updated periodically. The availability of Plan Hospitals may change. If you have questions, please call our Member Service Contact Center.

Plan Medical Office: Any medical office listed in the Provider Directory on our website at kp.org/facilities. In the directory, Kaiser Permanente Medical Centers may include Plan Medical Offices. The directory is updated periodically. The availability of Plan Medical Offices may change. If you have questions, please call our Member Service Contact Center.

Plan Optical Sales Office: An optical sales office owned and operated by Kaiser Permanente or another optical sales office that we designate. Refer to the Provider Directory on our website at kp.org/facilities for locations of Plan Optical Sales Offices. In the directory, Plan Optical Sales Offices may be called "Vision Essentials." The directory is updated periodically. The availability of Plan Optical Sales Offices may change. If you have questions, please call our Member Service Contact Center.

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Out-of-Pocket Maximum: The total amount of Cost Share you must pay under this *EOC* in the Accumulation Period for certain covered Services that you receive in the same Accumulation Period. Refer to the "Cost Share Summary" section to find your Plan Out-of-Pocket Maximum amount and to learn which Services apply to the Plan Out-of-Pocket Maximum.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Refer to the Provider Directory on our website at kp.org/facilities for locations of Plan Pharmacies. The directory is updated periodically. The availability of Plan Pharmacies may change. If you have questions, please call our Member Service Contact Center.

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

Plan Provider: A Plan Hospital, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other health care provider that Health Plan designates as a Plan Provider.

Plan Skilled Nursing Facility: A Skilled Nursing Facility approved by Health Plan.

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the Emergency Department) after your treating physician determines that this condition is Stabilized.

Premiums: The periodic amounts that your Group is responsible for paying for your membership under this *EOC*, except that you are responsible for paying Premiums if you have Cal-COBRA coverage. "Full Premiums" means 100 percent of Premiums for all of the coverage issued to each enrolled Member, as set forth in the "Premiums" section of Health Plan's *Agreement* with your Group.

Preventive Services: Covered Services that prevent or detect illness and do one or more of the following:

- Protect against disease and disability or further progression of a disease
- Detect disease in its earliest stages before noticeable symptoms develop

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Refer to the Provider Directory on our website at kp.org/facilities for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call our Member Service Contact Center.

Primary Care Visits: Evaluations and treatment provided by Primary Care Physicians and primary care Plan Providers who are not physicians (such as nurse practitioners).

Provider Directory: A directory of Plan Physicians and Plan Facilities in your Home Region. This directory is available on our website at kp.org/facilities. To obtain a printed copy, call our Member Service Contact Center. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call our Member Service Contact Center.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. Regions may change on January 1 of each year and are currently the District of Columbia and parts of

Northern California, Southern California, Colorado, Georgia, Hawaii, Idaho, Maryland, Oregon, Virginia, and Washington. For the current list of Region locations, please visit our website at kp.org or call our Member Service Contact Center.

Service Area: The ZIP codes below for each county are in our Service Area:

- All ZIP codes in Alameda County are inside our Northern California Service Area: 94501-02, 94505, 94514, 94536-46, 94550-52, 94555, 94557, 94560, 94566, 94568, 94577-80, 94586-88, 94601-15, 94617-21, 94622-24, 94649, 94659-62, 94666, 94701-10, 94712, 94720, 95377, 95391
- The following ZIP codes in Amador County are inside our Northern California Service Area: 95640, 95669
- All ZIP codes in Contra Costa County are inside our Northern California Service Area: 94505-07, 94509, 94511, 94513-14, 94516-31, 94547-49, 94551, 94553, 94556, 94561, 94563-65, 94569-70, 94572, 94575, 94582-83, 94595-98, 94706-08, 94801-08, 94820, 94850
- The following ZIP codes in El Dorado County are inside our Northern California Service Area: 95613-14, 95619, 95623, 95633-35, 95651, 95664, 95667, 95672, 95682, 95762
- The following ZIP codes in Fresno County are inside our Northern California Service Area: 93242, 93602, 93606-07, 93609, 93611-13, 93616, 93618-19, 93624-27, 93630-31, 93646, 93648-52, 93654, 93656-57, 93660, 93662, 93667-68, 93675, 93701-12, 93714-18, 93720-30, 93737, 93740-41, 93744-45, 93747, 93750, 93755, 93760-61, 93764-65, 9377179, 93786, 93790-94, 93844, 93888
- The following ZIP codes in Kings County are inside our Northern California Service Area: 93230, 93232, 93242, 93631, 93656
- The following ZIP codes in Madera County are inside our Northern California Service Area: 93601-02, 93604, 93614, 93623, 93626, 93636-39, 93643-45, 93653, 93669, 93720
- All ZIP codes in Marin County are inside our Northern California Service Area: 94901, 94903-04, 94912-15, 94920, 94924-25, 94929-30, 94933, 94937-42, 94945-50, 94956-57, 94960, 94963-66, 94970-71, 94973-74, 94976-79
- The following ZIP codes in Mariposa County are inside our Northern California Service Area: 93601, 93623, 93653
- All ZIP codes in Napa County are inside our Northern California Service Area: 94503, 94508, 94515, 94558-59, 94562, 94567, 94573-74, 94576, 94581, 94599, 95476
- The following ZIP codes in Placer County are inside our Northern California Service Area: 95602-04, 95610, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677-78, 95681, 95703, 95722, 95736, 95746-47, 95765
- All ZIP codes in Sacramento County are inside our Northern California Service Area: 94203-09, 94211, 94229-30, 94232, 94234-37, 94239-40, 94244-45, 94247-50, 94252, 94254, 94256-59, 94261-63, 94267-69, 94271, 94273-74, 94277-80, 94282-85, 94287-91, 94293-98, 94571, 95608-11, 95615, 95621, 95624, 95626, 95628, 95630, 95632, 9563839, 95641, 95652, 95655, 95660, 95662, 95670-71, 95673, 95678, 95680, 95683, 95690, 95693, 9574142, 95757-59, 95763, 95811-38, 95840-43, 95851-53, 95860, 95864-67, 95894, 95899
- All ZIP codes in San Francisco County are inside our Northern California Service Area: 94102-05, 94107-12, 94114-34, 94137, 94139-47, 94151, 94158-61, 94163-64, 94172, 94177, 94188
- All ZIP codes in San Joaquin County are inside our Northern California Service Area: 94514, 95201-15, 95219-20, 95227, 95230-31, 95234, 95236-37, 95240-42, 95253, 95258, 95267, 95269, 95296-97, 95304, 95320, 95330, 95336-37, 95361, 95366, 95376-78, 95385, 95391, 95632, 95686, 95690
- All ZIP codes in San Mateo County are inside our Northern California Service Area: 94002, 94005, 94010-11, 94014-21, 94025-28, 94030, 94037-38, 94044, 94060-66, 94070, 94074, 94080, 94083, 94128, 94303, 94401-04, 94497
- The following ZIP codes in Santa Clara County are inside our Northern California Service Area: 94022-24, 94035, 94039-43, 94085-89, 94301-06, 94309, 94550, 95002, 95008-09, 95011, 95013-15, 9502021, 95026, 95030-33, 95035-38, 95042, 95044, 95046, 95050-56, 95070-71, 95076, 95101, 95103, 95106, 95108-13, 95115-36, 95138-41, 95148, 95150-61, 95164, 95170, 95172-73, 95190-94, 95196
- All ZIP codes in Santa Cruz County are inside our Northern California Service Area: 95001, 95003, 95005-7, 95010, 95017-19, 95033, 95041, 95060-67, 95073, 95076-77
- All ZIP codes in Solano County are inside our Northern California Service Area: 94503, 94510, 94512, 94533-35, 94571, 94585, 94589-92, 95616, 95618, 95620, 95625, 95687-88, 95690, 95694, 95696
- The following ZIP codes in Sonoma County are inside our Northern California Service Area: 94515,

94922-23, 94926-28, 94931, 94951-55, 94972, 94975, 94999, 95401-07, 95409, 95416, 95419, 95421, 95425, 95430-31, 95433, 95436, 95439, 95441-42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471-73, 95476, 95486-87, 95492

- All ZIP codes in Stanislaus County are inside our Northern California Service Area: 95230, 95304, 95307, 95313, 95316, 95319, 95322-23, 95326, 95328-29, 95350-58, 95360-61, 95363, 95367-68, 95380-82, 95385-87, 95397
- The following ZIP codes in Sutter County are inside our Northern California Service Area: 95626, 95645, 95659, 95668, 95674, 95676, 95692, 95837
- The following ZIP codes in Tulare County are inside our Northern California Service Area: 93618, 93631, 93646, 93654, 93666, 93673
- The following ZIP codes in Yolo County are inside our Northern California Service Area: 95605, 95607, 95612, 95615-18, 95645, 95691, 95694-95, 9569798, 95776, 95798-99
- The following ZIP codes in Yuba County are inside our Northern California Service Area: 95692, 95903, 95961

For each ZIP code listed for a county, our 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 our 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 our Service Area, please call our Member Service Contact Center.

Note: We may expand our Service Area at any time by giving written notice to your Group. ZIP codes are subject to change by the U.S. Postal Service.

Services: Health care services or items ("health care" includes physical health care, mental health care, and substance use disorder treatment), and behavioral health treatment covered under "Behavioral Health Treatment for Autism Spectrum Disorder" in the "Benefits" section.

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

Spouse: The person to whom the Subscriber is legally married under applicable law. For the purposes of this *EOC*, the term "Spouse" includes the Subscriber's domestic partner. "Domestic partners" are two people who are registered and legally recognized as domestic partners by California (if your Group allows enrollment of domestic partners not legally recognized as domestic partners by California, "Spouse" also includes the Subscriber's domestic partner who meets your Group's eligibility requirements for domestic partners).

Stabilize: To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

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

Telehealth Visits: Interactive video visits and scheduled telephone visits between you and your provider.

Urgent Care: Medically Necessary Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition.

Premiums, Eligibility, and Enrollment

Premiums

Your Group is responsible for paying Full Premiums, except that you are responsible for paying Full Premiums as described in the "Continuation of Membership" section if you have Cal-COBRA coverage under this *EOC*. If you are 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 (through payroll deduction, for example).

Who Is Eligible

To enroll and to continue enrollment, you must meet all of the eligibility requirements described in this "Who Is Eligible" section, including your Group's eligibility requirements and our Service Area eligibility requirements.

Group eligibility requirements

You must meet your Group's eligibility requirements, such as the minimum number of hours that employees must work. Your Group is required to inform Subscribers of its eligibility requirements.

Service Area eligibility requirements

The "Definitions" section describes our Service Area and how it may change.

Subscribers must live or work inside our Service Area at the time they enroll. If after enrollment the Subscriber no longer lives or works inside our Service Area, the Subscriber can continue membership unless (1) they live inside or move to the service area of another Region and do not work inside our Service Area, or (2) your Group does not allow continued enrollment of Subscribers who do not live or work inside our Service Area.

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

If you are not eligible to continue enrollment because you live in or move to the service area of another Region, please contact your Group to learn about your Group health care options:

- **Regions outside California**. You may be able to enroll in the service area of another Region if there is an agreement between your Group and that Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*
- **Southern California Region's service area**. Your Group may have an arrangement with us that permits membership in the Southern California Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*. All terms and conditions in your application for enrollment in the Northern California Region, including the Arbitration Agreement, will continue to apply if the Subscriber does not submit a new enrollment form

For more information about the service areas of the other Regions, please call our Member Service Contact Center.

Eligibility as a Subscriber

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

- An employee of your Group
- A proprietor or partner of your Group
- Otherwise entitled to coverage under a trust agreement, retirement benefit program, or employment contract (unless the Internal Revenue Service considers you self-employed)

Eligibility as a Dependent

Enrolling a Dependent

Dependent eligibility is subject to your Group's eligibility requirements, which are not described in this *EOC*. You can obtain your Group's eligibility requirements directly from your Group. If you are a Subscriber under this *EOC* and if your Group allows enrollment of Dependents, Health Plan allows the following persons to enroll as your Dependents under this *EOC*:

- Your Spouse
- Your or your Spouse's Dependent children, who meet the requirements described under "Age limit of Dependent children," if they are any of the following:
  - sons, daughters, or stepchildren
  - adopted children
  - children placed with you for adoption, but not including children placed with you for foster care
  - children for whom you or your Spouse is the court-appointed guardian (or was when the child reached age 18)
- Children whose parent is a Dependent under your family coverage (including adopted children and children placed with your Dependent for adoption, but not including children placed with your Dependent for foster care) if they meet all of the following requirements:
  - they are not married and do not have a domestic partner (for the purposes of this requirement only, "domestic partner" means someone who is registered and legally recognized as a domestic partner by California)
  - they meet the requirements described under "Age limit of Dependent children"
  - they receive all of their support and maintenance from you or your Spouse
  - they permanently reside with you or your Spouse

If you have a baby

If you have a baby while enrolled under this *EOC*, the baby is not automatically enrolled in this plan. The Subscriber must request enrollment of the baby as described under "Special enrollment" in the "How to Enroll and When Coverage Begins" section below. If the Subscriber does not request enrollment within this special enrollment period, the baby will only be covered under this plan for 31 days (including the date of birth), or until the date the baby is enrolled in other coverage, whichever happens first.

Age limit of Dependent children

Children must be under age 26 as of the effective date of this *EOC* to enroll as a Dependent under your plan.

Dependent children are eligible to remain on the plan through the end of the month in which they reach the age limit.

Dependent children of the Subscriber or Spouse (including adopted children and children placed with you for adoption, but not including children placed with you for foster care) who reach the age limit may continue coverage under this *EOC* if all of the following conditions are met:

- They meet all requirements to be a Dependent except for the age limit
- Your Group permits enrollment of Dependents
- They are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred before they reached the age limit for Dependents
- They receive 50 percent or more of their support and maintenance from you or your Spouse
- You give us proof of their incapacity and dependency within 60 days after we request it (see "Disabled Dependent certification" below in this "Eligibility as a Dependent" section)

Disabled Dependent certification

One of the requirements for a Dependent to be eligible to continue coverage as a disabled Dependent is that the Subscriber must provide us documentation of the dependent's incapacity and dependency as follows:

- If the child is a Member, we will send the Subscriber a notice of the Dependent's membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. The Dependent's membership will terminate as described in our notice unless the Subscriber provides us documentation of the Dependent's incapacity and dependency within 60 days of receipt of our notice and we determine that the Dependent is eligible as a disabled dependent. If the Subscriber provides us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination. If we determine that the Dependent does not meet the eligibility requirements as a disabled dependent, we will notify the Subscriber that the Dependent is not eligible and let the Subscriber know the membership termination date. If we determine that the Dependent is eligible as a disabled dependent, there will be no lapse in coverage. Also, starting two years after the date that the Dependent reached the age limit, the Subscriber must provide us documentation of the Dependent's incapacity and dependency annually within 60 days after we request it so that we can determine if the Dependent continues to be eligible as a disabled dependent
- If the child is not a Member because you are changing coverage, you must give us proof, within 60 days after we request it, of the child's incapacity and dependency as well as proof of the child's coverage under your prior coverage. In the future, you must provide proof of the child's continued incapacity and dependency within 60 days after you receive our request, but not more frequently than annually

If the Subscriber is enrolled under a Kaiser Permanente Medicare plan

The dependent eligibility rules described in the "Eligibility as a Dependent" section also apply if you are a subscriber under a Kaiser Permanente Medicare plan offered by your Group (please ask your Group about your membership options). All of your dependents who are enrolled under this or any other non-Medicare evidence of coverage offered by your Group must be enrolled under the same non-Medicare evidence of coverage. A "non-Medicare" evidence of coverage is one that does not require members to have Medicare.

Persons barred from enrolling

You cannot enroll if you have had your entitlement to receive Services through Health Plan terminated for cause.

Members with Medicare and retirees

This *EOC* is not intended for most Medicare beneficiaries and some Groups do not offer coverage to retirees. If, during the term of this *EOC*, you are (or become) eligible for Medicare or you retire, please ask your Group about your membership options as follows:

- If a Subscriber who has Medicare Part B retires and the Subscriber's Group has a Kaiser Permanente

Senior Advantage plan for retirees, the Subscriber should enroll in the plan if eligible

- If the Subscriber has dependents who have Medicare and your Group has a Kaiser Permanente Senior Advantage plan (or of one our other plans that require members to have Medicare), the Subscriber may be able to enroll them as dependents under that plan
- If the Subscriber retires and your Group does not offer coverage to retirees, you may be eligible to continue membership as described in the "Continuation of Membership" section
- If federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary, your coverage under this *EOC* will be the same as it would be if you had not become eligible for Medicare. However, you may also be eligible to enroll in Kaiser Permanente Senior Advantage through your Group if you have Medicare Part B
- If you are (or become) eligible for Medicare and are in a class of beneficiaries for which your Group's health care coverage is secondary to Medicare, you should consider enrollment in Kaiser Permanente Senior Advantage through your Group if you are eligible
- If none of the above applies to you and you are eligible for Medicare or you retire, please ask your Group about your membership options

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

When Medicare is primary

Your Group's Premiums may increase if you are (or become) eligible for Medicare Part A or B as primary coverage, and you are not enrolled through your Group in Kaiser Permanente Senior Advantage for any reason (even if you are not eligible to enroll or the plan is not available to you).

When Medicare is secondary

Medicare is the primary coverage except when federal law requires that your Group's health care coverage be primary and Medicare coverage be secondary. Members who have Medicare when Medicare is secondary by law are subject to the same Premiums and receive the same benefits as Members who are under age 65 and do not have Medicare. In addition, any such Member for whom Medicare is secondary by law and who meets the eligibility requirements for the Kaiser Permanente Senior Advantage plan applicable when Medicare is secondary may also enroll in that plan if it is available. These Members receive the benefits and coverage described in this *EOC* and the Kaiser Permanente Senior Advantage evidence of coverage applicable when Medicare is secondary.

Medicare late enrollment penalties

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

How to Enroll and When Coverage Begins

Your Group is required to inform you when you are eligible to enroll and what your effective date of coverage is. If you are eligible to enroll as described under "Who Is Eligible" in this "Premiums, Eligibility, and Enrollment" section, enrollment is permitted as described below and membership begins at the beginning (12:00 a.m.) of the effective date of coverage indicated below, except that your Group may have additional requirements, which allow enrollment in other situations.

If you are eligible to be a Dependent under this *EOC* but the subscriber in your family is enrolled under a Kaiser Permanente Senior Advantage evidence of coverage offered by your Group, the rules for enrollment of Dependents in this "How to Enroll and When Coverage Begins" section apply, not the rules for enrollment of dependents in the subscriber's evidence of coverage.

New employees

When your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a Health Plan–approved enrollment application to your Group within 31 days.

Effective date of coverage
The effective date of coverage for new employees and their eligible family Dependents is determined by your Group in accord with waiting period requirements in state and federal law. Your Group is required to inform the Subscriber of the date your membership becomes effective. For example, if the hire date of an otherwise-eligible employee is January 19, the waiting period begins on January 19 and the effective date of coverage cannot be any later than April 19. Note: If the effective date of your Group's coverage is always on the first day of the month, in this example the effective date cannot be any later than April 1.

Open enrollment

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

Special enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless one of the following is true:

- You become eligible because you experience a qualifying event (sometimes called a "triggering event") as described in this "Special enrollment" section
- You did not enroll in any coverage offered by your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future. The effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application from the Subscriber

Special enrollment due to new Dependents
You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, within 30 days after marriage, establishment of domestic partnership, birth, adoption, or placement for adoption by submitting to your Group a Health Plan–approved enrollment application.

The effective date of an enrollment resulting from marriage or establishment of domestic partnership is no later than the first day of the month following the date your Group receives an enrollment application from the Subscriber. Enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, date of adoption, or the date you or your Spouse have newly assumed a legal right to control health care in anticipation of adoption.

Special enrollment due to loss of other coverage You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, if all of the following are true:

- The Subscriber or at least one of the Dependents had other coverage when they previously declined all coverage through your Group
- The loss of the other coverage is due to one of the following:
  - exhaustion of COBRA coverage
  - termination of employer contributions for non-COBRA coverage
  - loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, moving out of the plan's service area, reaching the age limit for dependent children, or the subscriber's death, termination of employment, or reduction in hours of employment
  - loss of eligibility (but not termination for cause) for coverage through Covered California, Medicaid coverage (known as Medi-Cal in California), Children's Health Insurance Program coverage, or Medi-Cal Access Program coverage
  - reaching a lifetime maximum on all benefits

Note: If you are enrolling yourself as a Subscriber along with at least one eligible Dependent, only one of you must meet the requirements stated above.

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 30 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for coverage through Covered California, Medicaid, Children's Health Insurance Program, or Medi-Cal Access Program coverage. The effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application from the Subscriber.

Special enrollment due to court or administrative order
Within 30 days after the date of a court or administrative order requiring a Subscriber to provide health care

coverage for a Spouse or child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or child as a Dependent by submitting to your Group a Health Plan–approved enrollment or change of enrollment application.

The effective date of coverage resulting from a court or administrative order is the first of the month following the date we receive the enrollment request, unless your Group specifies a different effective date (if your Group specifies a different effective date, the effective date cannot be earlier than the date of the order).

Special enrollment due to eligibility for premium assistance

You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, if you or a dependent become eligible for premium assistance through the Medi-Cal program. Premium assistance is when the Medi-Cal program pays all or part of premiums for employer group coverage for a Medi-Cal beneficiary. To request enrollment in your Group's health care coverage, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application to your Group within 60 days after you or a dependent become eligible for premium assistance. Please contact the California Department of Health Care Services to find out if premium assistance is available and the eligibility requirements.

Special enrollment due to reemployment after military service

If you terminated your health care coverage because you were called to active duty in the military service, you may be able to reenroll in your Group's health plan if required by state or federal law. Please ask your Group for more information.

Other special enrollment events

You may enroll as a Subscriber (along with any eligible Dependents) if you or your Dependents were not previously enrolled, and existing Subscribers may add eligible Dependents not previously enrolled, if any of the following are true:

- You lose employment for a reason other than gross misconduct
- Your employment hours are reduced
- You are a Dependent of someone who becomes entitled to Medicare
- You become divorced or legally separated
- You are a Dependent of someone who dies
- A Health Benefit Exchange (such as Covered California) determines that one of the following occurred because of misconduct on the part of a non-Exchange entity that provided enrollment assistance or conducted enrollment activities:
  - a qualified individual was not enrolled in a qualified health plan
  - a qualified individual was not enrolled in the qualified health plan that the individual selected
  - a qualified individual is eligible for, but is not receiving, advance payments of the premium tax credit or cost share reductions

To request special enrollment, you must submit a Health Plan-approved enrollment application to your Group within 30 days after loss of other coverage. You may be required to provide documentation that you have experienced a qualifying event. Membership becomes effective either on the first day of the next month (for applications that are received by the fifteenth day of a month) or on the first day of the month following the next month (for applications that are received after the fifteenth day of a month).

Note: If you are enrolling as a Subscriber along with at least one eligible Dependent, only one of you must meet one of the requirements stated above.

How to Obtain Services

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

- Authorized referrals as described under "Getting a Referral" in this "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Hospice care as described under "Hospice Care" in the "Benefits" section
- Visiting Member Services as described under "Receiving Care Outside of Your Home Region" in this "How to Obtain Services" section

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

Routine Care

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

- Preventive Services
- Periodic follow-up care (regularly scheduled follow-up care, such as visits to monitor a chronic condition)
- Other care that is not Urgent Care

To request a non-urgent appointment, you can call your local Plan Facility or request the appointment online. For appointment phone numbers, refer to our Provider Directory or call our Member Service Contact Center. To request an appointment online, go to our website at kp.org.

Urgent Care

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call our Member Service Contact Center.

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

Not Sure What Kind of Care You Need?

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

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

You can reach one of these licensed health care professionals by calling the appointment or advice phone number (for phone numbers, refer to our Provider Directory or call our Member Service Contact Center). When you call, a trained support person may ask you questions to help determine how to direct your call.

Your Personal Plan Physician

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

We encourage you to choose a personal Plan Physician. You may choose any available personal Plan Physician. Parents may choose a pediatrician as the personal Plan Physician for their child. Most personal Plan Physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians). Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal Plan Physicians. For example, some specialists in internal medicine and obstetrics/gynecology who are not designated as Primary Care Physicians may be available as personal Plan Physicians. However, if you choose a specialist who is not designated as a Primary Care Physician as your personal Plan Physician, the Cost Share for a Physician Specialist Visit will apply to all visits with the specialist except for routine preventive visits listed under "Preventive Services" in the "Benefits" section.

To learn how to select or change to a different personal Plan Physician, visit our website at kp.org or call our Member Service Contact Center. Refer to our Provider Directory for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call our Member Service Contact Center. You can change your personal Plan Physician at any time for any reason.

Getting a Referral

Referrals to Plan Providers

A Plan Physician must refer you before you can receive care from specialists, such as specialists in surgery, orthopedics, cardiology, oncology, dermatology, and physical, occupational, and speech therapies. Also, a Plan Physician must refer you before you can get care from Qualified Autism Service Providers covered under "Behavioral Health Treatment for Autism Spectrum Disorder" in the "Benefits" section. However, you do not need a referral or prior authorization to receive most care from any of the following Plan Providers:

- Your personal Plan Physician

- Generalists in internal medicine, pediatrics, and family practice
- Specialists in optometry, mental health Services, substance use disorder treatment, and obstetrics/gynecology

A Plan Physician must refer you before you can get care from a specialist in urology except that you do not need a referral to receive Services related to sexual or reproductive health, such as a vasectomy.

Although a referral or prior authorization is not required to receive most care from these providers, a referral may be required in the following situations:

- The provider may have to get prior authorization for certain Services in accord with "Medical Group authorization procedure for certain referrals" in this "Getting a Referral" section
- The provider may have to refer you to a specialist who has a clinical background related to your illness or condition

Standing referrals

If a Plan Physician refers you to a 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. For example, if you have a life-threatening, degenerative, or disabling condition, you can get a standing referral to a specialist if ongoing care from the specialist is required.

Medical Group authorization procedure for certain referrals

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

- Durable medical equipment
- Ostomy and urological supplies
- Services not available from Plan Providers
- Transplants

Utilization Management ("UM") is a process that determines whether a Service recommended by your treating provider is Medically Necessary for you. Prior authorization is a UM process that determines whether the requested services are Medically Necessary before care is provided. If it is Medically Necessary, then you will receive authorization to obtain that care in a clinically appropriate place consistent with the terms of your health coverage. Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

For the complete list of Services that require prior authorization, and the criteria that are used to make authorization decisions, please visit our website at kp.org/UM or call our Member Service Contact Center to request a printed copy.

Refer to "Post-Stabilization Care" under "Emergency Services" in the "Emergency Services and Urgent Care" section for authorization requirements that apply to Post-Stabilization Care from Non–Plan Providers.

Additional information about prior authorization for durable medical equipment and ostomy and urological supplies

The prior authorization process for durable medical equipment and ostomy and urological supplies includes the use of formulary guidelines. These guidelines were developed by a multidisciplinary clinical and operational work group with review and input from Plan 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 Plan Physician prescribes one of these items, they will submit a written referral in accord with the UM process described in this "Medical Group authorization procedure for certain referrals" section. If the formulary guidelines do not specify that the prescribed item is appropriate for your medical condition, the referral will be submitted to the Medical Group's designee Plan Physician, who will make an authorization decision as described under "Medical Group's decision time frames" in this "Medical Group authorization procedure for certain referrals" section.

Medical Group's decision time frames

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

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your physician will be informed of the scope of the authorized Services. If the Medical Group does not authorize all of the Services, Health Plan will send you a written decision and explanation within two business days after the decision is made. Any written criteria that the Medical Group uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request.

If the Medical Group does not authorize all of the Services requested and you want to appeal the decision, you can file a grievance as described under "Grievances" in the "Dispute Resolution" section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

Travel and lodging for certain referrals

The following are examples of when we will arrange or provide reimbursement for certain travel and lodging expenses in accord with our Travel and Lodging Program Description:

- If Medical Group refers you to a provider that is more than 50 miles from where you live for certain specialty Services such as bariatric surgery, complex thoracic surgery, transplant nephrectomy, or inpatient chemotherapy for leukemia and lymphoma
- If Medical Group refers you to a provider that is outside our Service Area for certain specialty Services such as a transplant or transgender surgery

For the complete list of specialty Services for which we will arrange or provide reimbursement for travel and lodging expenses, the amount of reimbursement, limitations and exclusions, and how to request reimbursement, refer to the Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at kp.org/specialty-care/travel-reimbursements or by calling our Member Service Contact Center.

Completion of Services from Non–Plan Providers

New Member

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

Terminated provider

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

Eligibility

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

- Acute conditions, which are medical conditions that involve a sudden onset of symptoms due to an illness, injury, or other medical problem that requires prompt medical attention and has a limited duration. We may cover these Services until the acute condition ends
- Serious chronic conditions until the earlier of (1) 12 months from your effective date of coverage if you are a new Member, (2) 12 months from the termination date of the terminated provider, or (3) the first day after a course of treatment is complete when it would be safe to transfer your care to a Plan Provider, as determined by Kaiser Permanente after consultation with the Member and Non–Plan Provider and consistent with good professional practice. Serious chronic conditions are illnesses or other medical conditions that are serious, if one of the following is true about the condition:
  - it persists without full cure
  - it worsens over an extended period of time
  - it requires ongoing treatment to maintain remission or prevent deterioration
- Pregnancy and immediate postpartum care. We may cover these Services for the duration of the pregnancy and immediate postpartum care
- Mental health conditions in pregnant Members that occur, or can impact the Member, during pregnancy or during the postpartum period including, but not limited to, postpartum depression. We may cover completion of these Services for up to 12 months from the mental health diagnosis or from the end of pregnancy, whichever occurs later
- Terminal illnesses, which are incurable or irreversible illnesses that have a high probability of causing death within a year or less. We may cover completion of these Services for the duration of the illness
- Children under age 3. We may cover completion of these Services until the earlier of (1) 12 months from the child's effective date of coverage if the child is a new Member, (2) 12 months from the termination

date of the terminated provider, or (3) the child's third birthday

- Surgery or another procedure that is documented as part of a course of treatment and has been recommended and documented by the provider to occur within 180 days of your effective date of coverage if you are a new Member or within 180 days of the termination date of the terminated provider

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

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

For completion of Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

More information

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

Second Opinions

If you want a second opinion, you can ask Member Services to help you arrange one with a Plan Physician who is an appropriately qualified medical professional for your condition. If there isn't a Plan Physician who is an appropriately qualified medical professional for your condition, Member Services will help you arrange a consultation with a Non–Plan Physician for a second opinion. For purposes of this "Second Opinions" provision, an "appropriately qualified medical professional" is a physician who is acting within their scope of practice and who possesses a clinical background, including training and expertise, related to the illness or condition associated with the request for a second medical opinion.

Here are some examples of when a second opinion may be provided or authorized:

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

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 the "Dispute Resolution" section.

For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

Contracts with Plan Providers

How Plan Providers are paid

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways,

such as salary, capitation, per diem rates, case rates, fee for service, and incentive payments. To learn more about how Plan Physicians are paid to provide or arrange medical and hospital care for Members, please visit our website at kp.org or call our Member Service Contact Center.

Financial liability

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

When you are referred to a Plan Provider for covered Services, you pay the Cost Share required for Services from that provider as described in this *EOC*.

Termination of a Plan Provider's contract If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for the covered Services you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements. You may be eligible to receive Services from a terminated provider; refer to "Completion of Services from Non–Plan Providers" under "Getting a Referral" in this "How to Obtain Services" section.

Provider groups and hospitals

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

Receiving Care Outside of Your Home Region

If you have questions about your coverage when you are away from home, call the Away from Home Travel Line at **1-951-268-3900** 24 hours a day, seven days a week (except closed holidays). For example, call this number for the following concerns:

- What you should do to prepare for your trip
- What Services are covered when you are outside our Service Area
- How to get care in another Region
- How to request reimbursement if you paid for covered Services outside our Service Area

You can also get information on our website at kp.org/travel.

Receiving care in the Service Area of another Region

If you are visiting in the service area of another Region, you may receive Visiting Member Services from designated providers in that Region. "Visiting Member Services" are Services that are covered under your Home Region plan that you receive in another Region, subject to exclusions, limitations, prior authorization or approval requirements, and reductions described in this *EOC* or the Visiting Member Brochure, which is available online at kp.org. Certain Services are not covered as Visiting Member Services. For more information about receiving Visiting Member Services in another Region, including provider and facility locations, or to obtain a copy of the Visiting Member Brochure, please call our Away from Home Travel Line at **1-951-268-3900** 24 hours a day, seven days a week (except closed holidays). Information is also available online at kp.org/travel.

For Visiting Member Services, you pay the Cost Share required for Services provided by a Plan Provider inside our Service Area as described in this *EOC*.

Receiving care outside of any Region

If you are traveling outside of a Kaiser Permanente Region, we cover Emergency Services and Urgent Care as described in the "Emergency Services and Urgent Care" section.

Your ID Card

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

Your ID card is for identification only. To receive covered Services, you must be a current Member. Anyone who is not a Member will be billed as a non-Member for any Services they receive. If you let someone else use your ID card, we may keep your ID card and terminate your membership as described under "Termination for Cause" in the "Termination of Membership" section.

Timely Access to Care

Standards for appointment availability

The California Department of Managed Health Care ("DMHC") developed the following standards for appointment availability. This information can help you know what to expect when you request an appointment.

- Urgent Care: within 48 hours
- Nonurgent Primary Care Visit or Non-Physician Specialist Visit: within 10 business days
- Physician Specialist Visit: within 15 business days

If you prefer to wait for a later appointment that will better fit your schedule or to see the Plan Provider of your choice, we will respect your preference. In some cases, your wait may be longer than the time listed if a licensed health care professional decides that a later appointment won't have a negative effect on your health.

The standards for appointment availability do not apply to Preventive Services. Your Plan Provider may recommend a specific schedule for Preventive Services, depending on your needs. The standards also do not apply to periodic follow-up care for ongoing conditions or standing referrals to specialists.

Timely access to telephone assistance

DMHC developed the following standards for answering telephone questions:

- For telephone advice about whether you need to get care and where to get care: within 30 minutes, 24 hours a day, seven days a week
- For general questions: within 10 minutes during normal business hours

Interpreter services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services, including sign language, are available during all business hours at no cost to you. For more information on the interpreter services we offer, please call our Member Service Contact Center.

Getting Assistance

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

Member Services

Member Services representatives can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain the following:

- Your Health Plan benefits
- How to make your first medical appointment
- What to do if you move
- How to replace your Kaiser Permanente ID card

You can reach Member Services in the following ways:

Call **1-800-464-4000 (**English and more than 150 languages using interpreter services**)**
1-800-788-0616 (Spanish**)**
1-800-757-7585 (Chinese dialects**)**
TTY users call **711**

24 hours a day, seven days a week (except closed holidays)

Visit Member Services Department at a Plan Facility (for addresses, refer to our Provider Directory or call our Member Service Contact Center)

Write Member Services Department at a Plan Facility (for addresses, refer to our Provider Directory or call our Member Service Contact Center)

Website kp.org

Cost Share estimates

For information about estimates, see "Getting an estimate of your Cost Share" under "Your Cost Share" in the "Benefits" section.

Plan Facilities

Plan Medical Offices and Plan Hospitals are listed in the Provider Directory for your Home Region. The directory describes the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services. This directory is available on our website at kp.org/facilities. To obtain a printed copy, call our Member Service Contact Center. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call our Member Service Contact Center.

At most of our Plan Facilities, you can usually receive all of the covered Services you need, including specialty care, pharmacy, and lab work. You are not restricted to a

particular Plan Facility, and we encourage you to use the facility that will be most convenient for you:

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Services are available from Plan Hospital Emergency Departments (for Emergency Department locations, refer to our Provider Directory or call our Member Service Contact Center)
- Same-day Urgent Care appointments are available at many locations (for Urgent Care locations, refer to our Provider Directory or call our Member Service Contact Center)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services Department (for locations, refer to our Provider Directory or call our Member Service Contact Center)

Note: State law requires evidence of coverage documents to include the following notice:

Some hospitals and other providers do not provide one or more of the following services that may be covered under your plan contract and that you or your family member might need: family planning; contraceptive services, including emergency contraception; sterilization, including tubal ligation at the time of labor and delivery; infertility treatments; or abortion. You should obtain more information before you enroll. Call your prospective doctor, medical group, independent practice association, or clinic, or call the Kaiser Permanente Member Service Contact Center, to ensure that you can obtain the health care services that you need.

Please be aware that if a Service is covered but not available at a particular Plan Facility, we will make it available to you at another facility.

Emergency Services and Urgent Care

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital Emergency Department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non–Plan Providers anywhere in the world.

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

Post-Stabilization Care

Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the Emergency Department) after your treating physician determines that this condition is Stabilized. Post-Stabilization Care also includes durable medical equipment covered under this *EOC*, if it is Medically Necessary after discharge from a hospital, and related to the same Emergency Medical Condition. For more information about durable medical equipment covered under this *EOC*, see "Durable Medical Equipment ("DME") for Home Use" in the "Benefits" section. We cover Post-Stabilization Care from a Non–Plan Provider only if we provide prior authorization for the care or if otherwise required by applicable law ("prior authorization" means that we must approve the Services in advance).

To request prior authorization, the Non–Plan Provider must call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card *before* you receive the care. We will discuss your condition with the Non–Plan Provider. If we determine that you require Post-Stabilization Care and that this care is part of your covered benefits, we will authorize your care from the Non–Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care. If we decide to have a Plan Hospital, Plan Skilled Nursing Facility, or designated Non–Plan Provider provide your care, we may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered.

Be sure to ask the Non–Plan Provider to tell you what care (including any transportation) we have authorized because we will not cover Post-Stabilization Care or related transportation provided by Non–Plan Providers that has not been authorized. If you receive care from a Non–Plan Provider that we have not authorized, you may have to pay the full cost of that care. If you are admitted to a Non–Plan Hospital, please notify us as soon as possible by calling **1-800-225-8883** or the notification phone number on your ID card.

Your Cost Share

Your Cost Share for covered Emergency Services and Post-Stabilization Care is described in the "Cost Share Summary" section of this *EOC*. Your Cost Share is the same whether you receive the Services from a Plan Provider or a Non–Plan Provider. For example:

- If you receive Emergency Services in the Emergency Department of a Non–Plan Hospital, you pay the Cost Share for an Emergency Department visit as described in the "Cost Share Summary" under "Emergency and Urgent Care visits"
- If we gave prior authorization for inpatient Post-Stabilization Care in a Non–Plan Hospital, you pay the Cost Share for hospital inpatient care as described in the "Cost Share Summary" under "Hospital inpatient care"
- If we gave prior authorization for durable medical equipment after discharge from a Non–Plan Hospital, you pay the Cost Share for durable medical equipment as described in the "Cost Share Summary" under "Durable Medical Equipment ("DME") for home use"

Urgent Care

Inside the Service Area

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For appointment and advice phone numbers, refer to our Provider Directory or call our Member Service Contact Center.

Out-of-Area Urgent Care

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

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

You do not need prior authorization for Out-of-Area Urgent Care. We cover Out-of-Area Urgent Care you receive from Non–Plan Providers if the Services would have been covered under this *EOC* if you had received them from Plan Providers.

To obtain follow-up care from a Plan Provider, call the appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call our Member Service Contact Center. We do not cover follow-up care from Non–Plan Providers after you no longer need Urgent Care, except for durable medical equipment covered under this *EOC*. For more information about durable medical equipment covered under this *EOC*, see "Durable Medical Equipment ("DME") for Home Use" in the "Benefits" section. If you require durable medical equipment related to your Urgent Care after receiving Out-of-Area Urgent Care, your provider must obtain prior authorization as described under "Getting a Referral" in the "How to Obtain Services" section.

Your Cost Share

Your Cost Share for covered Urgent Care is the Cost Share required for Services provided by Plan Providers as described in the "Cost Share Summary" section of this *EOC*. For example:

- If you receive an Urgent Care evaluation as part of covered Out-of-Area Urgent Care from a Non–Plan Provider, you pay the Cost Share for Urgent Care consultations, evaluations, and treatment as described in the "Cost Share Summary" under "Emergency and Urgent Care visits"
- If the Out-of-Area Urgent Care you receive includes an X-ray, you pay the Cost Share for an X-ray as described in the "Cost Share Summary" under "Outpatient imaging, laboratory, and other diagnostic and treatment Services," in addition to the Cost Share for the Urgent Care evaluation
- If we gave prior authorization for durable medical equipment provided as part of Out-of-Area Urgent Care, you pay the Cost Share for durable medical equipment as described in the "Cost Share Summary" under "Durable Medical Equipment ("DME") for home use"

Note: If you receive Urgent Care in an Emergency Department, you pay the Cost Share for an Emergency Department visit as described in the "Cost Share Summary" under "Emergency and Urgent Care visits."

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care from a Non–Plan Provider as described in this "Emergency Services and Urgent Care" section, or emergency ambulance Services described under "Ambulance Services" in the "Benefits" section, you are not responsible for any amounts beyond your Cost Share for covered Emergency Services.

However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. Also, you may be required to pay and file a claim for any Services prescribed by a Non–Plan Provider as part of covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care even if you receive the Services from a Plan Provider, such as a Plan Pharmacy.

For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Benefits

This section describes the Services that are covered under this *EOC*.

Services are covered under this *EOC* as specifically described in this *EOC*. Services that are not specifically described in this *EOC* are not covered, except as required by state or federal law. Services are subject to exclusions and limitations described in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. Except as otherwise described in this *EOC*, all of the following conditions must be satisfied:

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
  - Preventive Services
  - health care items and services for diagnosis, assessment, or treatment
  - health education covered under "Health Education" in this "Benefits" section
  - other health care items and services
- The Services are provided, prescribed, authorized, or directed by a Plan Physician, except for:
  - emergency ambulance Services, as described under "Ambulance Services" below
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
  - Visiting Member Services, as described under "Receiving Care Outside of Your Home Region" in the "How to Obtain Services" section
- You receive the Services from Plan Providers inside our Service Area, except for:
  - authorized referrals, as described under "Getting a Referral" in the "How to Obtain Services" section
  - emergency ambulance Services, as described under "Ambulance Services" below
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
  - hospice care, as described under "Hospice Care" below
  - Visiting Member Services, as described under "Receiving Care Outside of Your Home Region" in the "How to Obtain Services" section
- The Medical Group has given prior authorization for the Services, if required, as described under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

Please also refer to:

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

Your Cost Share

Your Cost Share is the amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance.

If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Similarly, if your coverage includes a Drug Deductible, and you receive Services that are subject to the Drug Deductible, your Cost Share for those Services will be Charges until you reach the Drug Deductible.

Refer to the "Cost Share Summary" section of this *EOC* for the amount you will pay for Services.

General rules, examples, and exceptions

Your Cost Share for covered Services will be the Cost Share in effect on the date you receive the Services, except as follows:

- If you are receiving covered inpatient hospital or Skilled Nursing Facility Services on the effective date of this *EOC*, you pay the Cost Share in effect on your admission date until you are discharged if the Services were covered under your prior Health Plan

evidence of coverage and there has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Cost Share in effect on the date you receive the Services

- For items ordered in advance, you pay the Cost Share in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Share 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 Share for Services received by newborn children of a Member

During the 31 days of automatic coverage for newborn children described under "Newborn coverage" under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section, the parent or guardian of the newborn must pay the Cost Share indicated in the "Cost Share Summary" section of this *EOC* for any Services that the newborn receives, whether or not the newborn is enrolled. When the "Cost Share Summary" indicates the Services are subject to the Plan Deductible, the Cost Share for those Services will be Charges if the newborn has not met the Plan Deductible.

Payment toward your Cost Share (and when you may be billed)

In most cases, your provider will ask you to make a payment toward your Cost Share at the time you receive Services. If you receive more than one type of Services (such as a routine physical maintenance exam and laboratory tests), you may be required to pay separate Cost Share for each of those Services. Keep in mind that your payment toward your Cost Share may cover only a portion of your total Cost Share for the Services you receive, and you will be billed for any additional amounts that are due. The following are examples of when you may be asked to pay (or you may be billed for) Cost Share amounts in addition to the amount you pay at check-in:

- You receive non-preventive Services during a preventive visit. For example, you go in for a routine physical maintenance exam, and at check-in you pay your Cost Share for the preventive exam (your Cost Share may be "no charge"). However, during your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional non-preventive diagnostic Services
- You receive diagnostic Services during a treatment visit. For example, you go in for treatment of an existing health condition, and at check-in you pay your Cost Share for a treatment visit. However, during the visit your provider finds a new problem with your health and performs or orders diagnostic Services (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional diagnostic Services
- You receive treatment Services during a diagnostic visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider confirms a problem with your health and performs treatment Services (such as an outpatient procedure). You may be asked to pay (or you will be billed for) your Cost Share for these additional treatment Services
- You receive Services from a second provider during your visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider requests a consultation with a specialist. You may be asked to pay (or you will be billed for) your Cost Share for the consultation with the specialist

In some cases, your provider will not ask you to make a payment at the time you receive Services, and you will be billed for your Cost Share (for example, some Laboratory Departments are not able to collect Cost Share, or your Plan Provider is not able to collect Cost Share, if any, for Telehealth Visits you receive at home).

When we send you a bill, it will list Charges for the Services you received, payments and credits applied to your account, and any amounts you still owe. Your current bill may not always reflect your most recent Charges and payments. Any Charges and payments that are not on the current bill will appear on a future bill. Sometimes, you may see a payment but not the related Charges for Services. That could be because your payment was recorded before the Charges for the Services were processed. If so, the Charges will appear on a future bill. Also, you may receive more than one bill for a single outpatient visit or inpatient stay. For example, you may receive a bill for physician services and a separate bill for hospital services. If you don't see all the Charges for Services on one bill, they will appear on a future bill. If we determine that you overpaid and are due a refund, then we will send a refund to you within four weeks after we make that determination. If

you have questions about a bill, please call the phone number on the bill.

In some cases, a Non–Plan Provider may be involved in the provision of covered Services at a Plan Facility or a contracted facility where we have authorized you to receive care. You are not responsible for any amounts beyond your Cost Share for the covered Services you receive at Plan Facilities or at contracted facilities where we have authorized you to receive care. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Primary Care Visits, Non-Physician Specialist Visits, and Physician Specialist Visits

The Cost Share for a Primary Care Visit applies to evaluations and treatment provided by generalists in internal medicine, pediatrics, or family practice, and by specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Some physician specialists provide primary care in addition to specialty care but are not designated as Primary Care Physicians. If you receive Services from one of these specialists, the Cost Share for a Physician Specialist Visit will apply to all consultations, evaluations, and treatment provided by the specialist except for routine preventive counseling and exams listed under "Preventive Services" in this "Benefits" section. For example, if your personal Plan Physician is a specialist in internal medicine or obstetrics/gynecology who is not a Primary Care Physician, you will pay the Cost Share for a Physician Specialist Visit for all consultations, evaluations, and treatment by the specialist except routine preventive counseling and exams listed under "Preventive Services" in this "Benefits" section. The Non-Physician Specialist Visit Cost Share applies to consultations, evaluations, and treatment provided by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

Noncovered Services

If you receive Services that are not covered under this *EOC*, you may have to pay the full price of those Services. Payments you make for noncovered Services do not apply to any deductible or out-of-pocket maximum.

Benefit limits

Some benefits may include a limit on the number of visits, days, or dollar amount that will be covered under your plan during a specified time period. If a benefit includes a limit, this will be indicated in the "Cost Share Summary" section of this *EOC*. The time period associated with a benefit limit may not be the same as the term of this *EOC*. We will count all Services you receive during the benefit limit period toward the benefit limit, including Services you received under a prior Health Plan *EOC* (as long as you have continuous coverage with Health Plan). Note: We will not count Services you received under a prior Health Plan *EOC* when you first enroll in individual plan coverage or a new employer group's plan, when you move from group to individual plan coverage (or vice versa), or when you received Services under a Kaiser Permanente Senior Advantage evidence of coverage. If you are enrolled in the Kaiser Permanente POS Plan, refer to your KPIC *Certificate of Insurance* and *Schedule of Coverage* for benefit limits that apply to your separate indemnity coverage provided by the Kaiser Permanente Insurance Company ("KPIC").

Getting an estimate of your Cost Share

If you have questions about the Cost Share for specific Services that you expect to receive or that your provider orders during a visit or procedure, please visit our website at kp.org/memberestimates to use our cost estimate tool or call our Member Service Contact Center.

- If you have a Plan Deductible and would like an estimate for Services that are subject to the Plan Deductible, please call **1-800-390-3507** (TTY users call **711**) Monday through Friday 6 a.m. to 5 p.m. Refer to the "Cost Share Summary" section of this *EOC* to find out if you have a Plan Deductible
- For all other Cost Share estimates, please call **1-800-464-4000** (TTY users call **711**) 24 hours a day, seven days a week (except closed holidays)

Cost Share estimates are based on your benefits and the Services you expect to receive. They are a prediction of cost and not a guarantee of the final cost of Services. Your final cost may be higher or lower than the estimate since not everything about your care can be known in advance.

Explanation of benefits

After you receive Services, we will send you an explanation of benefits statement. The explanation of benefits is not a bill. It shows your total accumulation toward the Plan Deductible and Plan Out-of-Pocket Maximum. You can also view a copy of your explanation of benefits on kp.org or you may request a copy by calling our Member Service Contact Center at **1-800-390-3507** (TTY users call **711**) Monday through Friday 6 a.m. to 5 p.m.

Drug Deductible

This *EOC* does not include a Drug Deductible.

Plan Deductible

In any Accumulation Period, you must pay Charges for Services subject to the Plan Deductible until you reach one of the Plan Deductible amounts listed in the "Cost Share Summary" section of this *EOC*.

If you are a Member in a Family of two or more Members, you reach the Plan Deductible either when you reach the amount for any one Member, or when your entire Family reaches the Family amount. For example, suppose you have reached the deductible amount for any one Member. For Services subject to the Plan Deductible, you will not pay Charges during the remainder of the Accumulation Period, but every other Member in your Family must continue to pay Charges during the remainder of the Accumulation Period until either they reach the deductible amount for any one Member, or the entire Family reaches the Family amount.

After you reach the Plan Deductible and for the remainder of the Accumulation Period, you pay the applicable Copayment or Coinsurance subject to the limits described under "Plan Out-of-Pocket Maximum" in this "Benefits" section.

Services that are subject to the Plan Deductible The Cost Share that you must pay for covered Services is described in the "Cost Share Summary" section of this *EOC*. When the "Cost Share Summary" indicates the Services are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Note: When the Cost Share for the Services is "no charge" and the "Cost Share Summary" indicates the Services are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible. Also, if you pay a Plan Deductible amount for a Service that has a limit, such as a visit limit, the Services count toward reaching the limit.

The only payments that count toward the Plan Deductible are those you make for covered Services that are subject to this Plan Deductible under this *EOC*.

Keeping track of the Plan Deductible

When you pay an amount toward your Plan Deductible, we will give you a receipt that shows how much you paid. To see how close you are to reaching your Plan Deductible, use our online Out-of-Pocket Summary tool at kp.org/outofpocket, refer to your summary or explanation of benefits, or call our Member Service Contact Center.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service, after you meet any applicable deductible, is described in this *EOC*.

Note: If Charges for Services are less than the Copayment described in this *EOC*, you will pay the lesser amount, subject to any applicable deductible or out-of-pocket maximum.

Plan Out-of-Pocket Maximum

There is a limit to the total amount of Cost Share you must pay under this *EOC* in the Accumulation Period for covered Services that you receive in the same Accumulation Period. The Services that apply to the Plan Out-of-Pocket Maximum are described under the "Payments that count toward the Plan Out-of-Pocket Maximum" section below. Refer to the "Cost Share Summary" section of this *EOC* for your applicable Plan Out-of-Pocket Maximum amounts.

If you are a Member in a Family of two or more Members, you reach the Plan Out-of-Pocket Maximum either when you reach the maximum for any one Member, or when your Family reaches the Family maximum. For example, suppose you have reached the Plan Out-of-Pocket Maximum for any one Member. For Services subject to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share during the remainder of the Accumulation Period, but every other Member in your Family must continue to pay Cost Share during the remainder of the Accumulation Period until either they reach the maximum for any one Member or your Family reaches the Family maximum.

Payments that count toward the Plan Out-of-Pocket Maximum

Any payments you make toward the Plan Deductible or Drug Deductible, if applicable, apply toward the maximum.

Most Copayments and Coinsurance you pay for covered Services apply to the maximum, however some may not. To find out whether a Copayment or Coinsurance for a covered Service will apply to the maximum refer to the "Cost Share Summary" section of this *EOC*.

If your plan includes pediatric dental Services described in a Pediatric Dental Services Amendment to this *EOC*, those Services will apply toward the maximum. If your plan has a Pediatric Dental Services Amendment, it will be attached to this *EOC*, and it will be listed in the *EOC's* Table of Contents.

Keeping track of the Plan Out-of-Pocket Maximum
When you receive Services, we will give you a receipt that shows how much you paid. To see how close you are to reaching your Plan Out-of-Pocket Maximum, use our online Out-of-Pocket Summary tool at kp.org/outofpocket or call our Member Service Contact Center.

Administered Drugs and Products

Administered drugs and products are medications and products that require administration or observation by medical personnel, such as:

- Whole blood, red blood cells, plasma, and platelets
- Allergy antigens (including administration)
- Cancer chemotherapy drugs and adjuncts
- Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products ("biologics") derived from tissue, cells, or blood
- Other administered drugs and products

We cover these items when prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility or during home visits.

Certain administered drugs are Preventive Services. Refer to "Family Planning Services" for information about administered contraceptives and refer to "Preventive Services" for information on immunizations.

Ambulance Services

Emergency

We cover Services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) in the following situations:

- You reasonably believed that the medical condition was an Emergency Medical Condition which required ambulance Services
- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

If you receive emergency ambulance Services that are not ordered by a Plan Provider, you are not responsible for any amounts beyond your Cost Share for covered emergency ambulance Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Post-Service Claims and Appeals" section.

Nonemergency

Inside our Service Area, we cover nonemergency ambulance and psychiatric transport van Services if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance (or psychiatric transport van) can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to or from covered Services.

Ambulance Services exclusions

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

Bariatric Surgery

We cover hospital inpatient care related to bariatric surgical procedures (including room and board, imaging, laboratory, 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, see "Hospital inpatient care" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient care.

For the following Services, refer to these sections

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

Behavioral Health Treatment for Autism Spectrum Disorder

The following terms have special meaning when capitalized and used in this "Behavioral Health Treatment for Autism Spectrum Disorder" section:

- "Qualified Autism Service Provider" means a provider who has the experience and competence to design, supervise, provide, or administer treatment for autism spectrum disorder and is either of the following:
  - a person who is certified by a national entity (such as the Behavior Analyst Certification Board) with a certification that is accredited by the National Commission for Certifying Agencies
  - a person licensed in California as a physician, physical therapist, occupational therapist, psychologist, marriage and family therapist, educational psychologist, clinical social worker, professional clinical counselor, speech-language pathologist, or audiologist
- "Qualified Autism Service Professional" means an individual who meets all of the following criteria:
  - provides behavioral health treatment, which may include clinical case management and case supervision under the direction and supervision of a qualified autism service provider
  - is supervised by a Qualified Autism Service Provider
  - provides treatment pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
  - is a behavioral health treatment provider who meets the education and experience qualifications described in Section 54342 of Title 17 of the California Code of Regulations for an Associate Behavior Analyst, Behavior Analyst, Behavior Management Assistant, Behavior Management Consultant, or Behavior Management Program
  - has training and experience in providing Services for autism spectrum disorder pursuant to Division 4.5 (commencing with Section 4500) of the Welfare and Institutions Code or Title 14 (commencing with Section 95000) of the Government Code
  - is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan
- "Qualified Autism Service Paraprofessional" means an unlicensed and uncertified individual who meets all of the following criteria:
  - is supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional at a level of clinical supervision that meets professionally recognized standards of practice
  - provides treatment and implements Services pursuant to a treatment plan developed and approved by the Qualified Autism Service Provider
  - meets the education and training qualifications described in Section 54342 of Title 17 of the California Code of Regulations
  - has adequate education, training, and experience, as certified by a Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers
  - is employed by the Qualified Autism Service Provider or an entity or group that employs Qualified Autism Service Providers responsible for the autism treatment plan

We cover behavioral health treatment for autism spectrum disorder (including applied behavior analysis and evidence-based behavior intervention programs) that develops or restores, to the maximum extent practicable, the functioning of a person with autism spectrum disorder and that meets all of the following criteria:

- The Services are provided inside our Service Area
- The treatment is prescribed by a Plan Physician, or is developed by a Plan Provider who is a psychologist
- The treatment is provided under a treatment plan prescribed by a Plan Provider who is a Qualified Autism Service Provider
- The treatment is administered by a Plan Provider who is one of the following:
  - a Qualified Autism Service Provider
  - a Qualified Autism Service Professional supervised by the Qualified Autism Service Provider
  - a Qualified Autism Service Paraprofessional supervised by a Qualified Autism Service Provider or Qualified Autism Service Professional
- The treatment plan has measurable goals over a specific timeline that is developed and approved by the Qualified Autism Service Provider for the Member being treated
- The treatment plan is reviewed no less than once every six months by the Qualified Autism Service Provider and modified whenever appropriate

- The treatment plan requires the Qualified Autism Service Provider to do all of the following:
  - describe the Member's behavioral health impairments to be treated
  - design an intervention plan that includes the service type, number of hours, and parent participation needed to achieve the plan's goal and objectives, and the frequency at which the Member's progress is evaluated and reported
  - provide intervention plans that utilize evidence-based practices, with demonstrated clinical efficacy in treating autism spectrum disorder
  - discontinue intensive behavioral intervention Services when the treatment goals and objectives are achieved or no longer appropriate
- The treatment plan is not used for either of the following:
  - for purposes of providing (or for the reimbursement of) respite care, day care, or educational services
  - to reimburse a parent for participating in the treatment program

We also cover behavioral health treatment that meets the same criteria to treat mental health conditions other than autism spectrum disorder when behavioral health treatment is clinically indicated.

Services from Non-Plan Providers

If we are not able to offer an appointment with a Plan Provider within required geographic and timely access standards, we will offer to refer you to a Non-Plan Provider (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section). For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

For the following Services, refer to these sections

- Behavioral health treatment for autism spectrum disorder provided during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Care" and "Skilled Nursing Facility Care")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient physical, occupational, and speech therapy visits (refer to "Rehabilitative and Habilitative Services")
- Services to diagnose autism spectrum disorder and Services to develop and revise the treatment plan (refer to "Mental Health Services")

Dental and Orthodontic Services

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

For covered dental and orthodontic procedures that you may receive, you will pay the Cost Share you would pay if the Services were not related to dental and orthodontic Services. For example, see "Hospital inpatient care" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient care.

Dental Services for radiation treatment

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

Dental Services for transplants

We cover dental services that are Medically Necessary to free the mouth from infection in order to prepare for a transplant covered under "Transplant Services" in this "Benefits" section, if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist for those Services (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental anesthesia

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

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

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

Dental and orthodontic Services for cleft palate

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

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

For the following Services, refer to these sections

- Accidental injury to teeth (refer to "Injury to Teeth")
- Office visits not described in the "Dental and Orthodontic Services" section (refer to "Office Visits")
- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient administered drugs (refer to "Administered Drugs and Products"), except that we cover outpatient administered drugs under "Dental anesthesia" in this "Dental and Orthodontic Services" section
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Telehealth Visits (refer to "Telehealth Visits")

Dialysis Care

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

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

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

For the following Services, refer to these sections

- Durable medical equipment for home use (refer to "Durable Medical Equipment ("DME") for Home Use")
- Hospital inpatient care (refer to "Hospital Inpatient Care")
- Office visits not described in the "Dialysis Care" section (refer to "Office Visits")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Telehealth Visits (refer to "Telehealth Visits")

Dialysis care exclusions

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

Durable Medical Equipment ("DME") for Home Use

DME coverage rules

DME for home use is an item that meets the following criteria:

- The item is intended for repeated use
- The item is primarily and customarily used to serve a medical purpose
- The item is generally useful only to an individual with an illness or injury
- The item is appropriate for use in the home

For a DME item to be covered, all of the following requirements must be met:

- Your *EOC* includes coverage for the requested DME item
- A Plan Physician has prescribed the DME item for your medical condition
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage 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.

Base DME Items

We cover Base DME Items (including repair or replacement of covered equipment) if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met. "Base DME Items" means the following items:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Bone stimulator
- Canes (standard curved handle or quad) and replacement supplies
- Cervical traction (over door)
- Crutches (standard or forearm) and replacement supplies
- Dry pressure pad for a mattress
- Infusion pumps (such as insulin pumps) and supplies to operate the pump
- IV pole
- Nebulizer and supplies
- Peak flow meters
- Phototherapy blankets for treatment of jaundice in newborns

Supplemental DME items

We cover DME that is not described under "Base DME Items" or "Breastfeeding supplies," including repair and replacement of covered equipment, if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met.

Breastfeeding supplies

We cover one retail-grade breast pump per pregnancy and the necessary supplies to operate it, such as one set of bottles. We will decide whether to rent or purchase the item and we choose the vendor. We cover this pump for convenience purposes. The pump is not subject to prior authorization requirements.

If you or your baby has a medical condition that requires the use of a breast pump, we cover a hospital-grade breast pump and the necessary supplies to operate it, in accord with the coverage rules described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section.

Outside our Service Area

We do not cover most DME for home use outside our Service Area. However, if you live outside our Service Area, we cover the following DME (subject to the Cost Share and all other coverage requirements that apply to DME for home use inside our Service Area) when the item is dispensed at a Plan Facility:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices) from a Plan Pharmacy
- Canes (standard curved handle)
- Crutches (standard)
- Insulin pumps and supplies to operate the pump, after completion of training and education on the use of the pump
- Nebulizers and their supplies for the treatment of pediatric asthma
- Peak flow meters from a Plan Pharmacy

For the following Services, refer to these sections

- Dialysis equipment and supplies required for home hemodialysis and home peritoneal dialysis (refer to "Dialysis Care")
- Diabetes urine testing supplies and insulin-administration devices other than insulin pumps (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Durable medical equipment related to an Emergency Medical Condition or Urgent Care episode (refer to "Post-Stabilization Care" and "Out-of-Area Urgent Care")

- Durable medical equipment related to the terminal illness for Members who are receiving covered hospice care (refer to “Hospice Care”)
- Insulin and any other drugs administered with an infusion pump (refer to “Outpatient Prescription Drugs, Supplies, and Supplements”)

DME for home use exclusions

- Comfort, convenience, or luxury equipment or features except for retail-grade breast pumps as described under “Breastfeeding supplies” in this “Durable Medical Equipment (“DME”) for Home Use” section
- Items not intended for maintaining normal activities of daily living, such as exercise equipment (including devices intended to provide additional support for recreational or sports activities)
- Hygiene equipment
- Nonmedical items, such as sauna baths or elevators
- Modifications to your home or car
- Devices for testing blood or other body substances (except diabetes blood glucose monitors and their supplies)
- Electronic monitors of the heart or lungs except infant apnea monitors
- Repair or replacement of equipment due to loss, theft, or misuse

Emergency and Urgent Care Visits

We cover the following Emergency and Urgent Care visits:

- Emergency Department visits
- Urgent Care consultations, evaluations, and treatment

Family Planning Services

We cover the following Services when provided for family planning purposes:

- Family planning counseling
- Injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices (“IUDs”) and office visits related to their insertion, removal, and management when provided to prevent pregnancy
- Female sterilization procedures
- Male sterilization procedures
- Termination of pregnancy

For the following Services, refer to these sections

- Fertility preservation Services for iatrogenic infertility (refer to “Fertility Preservation Services for Iatrogenic Infertility”)
- Services to diagnose or treat infertility (refer to “Fertility Services”)
- Office visits related to injectable contraceptives, internally implanted time-release contraceptives or intrauterine devices ("IUDs") when provided for medical reasons other than to prevent pregnancy (refer to "Office Visits")
- Outpatient administered drugs that are not contraceptives (refer to “Administered Drugs and Products”)
- Outpatient laboratory and imaging services associated with family planning services (refer to “Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services”)
- Outpatient contraceptive drugs and devices (refer to “Outpatient Prescription Drugs, Supplies, and Supplements”)
- Outpatient surgery and outpatient procedures when provided for medical reasons other than to prevent pregnancy (refer to "Outpatient Surgery and Outpatient Procedures")

Family planning Services exclusions

- Reversal of voluntary sterilization

Fertility Services

“Fertility Services” means treatments and procedures to help you become pregnant.

Before starting or continuing a course of fertility Services, you may be required to pay initial and subsequent deposits toward your Cost Share for some or all of the entire course of Services, along with any past-due fertility-related Cost Share. Any unused portion of your deposit will be returned to you. When a deposit is not required, you must pay the Cost Share for the procedure, along with any past-due fertility-related Cost Share, before you can schedule a fertility procedure.

Diagnosis and treatment of infertility

For purposes of this “Diagnosis and treatment of infertility” section, “infertility” means not being able to get pregnant or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception or having a medical or other demonstrated

condition that is recognized by a Plan Physician as a cause of infertility.

We cover the following Services for the diagnosis and treatment of infertility:

- Office visits
- Outpatient surgery and procedures
- Outpatient imaging, laboratory, and diagnostic Services
- Outpatient administered drugs that require administration or observation by medical personnel. We cover these items when they are prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility
- Inpatient hospital stay directly related to diagnosis and treatment of infertility

Artificial insemination

We cover the following Services for artificial insemination:

- Office visits
- Outpatient surgery and procedures
- Outpatient imaging, laboratory, and diagnostic Services
- Outpatient administered drugs that require administration or observation by medical personnel. We cover these items when they are prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility
- Inpatient hospital stays directly related to diagnosis and treatment of infertility

Assisted reproductive technology ("ART") Services

ART Services such as in vitro fertilization ("IVF"), gamete intra-fallopian transfer ("GIFT"), or zygote intrafallopian transfer ("ZIFT") are not covered under this *EOC*.

For the following Services, refer to these sections

- Fertility preservation Services for iatrogenic infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Fertility Services exclusions

- Services to reverse voluntary, surgically induced infertility
- Semen and eggs (and Services related to their procurement and storage)
- ART Services, such as ovum transplants, GIFT, IVF, and ZIFT

Fertility Preservation Services for Iatrogenic Infertility

Standard fertility preservation Services are covered for Members undergoing treatment or receiving covered Services that may directly or indirectly cause iatrogenic infertility. Fertility preservation Services do not include diagnosis or treatment of infertility.

For covered fertility preservation Services that you receive, you will pay the Cost Share you would pay if the Services were not related to fertility preservation. For example, see "Outpatient surgery and outpatient procedures" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for outpatient procedures.

Health Education

We cover a variety of health education counseling, programs, and materials that your personal Plan Physician or other Plan Providers provide during a visit covered under another part of this *EOC*.

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

For more information about our health education counseling, programs, and materials, please contact a Health Education Department or our Member Service Contact Center or go to our website at kp.org.

Hearing Services

We cover the following:

- Hearing exams with an audiologist to determine the need for hearing correction

- Physician Specialist Visits to diagnose and treat hearing problems

Hearing aids

Hearing aids and related Services are not covered under this *EOC*. For internally implanted devices, see "Prosthetic and Orthotic Devices" in this "Benefits" section.

For the following Services, refer to these sections

- Routine hearing screenings when performed as part of a routine physical maintenance exam (refer to "Preventive Services")
- Services related to the ear or hearing other than those described in this section, such as outpatient care to treat an ear infection or outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits" section)
- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")

Hearing Services exclusions

- Hearing aids and tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid

Home Health Care

"Home health care" means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists.

We cover home health care only if all of the following are true:

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

We cover only part-time or intermittent home health care, as follows:

- Up to two hours per visit for visits by a nurse, medical social worker, or physical, occupational, or speech therapist, and up to four hours per visit for visits by a home health aide
- Up to three visits per day (counting all home health visits)
- Up to 100 visits per Accumulation Period (counting all home health visits)

Note: If a visit by a nurse, medical social worker, or physical, occupational, or speech therapist lasts longer than two hours, then each additional increment of two hours counts as a separate visit. If a visit by a home health aide lasts longer than four hours, then each additional increment of four hours counts as a separate visit. For example, if a nurse comes to your home for three hours and then leaves, that counts as two visits. Also, each person providing Services counts toward these visit limits. For example, if a home health aide and a nurse are both at your home during the same two hours, that counts as two visits.

For the following Services, refer to these sections

- Behavioral health treatment for autism spectrum disorder (refer to "Behavioral Health Treatment for Autism Spectrum Disorder")
- Dialysis care (refer to "Dialysis Care")
- Durable medical equipment (refer to "Durable Medical Equipment ("DME") for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient physical, occupational, and speech therapy visits (refer to "Rehabilitative and Habilitative Services")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Home health care exclusions

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

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

Hospice Care

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

We cover the hospice Services listed below only if all of the following requirements are met:

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

If all of the above requirements are met, we cover the following hospice Services, if necessary for your hospice care:

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, and 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 a Plan Pharmacy. Certain drugs are limited to a maximum 30-day supply in any 30-day period (please call our Member Service Contact Center for the current list of these drugs)
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling

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:

- 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

Hospital Inpatient Care

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

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Plan Physicians, including consultation and treatment by specialists
- Anesthesia
- Drugs prescribed in accord with our drug formulary guidelines (for discharge drugs prescribed when you are released from the hospital, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits" section)
- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and other diagnostic and treatment Services, including MRI, CT, and PET scans
- Whole blood, red blood cells, plasma, platelets, and their administration

- Obstetrical care and delivery (including cesarean section). Note: If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge (for visits after you are released from the hospital, refer to "Office Visits" in this "Benefits" section)
- Behavioral health treatment that is Medically Necessary to treat mental health conditions that fall under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that are listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*
- Respiratory therapy
- Physical, occupational, and speech therapy (including treatment in our organized, multidisciplinary rehabilitation program)
- Medical social services and discharge planning

For the following Services, refer to these sections

- Bariatric surgical procedures (refer to "Bariatric Surgery")
- Dental and orthodontic procedures (refer to "Dental and Orthodontic Services")
- Dialysis care (refer to "Dialysis Care")
- Fertility preservation Services for iatrogenic infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Services related to diagnosis and treatment of infertility, artificial insemination, or assisted reproductive technology (refer to "Fertility Services")
- Hospice care (refer to "Hospice Care")
- Mental health Services (refer to "Mental Health Services")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Reconstructive surgery Services (refer to "Reconstructive Surgery")
- Services in connection with a clinical trial (refer to "Services in Connection with a Clinical Trial")
- Skilled inpatient Services in a Plan Skilled Nursing Facility (refer to "Skilled Nursing Facility Care")
- Substance use disorder treatment Services (refer to "Substance Use Disorder Treatment")
- Transplant Services (refer to "Transplant Services")

Injury to Teeth

Services for accidental injury to teeth are not covered under this *EOC*.

Mental Health Services

We cover Services specified in this "Mental Health Services" section only when the Services are for the prevention, diagnosis, or treatment of Mental Health Conditions. A "Mental Health Condition" is a mental health condition that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders.*

Outpatient mental health Services

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

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

Intensive psychiatric treatment programs

We cover intensive psychiatric treatment programs at a Plan Facility, such as:

- Partial hospitalization
- Multidisciplinary treatment in an intensive outpatient program
- Psychiatric observation for an acute psychiatric crisis

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized mental health treatment, the Services are generally and customarily provided by a mental health residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group mental health evaluation and treatment
- Medical services
- Medication monitoring

- Room and board
- Social services
- Drugs prescribed by a Plan 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 (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits" section)
- Discharge planning

Inpatient psychiatric hospitalization

We cover inpatient psychiatric hospitalization in a Plan Hospital. Coverage includes room and board, drugs, and Services of Plan Physicians and other Plan Providers who are licensed health care professionals acting within the scope of their license.

Services from Non-Plan Providers

If we are not able to offer an appointment with a Plan Provider within required geographic and timely access standards, we will offer to refer you to a Non-Plan Provider (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section). For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

For the following Services, refer to these sections

- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Telehealth Visits (refer to "Telehealth Visits")

Office Visits

We cover the following:

- Primary Care Visits and Non-Physician Specialist Visits
- Physician Specialist Visits
- Group appointments
- Acupuncture Services (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain)
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician

Ostomy and Urological Supplies

We cover ostomy and urological supplies if the following requirements are met:

- A Plan Physician has prescribed ostomy and urological supplies for your medical condition
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage 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.

Ostomy and urological supplies exclusions

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services

We cover the following Services only when part of care covered under other headings in this "Benefits" section. The Services must be prescribed by a Plan Provider.

- Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans
- Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds
- Nuclear medicine
- Routine retinal photography screenings
- Laboratory tests, including tests to monitor the effectiveness of dialysis and tests for specific genetic disorders for which genetic counseling is available
- Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs and EEGs)
- Radiation therapy
- Ultraviolet light treatments, including ultraviolet light therapy equipment for home use, if (1) the equipment has been approved for you through the Plan's prior

authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section 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.)

For the following Services, refer to these sections

- Outpatient imaging and laboratory Services that are Preventive Services, such as routine mammograms, bone density scans, and laboratory screening tests (refer to "Preventive Services")
- Outpatient procedures that include imaging and diagnostic Services (refer to "Outpatient Surgery and Outpatient Procedures")
- Services related to diagnosis and treatment of infertility, artificial insemination, or assisted reproductive technology ("ART") Services (refer to "Fertility Services")

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services exclusions

- Ultraviolet light therapy comfort, convenience, or luxury equipment or features
- Repair or replacement of ultraviolet light therapy equipment due to loss, theft, or misuse

Outpatient Prescription Drugs, Supplies, and Supplements

We cover outpatient drugs, supplies, and supplements specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section, in accord with our drug formulary guidelines, subject to any applicable exclusions or limitations under this *EOC*. We cover items described in this section when prescribed as follows:

- Items prescribed by Plan Providers, within the scope of their licensure and practice
- Items prescribed by the following Non–Plan Providers:
  - Non–Plan Physicians if the Medical Group authorizes a written referral to the Non–Plan Physician (in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section) and the drug, supply, or supplement is covered as part of that referral
  - Non–Plan Physicians if the prescription was obtained as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described under "Payment and Reimbursement" in the "Emergency Services and Urgent Care" section)

How to obtain covered items

You must obtain covered items at a Plan Pharmacy or through our mail-order service unless you obtain the item as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section.

For the locations of Plan Pharmacies, refer to our Provider Directory or call our Member Service Contact Center.

Note: Although most drugs, supplies, and supplements are not covered, you can purchase most noncovered items at Plan Pharmacies.

Refills

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

Day supply limit

The prescribing physician or dentist determines how much of a drug, supply, or supplement to prescribe. For purposes of day supply coverage limits, Plan Physicians determine the amount of an item that constitutes a Medically Necessary 30- or 100-day supply (or 365-day supply if the item is a hormonal contraceptive) for you. Upon payment of the Cost Share specified in the "Outpatient prescription drugs, supplies, and supplements" section of the "Cost Share Summary," you will receive the supply prescribed up to the day supply limit also specified in this section. The maximum you may receive at one time of a covered item, other than a hormonal contraceptive, is either one 30-day supply in a

30-day period or one 100-day supply in a 100-day period. If you wish to receive more than the covered day supply limit, then you must pay Charges for any prescribed quantities that exceed the day supply limit.

If your plan includes coverage for hormonal contraceptives, the maximum you may receive at one time of contraceptive drugs is a 365-day supply. Refer to the "Cost Share Summary" section of this *EOC* to find out if your plan includes coverage for hormonal contraceptives.

If your plan includes coverage for sexual dysfunction drugs, the maximum you may receive at one time of episodic drugs prescribed for the treatment of sexual dysfunction disorders is eight doses in any 30-day period or up to 27 doses in any 100-day period. Refer to the "Cost Share Summary" section of this *EOC* to find out if your plan includes coverage for sexual dysfunction drugs.

The pharmacy may reduce the day supply dispensed at the Cost Share specified in the "Outpatient prescription drugs, supplies, and supplements" section of the "Cost Share Summary" to a 30-day supply in any 30-day period if the pharmacy determines that the item is in limited supply in the market or for specific drugs (your Plan Pharmacy can tell you if a drug you take is one of these drugs).

About the drug formulary

The 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, please visit our website at kp.org/formulary. If you would like to request a copy of the drug formulary for your plan, please call our Member Service Contact Center. Note: The presence of a drug on the drug formulary does not necessarily mean that it will be prescribed for a particular medical condition.

Formulary exception process

Drug formulary guidelines allow you to obtain a non-formulary prescription drug (those not listed on our drug formulary for your condition) if it would otherwise be covered by your plan, as described above, and it is Medically Necessary. If you disagree with a Health Plan determination that a non-formulary prescription drug is not covered, you may file a grievance as described in the "Dispute Resolution" section.

Continuity drugs

If this *EOC* is amended to exclude a drug that we have been covering and providing to you under this *EOC*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the Federal Food and Drug Administration.

About drug tiers

Drugs on the drug formulary are categorized into one of three tiers, as described in the table below. Your Cost Share for covered items may vary based on the tier. Refer to "Outpatient prescription drugs, supplies, and supplements" in the "Cost Share Summary" section of this *EOC* for Cost Share for items covered under this section.

Drug Tier	Description
Generic drugs (Tier 1)	Generic drugs, supplies and supplements, and some low-cost brand-name drugs, supplies, and supplements
Brand drugs (Tier 2)*	Most brand-name drugs, supplies, and supplements
Specialty drugs (Tier 4)	Specialty drugs (see "About specialty drugs")

*Note: This plan does not have a tier for non-formulary drugs ("Tier 3"). You will pay the same Cost Share for non-formulary drugs as you would for formulary drugs, when approved through the formulary exception process described above (the generic drugs, brand drugs, or specialty drugs Cost Share will apply, as applicable).

About specialty drugs

Specialty drugs (Tier 4) are high-cost drugs that are on our specialty drug list. To obtain a list of specialty drugs that are on our formulary, or to find out if a non-formulary drug is on the specialty drugs tier, please call our Member Service Contact Center. 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.

General rules about coverage and your Cost Share

We cover the following outpatient drugs, supplies, and supplements as described in this "Outpatient Prescription Drugs, Supplies, and Supplements" section:

- Drugs for which a prescription is required by law. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary
- Disposable needles and syringes needed for injecting covered drugs and supplements
- Inhaler spacers needed to inhale covered drugs

Note:

- If Charges for the drug, supply, or supplement are less than the Copayment, you will pay the lesser amount, subject to any applicable deductible or out-of-pocket maximum
- Items can change tier at any time, in accord with formulary guidelines, which may impact your Cost Share (for example, if a brand-name drug is added to the specialty drug list, you will pay the Cost Share that applies to drugs on the specialty drugs tier (Tier 4), not the Cost Share for drugs on the brand drugs tier (Tier 2))

Schedule II drugs

You or the prescribing provider can request that the pharmacy dispense less than the prescribed amount of a covered oral, solid dosage form of a Schedule II drug (your Plan Pharmacy can tell you if a drug you take is one of these drugs). Your Cost Share will be prorated based on the amount of the drug that is dispensed. If the pharmacy does not prorate your Cost Share, we will send you a refund for the difference.

Mail-order service

Prescription refills can be mailed within 7 to 10 days at no extra cost for standard U.S. postage. The appropriate Cost Share (according to your drug coverage) will apply and must be charged to a valid credit card.

You may request mail-order service in the following ways:

- To order online, visit kp.org/rxrefill (you can register for a secure account at kp.org/registernow) or use the KP app from your smartphone or other mobile device
- Call the pharmacy phone number highlighted on your prescription label and select the mail delivery option
- On your next visit to a Kaiser Permanente pharmacy, ask our staff how you can have your prescriptions mailed to you

Note: Not all drugs can be mailed; restrictions and limitations apply.

Manufacturer coupon program

For outpatient prescription drugs or items that are covered under this "Outpatient 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 does not cover the entire amount of your Cost Share for your prescription. When you use an approved coupon for payment of your Cost Share, the coupon amount and any additional payment that you make will accumulate to your out-of-pocket maximum. Refer to the "Cost Share Summary" section of this *EOC* to find your applicable out-of-pocket maximum amount and to learn which drugs and items apply to the maximum. Certain health plan coverages are not eligible for coupons. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at kp.org/rxcoupons.

Base drugs, supplies, and supplements

Cost Share for the following items may be different than other drugs, supplies, and supplements. Refer to "Base drugs, supplies, and supplements" in the "Cost Share Summary" section of this *EOC*:

- Certain drugs for the treatment of life-threatening ventricular arrhythmia
- Drugs for the treatment of tuberculosis
- Elemental dietary enteral formula when used as a primary therapy for regional enteritis
- Hematopoietic agents for dialysis
- Hematopoietic agents for the treatment of anemia in chronic renal insufficiency
- Human growth hormone for long-term treatment of pediatric patients with growth failure from lack of adequate endogenous growth hormone secretion
- Immunosuppressants and ganciclovir and ganciclovir prodrugs for the treatment of cytomegalovirus when prescribed in connection with a transplant
- Phosphate binders for dialysis patients for the treatment of hyperphosphatemia in end stage renal disease

For the following Services, refer to these sections

- Administered contraceptives (refer to "Family Planning Services")

- Diabetes blood-testing equipment and their supplies, and insulin pumps and their supplies (refer to "Durable Medical Equipment ("DME") for Home Use")
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Care" and "Skilled Nursing Facility Care")
- Drugs prescribed for pain control and symptom management of the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Durable medical equipment used to administer drugs (refer to "Durable Medical Equipment ("DME") for Home Use")
- Outpatient administered drugs that are not contraceptives (refer to "Administered Drugs and Products")

Outpatient prescription drugs, supplies, and supplements exclusions

- Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging
- Compounded products unless the drug is listed on our drug formulary or one of the ingredients requires a prescription by law
- Drugs prescribed to shorten the duration of the common cold
- Prescription drugs for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the prescription drug). This exclusion does not apply to:
  - insulin
  - over-the-counter drugs covered under "Preventive Services" in this "Benefits" section (this includes tobacco cessation drugs and contraceptive drugs)
  - an entire class of prescription drugs when one drug within that class becomes available over-the-counter
- Drugs prescribed for the treatment of sexual dysfunction disorders
- All drugs, supplies, and supplements for diagnosis and treatment of infertility or related to artificial insemination
- All drugs, supplies, and supplements related to assisted reproductive technology ("ART") Services

Outpatient Surgery and Outpatient Procedures

We cover the following outpatient care Services:

- Outpatient surgery
- Outpatient procedures (including imaging and diagnostic Services) when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or in any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort

For the following Services, refer to these sections

- Fertility preservation Services for iatrogenic infertility (refer to "Fertility Preservation Services for Iatrogenic Infertility")
- Outpatient procedures (including imaging and diagnostic Services) that do not require a licensed staff member to monitor your vital signs (refer to the section that would otherwise apply for the procedure; for example, for radiology procedures that do not require a licensed staff member to monitor your vital signs, refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")

Preventive Services

We cover a variety of Preventive Services, as listed on our website at kp.org/prevention, including the following:

- Services recommended by the United States Preventive Services Task Force with rating of "A" or "B." The complete list of these services can be found at uspreventiveservicestaskforce.org
- Immunizations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention. The complete list of recommended immunizations can be found at www.cdc.gov/vaccines/schedules
- Preventive services for women recommended by the Health Resources and Services Administration and incorporated into the Affordable Care Act. The complete list of these services can be found at www.hrsa.gov/womens-guidelines

The list of Preventive Services recommended by the above organizations is subject to change. These Preventive Services are subject to all coverage requirements described in this "Benefits" section and all

provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section.

If you are enrolled in a grandfathered plan, certain preventive items listed on our website, such as over-the-counter drugs, may not be covered. Refer to the "Certain preventive items" table in the "Cost Share Summary" section of this *EOC* for coverage information. If you have questions about Preventive Services, please call our Member Service Contact Center.

Note: Preventive Services help you stay healthy, before you have symptoms. If you have symptoms, you may need other care, such as diagnostic or treatment Services. If you receive any other covered Services that are not Preventive Services before, during, or after a visit that includes Preventive Services, you will pay the applicable Cost Share for those other Services. For example, if laboratory tests or imaging Services ordered during a preventive office visit are not Preventive Services, you will pay the applicable Cost Share for those Services.

For the following Services, refer to these sections

- Breast pumps and breastfeeding supplies (refer to "Breastfeeding supplies" under "Durable Medical Equipment ("DME") for Home Use")
- Health education programs (refer to "Health Education")
- Outpatient drugs, supplies, and supplements that are Preventive Services (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Women's family planning counseling, consultations, and sterilization Services (refer to "Family Planning Services")

Prosthetic and Orthotic Devices

Prosthetic and orthotic devices coverage rules

We cover the prosthetic and orthotic devices specified in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor that we select
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage includes fitting and adjustment of these devices, their repair or replacement, and Services to determine whether you need a prosthetic or orthotic device. If we cover a replacement device, then you pay the Cost Share that you would pay for obtaining that device.

Base prosthetic and orthotic devices

If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the items described in this "Base prosthetic and orthotic devices" section.

Internally implanted devices

We cover prosthetic and orthotic devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, if they are implanted during a surgery that we are covering under another section of this "Benefits" section.

External devices

We cover the following external prosthetic and orthotic devices:

- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- After Medically Necessary removal of all or part of a breast:
  - prostheses, including custom-made prostheses when Medically Necessary
  - up to three brassieres required to hold a prosthesis in any 12-month period
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Enteral pump and supplies
- Tracheostomy tube and supplies
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect

Supplemental prosthetic and orthotic devices

If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the following items:

- Prosthetic devices required to replace all or part of an organ or extremity, but only if they also replace the function of the organ or extremity
- Rigid and semi-rigid orthotic devices required to support or correct a defective body part

For the following Services, refer to these sections

- Eyeglasses and contact lenses, including contact lenses to treat aniridia or aphakia (refer to "Vision Services for Adult Members" and "Vision Services for Pediatric Members")
- Hearing aids other than internally implanted devices described in this section (refer to "Hearing Services")
- Injectable implants (refer to "Administered Drugs and Products")

Prosthetic and orthotic devices exclusions

- Multifocal intraocular lenses and intraocular lenses to correct astigmatism
- Nonrigid supplies, such as elastic stockings and wigs, except as otherwise described above in this "Prosthetic and Orthotic Devices" section
- Comfort, convenience, or luxury equipment or features
- Repair or replacement of device due to loss, theft, or misuse
- Shoes, shoe inserts, arch supports, or any other footwear, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications
- Prosthetic and orthotic devices not intended for maintaining normal activities of daily living (including devices intended to provide additional support for recreational or sports activities)

Reconstructive Surgery

We cover the following reconstructive surgery Services:

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

For covered Services related to reconstructive surgery that you receive, you will pay the Cost Share you would pay if the Services were not related to reconstructive surgery. For example, see "Hospital inpatient care" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient care, and see "Outpatient surgery and outpatient procedures" in the "Cost Share Summary" for the Cost Share that applies for outpatient surgery.

For the following Services, refer to these sections

- Dental and orthodontic Services that are an integral part of reconstructive surgery for cleft palate (refer to "Dental and Orthodontic Services")
- Office visits not described in the "Reconstructive Surgery" section (refer to "Office Visits")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Telehealth Visits (refer to "Telehealth Visits")

Reconstructive surgery exclusions

- Surgery that, in the judgment of a Plan Physician specializing in reconstructive surgery, offers only a minimal improvement in appearance

Rehabilitative and Habilitative Services

We cover the Services described in this "Rehabilitative and Habilitative Services" section if all of the following requirements are met:

- The Services are to address a health condition
- The Services are to help you keep, learn, or improve skills and functioning for daily living
- You receive the Services at a Plan Facility unless a Plan Physician determines that it is Medically Necessary for you to receive the Services in another location

We cover the following Services:

- Individual outpatient physical, occupational, and speech therapy
- Group outpatient physical, occupational, and speech therapy
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program

For the following Services, refer to these sections

- Behavioral health treatment for autism spectrum disorder (refer to "Behavioral Health Treatment for Autism Spectrum Disorder")
- Home health care (refer to "Home Health Care")
- Durable medical equipment (refer to "Durable Medical Equipment ("DME") for Home Use")
- Ostomy and urological supplies (refer to "Ostomy and Urological Supplies")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")
- Physical, occupational, and speech therapy provided during a covered stay in a Plan Hospital or Skilled Nursing Facility (refer to "Hospital Inpatient Care" and "Skilled Nursing Facility Care")

Rehabilitative and habilitative Services exclusions

- Items and services that are not health care items and services (for example, respite care, day care, recreational care, residential treatment, social services, custodial care, or education services of any kind, including vocational training)

Services in Connection with a Clinical Trial

We cover Services you receive in connection with a clinical trial if all of the following requirements are met:

- We would have covered the Services if they were not related to a clinical trial
- You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
  - a Plan Provider makes this determination
  - you provide us with medical and scientific information establishing this determination
- If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live
- The clinical trial is an Approved Clinical Trial

"Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition, and that meets one of the following requirements:

- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having an investigational new drug application
- The study or investigation is approved or funded by at least one of the following:
  - the National Institutes of Health
  - the Centers for Disease Control and Prevention
  - the Agency for Health Care Research and Quality
  - the Centers for Medicare & Medicaid Services
  - a cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs
  - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
  - the Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review

For covered Services related to a clinical trial, you will pay the Cost Share you would pay if the Services were not related to a clinical trial. For example, see "Hospital inpatient care" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient care.

Services in connection with a clinical trial exclusions

- The investigational Service
- Services that are provided solely to satisfy data collection and analysis needs and are not used in your clinical management

Skilled Nursing Facility Care

Inside our Service Area, we cover skilled inpatient Services in a Plan Skilled Nursing Facility. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

We cover the following Services:

- Physician and nursing Services
- Room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment in accord with our prior authorization procedure if Skilled Nursing Facilities ordinarily furnish the equipment (refer to "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section)
- Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Whole blood, red blood cells, plasma, platelets, and their administration
- Medical supplies
- Behavioral health treatment that is Medically Necessary to treat mental health conditions that fall under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that are listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*
- Physical, occupational, and speech therapy
- Respiratory therapy

For the following Services, refer to these sections

- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient physical, occupational, and speech therapy (refer to "Rehabilitative and Habilitative Services")

Substance Use Disorder Treatment

We cover Services specified in this "Substance Use Disorder Treatment" section only when the Services are for the prevention, diagnosis, or treatment of Substance Use Disorders. A "Substance Use Disorder" is a substance use disorder that falls under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that is listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

Outpatient substance use disorder treatment

We cover the following Services for treatment of substance use disorders:

- Day-treatment programs
- Individual and group substance use disorder counseling
- Intensive outpatient programs
- Medical treatment for withdrawal symptoms

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized substance use disorder treatment, the Services are generally and customarily provided by a substance use disorder residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group substance use disorder counseling
- Medical services
- Medication monitoring
- Room and board
- Social services
- Drugs prescribed by a Plan 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 (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits" section)

- Discharge planning

Inpatient detoxification

We cover hospitalization in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

Services from Non-Plan Providers

If we are not able to offer an appointment with a Plan Provider within required geographic and timely access standards, we will offer to refer you to a Non-Plan Provider (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section). For these referral Services, you pay the Cost Share required for Services provided by a Plan Provider as described in this *EOC*.

For the following Services, refer to these sections

- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient self-administered drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Telehealth Visits (refer to "Telehealth Visits")

Telehealth Visits

Telehealth Visits are intended to make it more convenient for you to receive covered Services, when a Plan Provider determines it is medically appropriate for your medical condition. You may receive covered Services via Telehealth Visits, when available and if the Services would have been covered under this *EOC* if provided in person. You are not required to use Telehealth Visits.

We cover the following types of Telehealth Visits with Primary Care Physicians, Non-Physician Specialists, and Physician Specialists:

- Interactive video visits
- Scheduled telephone visits

Transplant Services

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

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

- If either the Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will only cover Services you receive before that determination is made
- Health Plan, Plan Hospitals, the Medical Group, and Plan Physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with our guidelines for Services for living transplant donors, we provide certain donation-related Services for a donor, or an individual identified by the Medical Group as a potential donor, whether or not the donor is a Member. These Services must be directly related to a covered transplant for you, which may include certain Services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Please call our Member Service Contact Center for questions about donor Services

For covered transplant Services that you receive, you will pay the Cost Share you would pay if the Services were not related to a transplant. For example, see "Hospital inpatient care" in the "Cost Share Summary" section of this *EOC* for the Cost Share that applies for hospital inpatient care. We provide or pay for donation-related Services for actual or potential donors (whether or not they are Members) in accord with our guidelines for donor Services at **no charge** (not subject to the Plan Deductible).

For the following Services, refer to these sections

- Dental Services that are Medically Necessary to prepare for a transplant (refer to "Dental and Orthodontic Services")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Administered Drugs and Products")

Vision Services for Adult Members

For the purpose of this "Vision Services for Adult Members" section, an "Adult Member" is a Member who is age 19 or older and is not a Pediatric Member, as defined under "Vision Services for Pediatric Members" in this "Benefits" section. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1.

We cover the following for Adult Members:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction (including dilation Services when Medically Necessary) and to provide a prescription for eyeglass lenses
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye

Optical Services

We cover the Services described in this "Optical Services" section when received from Plan Medical Offices or Plan Optical Sales Offices.

We do not cover eyeglasses or contact lenses under this *EOC* (except for special contact lenses described in this "Vision Services for Adult Members" section).

Special contact lenses

We cover the following:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist
- For aphakia (absence of the crystalline lens of the eye), we cover up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist

Low vision devices

Low vision devices (including fitting and dispensing) are not covered under this *EOC*.

For the following Services, refer to these sections

- Routine vision screenings when performed as part of a routine physical exam (refer to "Preventive Services")
- Services related to the eye or vision other than Services covered under this "Vision Services for Adult Members" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits" section)

Vision Services for Adult Members exclusions

- Contact lenses, including fitting and dispensing, except as described under this "Vision Services for Adult Members" section
- Eyeglass lenses and frames
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Low vision devices

Vision Services for Pediatric Members

For the purpose of this "Vision Services for Pediatric Members" section, a "Pediatric Member" is a Member from birth through the end of the month of their 19th birthday. For example, if you turn 19 on June 25, you will be an Adult Member starting July 1 and your last minute as a Pediatric Member will be 11:59 p.m. on June 30.

We cover the following for Pediatric Members:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction (including dilation Services when Medically Necessary) and to provide a prescription for eyeglass lenses
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye

Optical Services

We cover the Services described in this "Optical Services" section when received from Plan Medical Offices or Plan Optical Sales Offices.

We do not cover eyeglasses or contact lenses under this *EOC* (except for special contact lenses described in this "Vision Services for Pediatric Members" section).

Special contact lenses

We cover the following:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist

- For aphakia (absence of the crystalline lens of the eye), we cover up to six Medically Necessary aphakic contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist

Low vision devices

Low vision devices (including fitting and dispensing) are not covered under this *EOC*.

For the following Services, refer to these sections

- Routine vision screenings when performed as part of a routine physical exam (refer to "Preventive Services")
- Services related to the eye or vision other than Services covered under this "Vision Services for Pediatric Members" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits" section)

Vision Services for Pediatric Members exclusions

- Contact lenses, including fitting and dispensing, except as described under this "Vision Services for Pediatric Members" section
- Eyeglass lenses and frames
- Eye exams for the purpose of obtaining or maintaining contact lenses
- Low vision devices

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this *EOC* regardless of whether the services are within the scope of a provider's license or certificate. These exclusions or limitations do not apply to Services that are Medically Necessary to treat mental health conditions or substance use disorders that fall under any of the diagnostic categories listed in the mental and behavioral disorders chapter of the most recent edition of the *International Classification of Diseases* or that are listed in the most recent version of the *Diagnostic and Statistical Manual of Mental Disorders*.

Certain exams and Services

Routine physical exams and other Services that are not Medically Necessary, such as when required (1) for obtaining or maintaining employment or participation in employee programs, (2) for insurance, credentialing or licensing, (3) for travel, or (4) by court order or for parole or probation.

Chiropractic Services

Chiropractic Services and the Services of a chiropractor, unless you have coverage for supplemental chiropractic Services as described in an amendment to this *EOC*.

Cosmetic Services

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

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

Custodial care

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

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

Dental and orthodontic Services

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

This exclusion does not apply to the following Services:

- Services covered under "Dental and Orthodontic Services" in the "Benefits" section
- Service described under "Injury to Teeth" in the "Benefits" section

- Pediatric dental Services described in a Pediatric Dental Services Amendment to this *EOC*, if any. If your plan has a Pediatric Dental Services Amendment, it will be attached to this *EOC*, and it will be listed in the *EOC's* Table of Contents

Disposable supplies

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

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

Experimental or investigational Services

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

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

This exclusion does not apply to any of the following:

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

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

Hair loss or growth treatment

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

Intermediate care

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

Items and services that are not health care items and services

For example, we do not cover:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services for the purpose of increasing academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching you how to read, whether or not you have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play or swimming
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy, except that this exclusion for aquatic therapy and other water therapy does not apply to therapy Services that are part of a physical therapy treatment plan and covered under "Home Health Care," "Hospice Services," "Hospital Inpatient Care," "Rehabilitative and Habilitative Services," or "Skilled Nursing Facility Care" in the "Benefits" section

Items and services to correct refractive defects of the eye

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

Massage therapy

Massage therapy, except that this exclusion does not apply to therapy Services that are part of a physical therapy treatment plan and covered under "Home Health Care," "Hospice Services," "Hospital Inpatient Care,"

"Rehabilitative and Habilitative Services," or "Skilled Nursing Facility Care" in the "Benefits" section.

Oral nutrition

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

This exclusion does not apply to any of the following:

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

Residential care

Care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a Skilled Nursing Facility, or inpatient respite care covered in the "Hospice Care" section.

Routine foot care items and services

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

Services not approved by the federal Food and Drug Administration

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

This exclusion does not apply to any of the following:

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

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

Services performed by unlicensed people

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

Services related to a noncovered Service

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

Surrogacy

Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. A "Surrogacy Arrangement" is one in which a woman (the surrogate) agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Refer to "Surrogacy arrangements" under "Reductions" in this "Exclusions, Limitations, Coordination of Benefits, and Reductions" section for information about your obligations to us in connection with a Surrogacy Arrangement, including your obligations to reimburse us for any Services we cover and to provide information about anyone who may be financially responsible for Services the baby (or babies) receive.

Travel and lodging expenses

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

Limitations

We will make a good faith effort to provide or arrange for covered Services within the remaining availability of facilities or personnel in the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC*, such as a major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor dispute. Under these circumstances, if you have an Emergency

Medical Condition, call 911 or go to the nearest hospital as described under "Emergency Services" in the "Emergency Services and Urgent Care" section, and we will provide coverage and reimbursement as described in that section.

Coordination of Benefits

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

Coverage other than Medicare coverage

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

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

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

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

Medicare coverage

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

Reductions

Employer responsibility

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

Government agency responsibility

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

Injuries or illnesses alleged to be caused by other parties

If you obtain a judgment or settlement from or on behalf of another party who allegedly caused an injury or illness for which you received covered Services, you must reimburse us to the maximum extent allowed under California Civil Code Section 3040. The reimbursement due to us is not limited by or subject to the Plan Out-of-Pocket Maximum. Note: This "Injuries or illnesses alleged to be caused by other parties" section does not affect your obligation to pay your Cost Share for these Services.

To the extent permitted or required by law, we have the option of becoming subrogated to all claims, causes of action, and other rights you may have against another 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 other 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 on the proceeds of any judgment or settlement you or we obtain against another party. The proceeds of any judgment or settlement that you or we obtain shall first be applied to satisfy our lien, regardless of whether the total amount of the proceeds is less than the actual losses and damages you incurred.

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

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

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the other party, and the other 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 another 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 other party. We may assign our rights to enforce our liens and other rights.

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

Some providers have contracted with Kaiser Permanente to provide certain Services to Members at rates that are typically less than the fees that the providers ordinarily charge to the general public ("General Fees"). However, these contracts may allow the providers to recover all or a portion of the difference between the fees paid by Kaiser Permanente and their General Fees by means of a lien claim under California Civil Code Sections 3045.13045.6 against a judgment or settlement that you receive from or on behalf of another party. For Services the provider furnished, our recovery and the provider's recovery together will not exceed the provider's General Fees.

Surrogacy arrangements

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

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

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

You must send this information to:

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

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

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

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

U.S. Department of Veterans Affairs

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

Workers' compensation or employer's liability benefits

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

Post-Service Claims and Appeals

This "Post-Service Claims and Appeals" section explains how to file a claim for payment or reimbursement for Services that you have already received. Please use the procedures in this section in the following situations:

- You have received Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services from a Non–Plan Provider and you want us to pay for the Services
- You have received Services from a Non–Plan Provider that we did not authorize (other than Emergency Services, Out-of-Area Urgent Care, Post-Stabilization Care, or emergency ambulance Services) and you want us to pay for the Services
- You want to appeal a denial of an initial claim for payment

Please follow the procedures under "Grievances" in the "Dispute Resolution" section in the following situations:

- You want us to cover Services that you have not yet received
- You want us to continue to cover an ongoing course of covered treatment
- You want to appeal a written denial of a request for Services that require prior authorization (as described under "Medical Group authorization procedure for certain referrals")

Who May File

The following people may file claims:

- You may file for yourself
- You can ask a friend, relative, attorney, or any other individual to file a claim for you by appointing them in writing as your authorized representative
- A parent may file for their child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the claim
- A court-appointed guardian may file for their ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the claim

- A court-appointed conservator may file for their conservatee
- An agent under a currently effective health care proxy, to the extent provided under state law, may file for their principal

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services Department at a Plan Facility, on our website at kp.org, or by calling our Member Service Contact Center. Your written authorization must accompany the claim. You must pay the cost of anyone you hire to represent or help you.

Supporting Documents

You can request payment or reimbursement orally or in writing. Your request for payment or reimbursement, and any related documents that you give us, constitute your claim.

Claim forms for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services

To file a claim in writing for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, and emergency ambulance Services, please use our claim form. You can obtain a claim form in the following ways:

- By visiting our website at kp.org
- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call our Member Service Contact Center)
- By calling our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**)

Claims forms for all other Services

To file a claim in writing for all other Services, you may use our Complaint or Benefit Claim/Request form. You can obtain this form in the following ways:

- By visiting our website at kp.org
- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call our Member Service Contact Center)
- By calling our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**)

Other supporting information

When you file a claim, please include any information that clarifies or supports your position. For example, if you have paid for Services, please include any bills and receipts that support your claim. To request that we pay a Non–Plan Provider for Services, include any bills from the Non–Plan Provider. If the Non–Plan Provider states that they will file the claim, you are still responsible for making sure that we receive everything we need to process the request for payment. When appropriate, we will request medical records from Plan Providers on your behalf. If you tell us that you have consulted with a Non– Plan Provider and are unable to provide copies of relevant medical records, we will contact the provider to request a copy of your relevant medical records. We will ask you to provide us a written authorization so that we can request your records.

If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. You also have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim. To make a request, you should follow the steps in the written notice sent to you about your claim.

Initial Claims

To request that we pay a provider (or reimburse you) for Services that you have already received, you must file a claim. If you have any questions about the claims process, please call our Member Service Contact Center.

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

If you have received Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services from a Non–Plan Provider, then as soon as possible after you received the Services, you must file your claim by mailing a completed claim form and supporting information to the following address:

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

Please call our Member Service Contact Center if you need help filing your claim.

Submitting a claim for all other Services

If you have received Services from a Non–Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services), then as soon as possible after you receive the Services, you must file your claim in one of the following ways:

- By delivering your claim to a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call our Member Service Contact Center)
- By mailing your claim to a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call our Member Service Contact Center)
- By calling our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**)
- By visiting our website at kp.org

Please call our Member Service Contact Center if you need help filing your claim.

After we receive your claim

We will send you an acknowledgment letter within five days after we receive your claim.

After we review your claim, we will respond as follows:

- If we have all the information we need we will send you a written decision within 30 days after we receive your claim. We may extend the time for making a decision for an additional 15 days if circumstances beyond our control delay our decision, if we notify you within 30 days after we receive your claim
- If we need more information, we will ask you for the information before the end of the initial 30-day decision period. We will send our written decision no later than 15 days after the date we receive the additional information. If we do not receive the necessary information within the timeframe specified in our letter, we will make our decision based on the information we have within 15 days after the end of that timeframe

If we pay any part of your claim, we will subtract applicable Cost Share from any payment we make to you or the Non–Plan Provider. You are not responsible for any amounts beyond your Cost Share for covered Emergency Services. If we deny your claim (if we do not agree to pay for all the Services you requested other than the applicable Cost Share), our letter will explain why we denied your claim and how you can appeal.

If you later receive any bills from the Non–Plan Provider for covered Services (other than bills for your Cost Share), please call our Member Service Contact Center for assistance.

Appeals

Claims for Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services from a Non–Plan Provider

If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By mailing your appeal to the Claims Department at the following address:

  Kaiser Foundation Health Plan, Inc.
  Special Services Unit
  P.O. Box 23280
  Oakland, CA 94623
- By calling our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**)
- By visiting our website at kp.org

Claims for Services from a Non–Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services)

If we did not decide fully in your favor and you want to appeal our decision, you may submit your appeal in one of the following ways:

- By visiting our website at kp.org
- By mailing your appeal to the Member Services Department at a Plan Facility (for addresses, refer to our Provider Directory or call our Member Service Contact Center)
- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call our Member Service Contact Center)
- By calling our Member Service Contact Center at **1-800-464-4000** (TTY users call **711**)

When you file an appeal, please include any information that clarifies or supports your position. If you want to review the information that we have collected regarding your claim, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should call our Member Service Contact Center.

Additional information regarding a claim for Services from a Non–Plan Provider that we did not authorize (other than Emergency Services, Post-Stabilization Care, Out-of-Area Urgent Care, or emergency ambulance Services)

If we initially denied your request, you must file your appeal within 180 days after the date you received our denial letter. You may send us information including comments, documents, and medical records that you believe support your claim. If we asked for additional information and you did not provide it before we made our initial decision about your claim, then you may still send us the additional information so that we may include it as part of our review of your appeal. Please send all additional information to the address or fax mentioned in your denial letter.

Also, you may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter, sent to you within five days after we receive your appeal. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your appeal file and we will review it without regard to whether this information was filed or considered in our initial decision regarding your request for Services. You have the right to request any diagnosis and treatment codes and their meanings that are the subject of your claim.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our final decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your appeal file.

We will send you a resolution letter within 30 days after we receive your appeal. If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

External Review

You must exhaust our internal claims and appeals procedures before you may request external review unless we have failed to comply with the claims and appeals procedures described in this "Post-Service Claims and Appeals" section. For information about external review process, see "Independent Medical Review ("IMR")" in the "Dispute Resolution" section.

Additional Review

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

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

Dispute Resolution

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

Grievances

This "Grievances" section describes our grievance procedure. A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. If you want to make a claim for payment or reimbursement for Services that you have already received from a Non–Plan Provider, please follow the procedure in the "Post-Service Claims and Appeals" section.

Here are some examples of reasons you might file a grievance:

- You are not satisfied with the quality of care you received
- You received a written denial of Services that require prior authorization from the Medical Group and you want us to cover the Services

- You received a written denial for a second opinion or we did not respond to your request for a second opinion in an expeditious manner, as appropriate for your condition
- Your treating physician has said that Services are not Medically Necessary and you want us to cover the Services
- You were told that Services are not covered and you believe that the Services should be covered
- You want us to continue to cover an ongoing course of covered treatment
- You are dissatisfied with how long it took to get Services, including getting an appointment, in the waiting room, or in the exam room
- You want to report unsatisfactory behavior by providers or staff, or dissatisfaction with the condition of a facility
- You believe you have faced discrimination from providers, staff, or Health Plan
- We terminated your membership and you disagree with that termination

Who may file

The following people may file a grievance:

- You may file for yourself
- You can ask a friend, relative, attorney, or any other individual to file a grievance for you by appointing them in writing as your authorized representative
- A parent may file for their child under age 18, except that the child must appoint the parent as authorized representative if the child has the legal right to control release of information that is relevant to the grievance
- A court-appointed guardian may file for their ward, except that the ward must appoint the court-appointed guardian as authorized representative if the ward has the legal right to control release of information that is relevant to the grievance
- A court-appointed conservator may file for their conservatee
- An agent under a currently effective health care proxy, to the extent provided under state law, may file for their principal
- Your physician may act as your authorized representative with your verbal consent to request an urgent grievance as described under "Urgent procedure" in this "Grievances" section

Authorized representatives must be appointed in writing using either our authorization form or some other form of written notification. The authorization form is available from the Member Services Department at a Plan Facility, on our website at kp.org, or by calling our Member Service Contact Center. Your written authorization must accompany the grievance. You must pay the cost of anyone you hire to represent or help you.

How to file

You can file a grievance orally or in writing. Your grievance must explain your issue, such as the reasons why you believe a decision was in error or why you are dissatisfied with the Services you received.

To file a grievance online, use the grievance form on our website at kp.org.

To file a grievance in writing, please use our Complaint or Benefit Claim/Request form. You can obtain the form in the following ways:

- By visiting our website at kp.org
- In person from any Member Services office at a Plan Facility and from Plan Providers (for addresses, refer to our Provider Directory or call our Member Service Contact Center)
- By calling our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **711**)

You must file your grievance within 180 days following the incident or action that is subject to your dissatisfaction. You may send us information including comments, documents, and medical records that you believe support your grievance.

Standard procedure

You must file your grievance in one of the following ways:

- By completing a Complaint or Benefit Claim/Request form at a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call our Member Service Contact Center)
- By mailing your grievance to a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call our Member Service Contact Center)
- By calling our Member Service Contact Center toll free at **1-800-464-4000** (TTY users call **711**)
- By completing the grievance form on our website at kp.org

Please call our Member Service Contact Center if you need help filing a grievance.

If your grievance involves a request to obtain a non-formulary prescription drug, we will notify you of our decision within 72 hours. If we do not decide in your favor, our letter will explain why and describe your further appeal rights. For information on how to request a review by an independent review organization, see "Independent Review Organization for Non-Formulary Prescription Drug Requests" in this "Dispute Resolution" section.

For all other grievances, we will send you an acknowledgment letter within five days after we receive your grievance. We will send you a resolution letter within 30 days after we receive your grievance. If you are requesting Services, and we do not decide in your favor, our letter will explain why and describe your further appeal rights.

If you want to review the information that we have collected regarding your grievance, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a request, you should call our Member Service Contact Center.

Urgent procedure

If you want us to consider your grievance on an urgent basis, please tell us that when you file your grievance. Note: Urgent is sometimes referred to as "exigent." If exigent circumstances exist, your grievance may be reviewed using the urgent procedure described in this section.

You must file your urgent grievance in one of the following ways:

- By calling our Expedited Review Unit toll free at **1-888-987-7247** (TTY users call **711**)
- By mailing a written request to:

  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 23170
  Oakland, CA 94623-0170
- By faxing a written request to our Expedited Review Unit toll free at **1-888-987-2252**
- By visiting a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call our Member Service Contact Center)
- By completing the grievance form on our website at kp.org

We will decide whether your grievance is urgent or non-urgent unless your attending health care provider tells us your grievance is urgent. If we determine that your grievance is not urgent, we will use the procedure described under "Standard procedure" in this "Grievances" section. Generally, a grievance is urgent only if one of the following is true:

- Using the standard procedure could seriously jeopardize your life, health, or ability to regain maximum function
- Using the standard procedure would, in the opinion of a physician with knowledge of your medical condition, subject you to severe pain that cannot be adequately managed without extending your course of covered treatment
- A physician with knowledge of your medical condition determines that your grievance is urgent
- You have received Emergency Services but have not been discharged from a facility and your request involves admissions, continued stay, or other health care Services
- You are undergoing a current course of treatment using a non-formulary prescription drug and your grievance involves a request to refill a non-formulary prescription drug

For most grievances that we respond to on an urgent basis, we will give you oral notice of our decision as soon as your clinical condition requires, but not later than 72 hours after we received your grievance. We will send you a written confirmation of our decision within three days after we received your grievance.

If your grievance involves a request to obtain a non-formulary prescription drug and we respond to your request on an urgent basis, we will notify you of our decision within 24 hours of your request. For information on how to request a review by an independent review organization, see "Independent Review Organization for Non- Formulary Prescription Drug Requests" in this "Dispute Resolution" section.

If we do not decide in your favor, our letter will explain why and describe your further appeal rights.

Note: If you have an issue that involves an imminent and serious threat to your health (such as severe pain or potential loss of life, limb, or major bodily function), you can contact the California Department of Managed Health Care at any time at **1-888-466-2219** (TDD **1-877-688-9891**) without first filing a grievance with us.

If you want to review the information that we have collected regarding your grievance, you may request, and we will provide without charge, copies of all relevant documents, records, and other information. To make a

request, you should call our Member Service Contact Center.

Additional information regarding pre-service requests for Medically Necessary Services
You may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your grievance file and we will consider it in our decision regarding your pre-service request for Medically Necessary Services.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If your grievance is urgent, the information will be provided to you orally and followed in writing. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your grievance file.

Additional information regarding appeals of written denials for Services that require prior authorization
You must file your appeal within 180 days after the date you received our denial letter.

You have the right to request any diagnosis and treatment codes and their meanings that are the subject of your appeal.

Also, you may give testimony in writing or by phone. Please send your written testimony to the address mentioned in our acknowledgment letter. To arrange to give testimony by phone, you should call the phone number mentioned in our acknowledgment letter.

We will add the information that you provide through testimony or other means to your appeal file and we will consider it in our decision regarding your appeal.

We will share any additional information that we collect in the course of our review and we will send it to you. If we believe that your request should not be granted, before we issue our decision letter, we will also share with you any new or additional reasons for that decision. We will send you a letter explaining the additional information and/or reasons. Our letters about additional information and new or additional rationales will tell you how you can respond to the information provided if you choose to do so. If your appeal is urgent, the information will be provided to you orally and followed in writing. If you do not respond before we must issue our final decision letter, that decision will be based on the information in your appeal file.

Independent Review Organization for Non-Formulary Prescription Drug Requests

If you filed a grievance to obtain a non-formulary prescription drug and we did not decide in your favor, you may submit a request for a review of your grievance by an independent review organization ("IRO"). You must submit your request for IRO review within 180 days of the receipt of our decision letter.

You must file your request for IRO review in one of the following ways:

- By calling our Expedited Review Unit toll free at **1-888-987-7247** (TTY users call **711**)
- By mailing a written request to:

  Kaiser Foundation Health Plan, Inc.
  Expedited Review Unit
  P.O. Box 23170
  Oakland, CA 94623-0170
- By faxing a written request to our Expedited Review Unit toll free at **1-888-987-2252**
- By visiting a Member Services office at a Plan Facility (for addresses, refer to our Provider Directory or call our Member Service Contact Center)
- By completing the grievance form on our website at kp.org

For urgent IRO reviews, we will forward to you the independent reviewer's decision within 24 hours. For non-urgent requests, we will forward the independent reviewer's decision to you within 72 hours. If the independent reviewer does not decide in your favor, you may submit a complaint to the Department of Managed Health Care, as described under "Department of Managed Health Care Complaints" in this "Dispute Resolution" section. You may also submit a request for an Independent Medical Review as described under "Independent Medical Review" in this "Dispute Resolution" section.

Department of Managed Health Care Complaints

The California Department of Managed Health Care is responsible for regulating health care service plans. If you have a grievance against your health plan, you should first telephone your health plan toll free at **1-800-464-4000** (TTY users call **711**) and use your health plan's grievance process before contacting the department. Utilizing this grievance procedure does not prohibit any potential legal rights or remedies that may be available to you. If you need help with a grievance involving an emergency, a grievance that has not been satisfactorily resolved by your health plan, or a grievance that has remained unresolved for more than 30 days, you may call the department for assistance. You may also be eligible for an Independent Medical Review (IMR). If you are eligible for IMR, the IMR process will provide an impartial review of medical decisions made by a health plan related to the medical necessity of a proposed service or treatment, coverage decisions for treatments that are experimental or investigational in nature and payment disputes for emergency or urgent medical services. The department also has a toll-free telephone number **(1-888-466-2219)** and a TDD line **(1-877-688-9891)** for the hearing and speech impaired. The department's Internet website www.dmhc.ca.gov has complaint forms, IMR application forms and instructions online.

Independent Medical Review ("IMR")

Except as described in this "Independent Medical Review ("IMR")" section, you must exhaust our internal grievance procedure before you may request independent medical review unless we have failed to comply with the grievance procedure described under "Grievances" in this "Dispute Resolution" section. If you qualify, you or your authorized representative may have your issue reviewed through the IMR process managed by the California Department of Managed Health Care ("DMHC"). The DMHC determines which cases qualify for IMR. This review is at no cost to you. If you decide not to request an IMR, you may give up the right to pursue some legal actions against us.

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

- One of these situations applies to you:
  - you have a recommendation from a provider requesting Medically Necessary Services
  - you have received Emergency Services, emergency ambulance Services, or Urgent Care from a provider who determined the Services to be Medically Necessary
  - you have been seen by a Plan Provider for the diagnosis or treatment of your medical condition
- Your request for payment or Services has been denied, modified, or delayed based in whole or in part on a decision that the Services are not Medically Necessary
- You have filed a grievance and we have denied it or we haven't made a decision about your grievance within 30 days (or three days for urgent grievances). The DMHC may waive the requirement that you first file a grievance with us in extraordinary and compelling cases, such as severe pain or potential loss of life, limb, or major bodily function. If we have denied your grievance, you must submit your request for an IMR within six months of the date of our written denial. However, the DMHC may accept your request after six months if they determine that circumstances prevented timely submission

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

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

Experimental or investigational denials

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

- Your treating physician provided us a written statement that you have a life-threatening or seriously debilitating condition and that standard therapies have not been effective in improving your condition, or that standard therapies would not be appropriate, or that there is no more beneficial standard therapy we cover than the therapy being requested. "Life-threatening" means diseases or conditions where the likelihood of death is high unless the course of the disease is interrupted, or diseases or conditions with potentially fatal outcomes where the end point of clinical intervention is survival. "Seriously

debilitating" means diseases or conditions that cause major irreversible morbidity

- If your treating physician is a Plan Physician, they recommended a treatment, drug, device, procedure, or other therapy and certified that the requested therapy is likely to be more beneficial to you than any available standard therapies and included a statement of the evidence relied upon by the Plan Physician in certifying their recommendation
- You (or your Non–Plan Physician who is a licensed, and either a board-certified or board-eligible, physician qualified in the area of practice appropriate to treat your condition) requested a therapy that, based on two documents from the medical and scientific evidence, as defined in California Health and Safety Code Section 1370.4(d), is likely to be more beneficial for you than any available standard therapy. The physician's certification included a statement of the evidence relied upon by the physician in certifying their recommendation. We do not cover the Services of the Non–Plan Provider

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

Office of Civil Rights Complaints

If you believe that you have been discriminated against by a Plan Provider or by us because of your race, color, national origin, disability, age, sex (including sex stereotyping and gender identity), or religion, you may file a complaint with the Office of Civil Rights in the United States Department of Health and Human Services ("OCR").

You may file your complaint with the OCR within 180 days of when you believe the act of discrimination occurred. However, the OCR may accept your request after six months if they determine that circumstances prevented timely submission. For more information on the OCR and how to file a complaint with the OCR, go to hhs.gov/civil-rights.

Additional Review

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

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

Binding Arbitration

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

Scope of arbitration

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

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

Members enrolled under this *EOC* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeal procedure as applicable to Kaiser Permanente Senior Advantage Members

- Claims that cannot be subject to binding arbitration under governing law

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

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

"Kaiser Permanente Parties" include:

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

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

Rules of Procedure

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

Initiating arbitration

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

Serving Demand for Arbitration

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

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

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

Filing fee

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

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

Number of arbitrators

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

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

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

Payment of arbitrators' fees and expenses

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

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

Costs

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

General provisions

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

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

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

Termination of Membership

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2023, your last minute of coverage was at 11:59 p.m. on December 31, 2022). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *EOC* after your membership terminates, except as provided under "Payments after Termination" in this "Termination of Membership" section.

Termination Due to Loss of Eligibility

If you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section, your Group will notify you of the date that your membership will end. Your membership termination date is the first day you are not covered. For example, if your termination date is January 1, 2023, your last minute of coverage was at 11:59 p.m. on December 31, 2022.

Termination of *Agreement*

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

Termination for Cause

If you intentionally commit fraud in connection with membership, Health Plan, or a Plan Provider, we may terminate your membership by sending written notice to the Subscriber; termination will be effective 30 days from the date we send the notice. Some examples of fraud include:

- Misrepresenting eligibility information about you or a Dependent
- Presenting an invalid prescription or physician order
- Misusing a Kaiser Permanente ID card (or letting someone else use it)
- Giving us incorrect or incomplete material information. For example, you have entered into a Surrogacy Arrangement and you fail to send us the information we require under "Surrogacy arrangements" under "Reductions" in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section
- Failing to notify us of changes in family status or Medicare coverage that may affect your eligibility or benefits

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

Termination of a Product or all Products

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

Payments after Termination

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

- Refund any amounts we owe your Group for Premiums paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Emergency Services and Urgent Care" and "Dispute Resolution" sections

We will deduct any amounts you owe Health Plan or Plan Providers from any payment we make to you.

State Review of Membership Termination

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

Continuation of Membership

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

Continuation of Group Coverage

COBRA

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

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

If you enroll in COBRA and exhaust the time limit for COBRA coverage, you may be able to continue Group coverage under state law as described under "Cal-COBRA" in this "Continuation of Group Coverage" section.

Cal-COBRA

If you are eligible for coverage under the California Continuation Benefits Replacement Act ("Cal-COBRA"), you can continue coverage as described in this "Cal-COBRA" section if you apply for coverage in compliance with Cal-COBRA law and pay applicable Premiums.

Eligibility and effective date of coverage for Cal-COBRA after COBRA

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

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

You must request an enrollment application by calling our Member Service Contact Center within 60 days of the date of when your COBRA coverage ends.

Cal-COBRA enrollment and Premiums

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

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

After that first payment, your Premium payment for the upcoming coverage month is due on first day of that month. The Premiums will not exceed 110 percent of the applicable Premiums charged to a similarly situated individual under the Group benefit plan except that Premiums for disabled individuals after 18 months of COBRA coverage will not exceed 150 percent instead of 110 percent. Returned checks or insufficient funds on electronic payments will be subject to a $25 fee.

If you have selected Ancillary Coverage provided under any other program, the Premium for that Ancillary Coverage will be billed together with required Premiums for coverage under this *EOC*. Full Premiums will then also include Premium for Ancillary Coverage. This means if you do not pay the Full Premiums owed by the due date, we may terminate your membership under this *EOC* and any Ancillary Coverage, as described in the "Termination for nonpayment of Cal-COBRA Premiums" section.

Changes to Cal-COBRA coverage and Premiums

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

Cal-COBRA open enrollment or termination of another health plan

If you previously elected Cal-COBRA coverage through another health plan available through your Group, you may be eligible to enroll in Kaiser Permanente during your Group's annual open enrollment period, or if your Group terminates its agreement with the health plan you are enrolled in. You will be entitled to Cal-COBRA coverage only for the remainder, if any, of the coverage period prescribed by Cal-COBRA. Please ask your Group for information about health plans available to

you either at open enrollment or if your Group terminates a health plan's agreement.

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

How you may terminate your Cal-COBRA coverage
You may terminate your Cal-COBRA coverage by sending written notice, signed by the Subscriber, to the address below. Your membership will terminate at 11:59 p.m. on the last day of the month in which we receive your notice. Also, you must include with your notice all amounts payable related to your Cal-COBRA coverage, including Premiums, for the period prior to your termination date.

Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 23127
San Diego, CA 92193-3127

Termination for nonpayment of Cal-COBRA Premiums If you do not pay Full Premiums by the due date, we may terminate your membership as described in this "Termination for nonpayment of Cal-COBRA Premiums" section. If you intend to terminate your membership, be sure to notify us as described under "How you may terminate your Cal-COBRA coverage" in this "Cal-COBRA" section, as you will be responsible for any Premiums billed to you unless you let us know before the first of the coverage month that you want us to terminate your coverage.

Your Premium payment for the upcoming coverage month is due on the first day of that month. If we do not receive full Premium payment on or before the first day of the coverage month, we will send a notice of nonreceipt of payment (a "Late Notice") to the Subscriber's address of record. This Late Notice will include the following information:

- A statement that we have not received full Premium payment and that we will terminate the memberships of everyone in your Family for nonpayment if we do not receive the required Premiums within 30 days after the date of the Late Notice
- The amount of Premiums that are due
- The specific date and time when the memberships of everyone in your Family will end if we do not receive the Premiums

If we terminate your Cal-COBRA coverage because we did not receive Full Premiums when due, your membership will end at 11:59 p.m. on the 30th day after the date of the Late Notice. Your coverage will continue during this 30-day grace period, but upon termination you will be responsible for paying all past due Premiums, including the Premiums for this grace period.

We will mail a Termination Notice to the Subscriber's address of record if we do not receive full Premium payment within 30 days after the date of the Late Notice. The Termination Notice will include the following information:

- A statement that we have terminated the memberships of everyone in your Family for nonpayment of Premiums
- The specific date and time when the memberships of everyone in your Family ended
- The amount of Premiums that are due
- Information explaining whether or not you can reinstate your memberships
- Your appeal rights

If we terminate your membership, you are still responsible for paying all amounts due.

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

Termination of Cal-COBRA coverage

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

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

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

Group responsibilities

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

USERRA

If you are called to active duty in the uniformed services, you may be able to continue your coverage under this *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal Uniformed Services Employment and Reemployment Rights Act ("USERRA"). You must submit a USERRA election form to your Group within 60 days after your call to active duty. Please contact your Group to find out how to elect USERRA coverage and how much you must pay your Group.

Coverage for a Disabling Condition

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

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

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

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

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

To request continuation of coverage for your disabling condition, you must call our Member Service Contact

Center within 30 days after your Group's *Agreement* with us terminates.

Continuation of Coverage under an Individual Plan

If you want to remain a Health Plan member when your Group coverage ends, you might be able to enroll in one of our Kaiser Permanente for Individuals and Families plans. The premiums and coverage under our individual plan coverage are different from those under this *EOC*.

If you want your individual plan coverage to be effective when your Group coverage ends, you must submit your application within the special enrollment period for enrolling in an individual plan due to loss of other coverage. Otherwise, you will have to wait until the next annual open enrollment period.

To request an application to enroll directly with us, please go to buykp.org or call our Member Service Contact Center. For information about plans that are available through Covered California, see "Covered California" below.

Covered California

U.S. citizens or legal residents of the U.S. can buy health care coverage from Covered California. This is California's health benefit exchange ("the Exchange"). You may apply for help to pay for premiums and copayments but only if you buy coverage through Covered California. This financial assistance may be available if you meet certain income guidelines. To learn more about coverage that is available through Covered California, visit CoveredCA.com or call Covered California at **1-800-300-1506** (TTY users call **711**).

Miscellaneous Provisions

Administration of *Agreement*

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

Advance Directives

The California Health Care Decision Law offers several ways for you to control the kind of health care you will receive if you become very ill or unconscious, including the following:

- A *Power of Attorney for Health Care* lets you name someone to make health care decisions for you when you cannot speak for yourself. It also lets you write down your own views on life support and other treatments
- *Individual health care instructions* let you express your wishes about receiving life support and other treatment. You can express these wishes to your doctor and have them documented in your medical chart, or you can put them in writing and have that included in your medical chart

To learn more about advance directives, including how to obtain forms and instructions, contact the Member Services Department at a Plan Facility. For more information about advance directives, refer to our website at kp.org or call our Member Service Contact Center.

Amendment of *Agreement*

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

Applications and Statements

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

Assignment

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

Attorney and Advocate Fees and Expenses

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

Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this *EOC* and we have the

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

EOC Binding on Members

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

ERISA Notices

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

Newborns' and Mothers' Health Protection Act

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

Women's Health and Cancer Rights Act

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

Governing Law

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

Group and Members Not Our Agents

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

No Waiver

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

Notices Regarding Your Coverage

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call our Member Service Contact Center as soon as possible to give us their new address. If a Member does not reside with the Subscriber, or needs to have confidential information sent to an address other than the Subscriber's address, they should call our Member Service Contact Center to discuss alternate delivery options.

Note: When we tell your Group about changes to this *EOC* or provide your Group other information that affects you, your Group is required to notify the Subscriber within 30 days (or five days if we terminate your Group's *Agreement*) after receiving the information from us.

Overpayment Recovery

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

Privacy Practices

Kaiser Permanente will protect the privacy of your protected health information. We also require contracting providers to protect your protected health information. Your protected health information is individually-identifiable information (oral, written, or electronic) about your health, health care services you receive, or payment for your health care. You may generally see and receive copies of your protected health information, correct or update your protected health information, and ask us for an accounting of certain disclosures of your protected health information. You can request delivery of confidential communication to a location other than your usual address or by a means of delivery other than the usual means.

We may use or disclose your protected health information for treatment, health research, payment, and health care operations purposes, such as measuring the quality of Services. We are sometimes required by law to give protected health information to others, such as government agencies or in judicial actions. In addition, protected health information is shared with your Group only with your authorization or as otherwise permitted by law.

We will not use or disclose your protected health information for any other purpose without your (or your representative's) written authorization, except as described in our *Notice of Privacy Practices* (see below). Giving us authorization is at your discretion.

This is only a brief summary of some of our key privacy practices. OUR *NOTICE OF PRIVACY PRACTICES*, WHICH PROVIDES ADDITIONAL INFORMATION ABOUT OUR PRIVACY PRACTICES AND YOUR RIGHTS REGARDING YOUR PROTECTED HEALTH INFORMATION, IS AVAILABLE AND WILL BE FURNISHED TO YOU UPON REQUEST. To request a copy, please call our Member Service Contact Center. You can also find the notice at a Plan Facility or on our website at kp.org.

Public Policy Participation

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

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

Helpful Information

How to Obtain this *EOC* in Other Formats

You can request a copy of this *EOC* in an alternate format (Braille, audio, electronic text file, or large print) by calling our Member Service Contact Center.

Provider Directory

Refer to the Provider Directory for your Home Region for the following information:

- A list of Plan Physicians
- The location of Plan Facilities and the types of covered Services that are available from each facility
- Hours of operation
- Appointments and advice phone numbers

This directory is available on our website at kp.org. To obtain a printed copy, call our Member Service Contact Center. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call our Member Service Contact Center.

Online Tools and Resources

Here are some tools and resources available on our website at kp.org:

- How to use our Services and make appointments

- Tools you can use to email your doctor's office, view test results, refill prescriptions, and schedule routine appointments
- Health education resources
- Preventive care guidelines
- Member rights and responsibilities

You can also access tools and resources using the KP app on your smartphone or other mobile device.

How to Reach Us

Appointments

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

Call The appointment phone number at a Plan Facility (for phone numbers, refer to our Provider Directory or call our Member Service Contact Center)

Website kp.org for routine (non-urgent) appointments with your personal Plan Physician or another Primary Care Physician

Not sure what kind of care you need?

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

Call The appointment or advice phone number at a Plan Facility (for phone numbers, refer to our Provider Directory or call our Member Service Contact Center)

Member Services

If you have questions or concerns about your coverage, how to obtain Services, or the facilities where you can receive care, you can reach us in the following ways:

Call **1-800-464-4000** (English and more than 150 languages using interpreter services)
1-800-788-0616 (Spanish)
1-800-757-7585 (Chinese dialects)
TTY users call **711**

24 hours a day, seven days a week (except closed holidays)

Visit Member Services Department at a Plan Facility (for addresses, refer to our Provider Directory or call our Member Service Contact Center)

Write Member Services Department at a Plan Facility for addresses, refer to our Provider Directory or call our Member Service Contact Center)

Website kp.org

Estimates, bills, and statements

For the following concerns, please call us at the number below:

- If you have questions about a bill
- To find out how much you have paid toward your Plan Deductible (if applicable) or Plan Out-of-Pocket Maximum
- To get an estimate of Charges for Services that are subject to the Plan Deductible (if applicable)

Call **1-800-390-3507** (TTY users call **711**)

Monday through Friday 6 a.m. to 5 p.m.

Website kp.org/memberestimates

Away from Home Travel Line

If you have questions about your coverage when you are away from home:

Call **1-951-268-3900**

24 hours a day, seven days a week (except closed holidays)

Website kp.org/travel

Authorization for Post-Stabilization Care

To request prior authorization for Post-Stabilization Care as described under "Emergency Services" in the "Emergency Services and Urgent Care" section:

Call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card (TTY users call **711**)

24 hours a day, seven days a week

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

If you need a claim form to request payment or reimbursement for Services described in the "Emergency Services and Urgent Care" section or under "Ambulance Services" in the "Benefits" section, or if you need help completing the form, you can reach us by calling or by visiting our website.

Call **1-800-464-4000** (TTY users call **711**)

24 hours a day, seven days a week (except closed holidays)

Website kp.org

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

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

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

Text telephone access ("TTY")

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

Interpreter services

If you need interpreter services when you call us or when you get covered Services, please let us know. Interpreter services, including sign language, are available during all business hours at no cost to you. For more information on the interpreter services we offer, please call our Member Service Contact Center.

Payment Responsibility

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

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

Important Notices

Language Assistance Services

English: Language assistance is available at no cost to you, 24 hours a day, 7 days a week. You can request interpreter services, materials translated into your language, or in alternative formats. Just call us at **1-800-464-4000**, 24 hours a day, 7 days a week (closed holidays). TTY users call **711**.

Arabic: ةفاك ةعاسلا رادم ىلع انًاجم كل ةرفوتم ةيروفلا ةمجرتلا تامدخ وأ كتغلب ةمجرتم وأ ةيروفلا ةمجرتلا ةمدخ بلط كناكمإب .عوبسلأا مايأ ةمجرت

مقرلا ىلع انب لاصتلاا ىوس كيلع ام .ىرخأ غيصل ةمدخ **1-800-464-4000** ىلع رادم ةعاسلا ةفاك مايأ عوبسلأا)قلغم مايأ تلاطعلا(.يمدختسمل مقرلا ىلع لاصتلاا ىجري ىصنلا فتاهلا (**711**).

Armenian: Ձեզ կարող է անվճար օգնություն տրամադրվել լեզվի հարցում` օրը 24 ժամ, շաբաթը 7 օր: Դուք կարող եք պահանջել բանավոր թարգմանչի ծառայություններ, Ձեր լեզվով թարգմանված կամ այլընտրանքային ձևաչափով պատրաստված նյութեր: Պարզապես զանգահարեք մեզ` **1-800-464-4000** հեռախոսահամարով` օրը 24 ժամ` շաբաթը 7 օր (տոն օրերին փակ է): TTY-ից օգտվողները պետք է զանգահարեն **711**:

Chinese: 您每週 7 天˙每天 24 小時均可獲得免費語言協助。您可以申請口譯服務、要求將資料翻譯成您所用語言或轉換為其他格式。我們每週 7 天˙每天 24 小時均歡迎您打電話 **1-800-757-7585** 前來聯絡（節假日 休息）。聽障及語障專線 (TTY) 使用者請撥 **711**。

Farsi: نودب هتفه زور 7 و زورنابش تعاس 24 رد ىنابز تامدخ مجرتم تامدخ یارب دیناوت یم امش .تسا امش رایتخا رد هنیزه نخا رگید یاهتروص هب ای و امش نابز هب تاوزج همجرت ،یهافش هتفه زور 7 و زورنابش تعاس 24 رد تسیفاک دینک تساوخرد **1-800-464-4000** هرامش هب ام اب (لیطعت یاهزور یانثتسا. نارباک .دیریگب سامت **711** هرامش اب (دنریگب سامت TTY هب.

Hindi: बिना किसी लागत िे दुभाबिया सेवाएँ, कदन िे 24 घंटे, सप्ताह िे सातों कदन उपलब्ध हैं। आप एि दुभाबिये िी सेवाओं िे बलए, बिना किसी लागत िे सामबियों िो अपनी भाि़ा में अनुवाद िरवाने िे बलए, या वैिबपपि प्रारूपों िे बलए अनुरोध िर सिते हैं। िस िेवल हमें **1-800-464-4000** पर, कदन िे 24 घंटे, सप्ताह िे सातों कदन (छुट्टियों वाले कदन िंद रहता है) िॉल िरें। TTY उपयोगिताा **711** पर िॉल िरें।

Hmong: Muajkwc pab txhais lus pub dawb rau koj, 24 teev ib hnub twg, 7 hnub ib lim tiam twg. Koj thov tau cov kev pab txhais lus, muab cov ntaub ntawv txhais ua koj hom lus, los yog ua lwm hom.Tsuas hu rau **1-800-464-4000**, 24 teev ib hnub twg, 7 hnub ib lim tiam twg (cov hnub caiv kaw). Cov neeg siv TTY hu **711**.

Japanese: 当院では、言語支援を無料で、年中無休、終日ご利用いただけます。通訳サービス、日本語に翻訳された資料、あるいは資料を別の書式でも依頼できます。お気軽に **1-800-464-4000** までお電話ください（祭日を除き年中無休）。TTY ユーザーは **711**にお電話ください。

Khmer: ជំនួយភាសា គឺមានឥតអស់ថ្លៃដល់អនកឡើយ 24 ឡមាងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិតយ។ អនកអាចឡសនើសំឡសវាអនកបកប្រប សំភារៈប្កលបានបកប្របឡៅជាភាសាប្ខរ ឬជាទំរង់ផសឹងឡទៀត។ រាន់ប្តូទូរស័ព្ទ មកឡយើងតាមឡលម **1-800-464-4000** បាន 24 ឡមាងមួយថ្ងៃ 7 ថ្ងៃមួយអាទិតយ (បិទថ្ងៃបណយ)។ អនកឡរបើ TTY ឡៅឡលម **711**។

Korean: 요일 및 시간에 관계없이 언어 지원 서비스를 무료로 이용하실 수 있습니다. 귀하는 통역 서비스, 귀하의 언어로 번역된 자료 또는 대체 형 식의 자료를 요청할 수 있습니다. 요일 및 시간에
관계없이 **1-800-464-4000** 번으로 전화하십시오 (공휴일 휴무). TTY 사용자 번호 **711**.

อ ด้ า น พ า ส า ม ิ ใ ห้ ไ ด ย บ ่
า น , ต ะ ห อ ด 24 ช ่ อ ม ง , 7
อ ั น ต ่ อ า ท ิ ด . ท ่ า น ส า ม า ถ
้ อ ง ข ร ้ บ บ
ล ิ ก า น น า ย พ า ส า ,
ใ ห ้ ฉ บ เ อ ก ะ ่

่

ส า น เ ป ็ น พ า ส ู า ข อ ง ท ่ า น , ห ุ ี
ใ น ร ู บ ฉ บ บ อ ็ น . พ ง ง
ฉ ต ่ ไ ท ร ท า พ ์ อ ก เ ร า ท ี ่ **1-800-464-4000**, ต ะ ห อ ด 24 ช
่ อ ม ง , 7 อ ั น ต ่ อ า ท ิ ด
(ป ด อ ั น พ ั ก ต ่ า ง ๆ). ผ ู ้ ใ ช ้ ส า ย
T T Y ไ ท ร **7 1 1**.

Laotian: ອ ຍ ີ ເ ສ ັ ້ า

ฉ ท

Navajo: Saad bee áká’a’ayeed náhóló t’áá jiik’é, naadiin doo bibąą’ dį́ į́ ’ ahéé’iikeed tsosts’id yiskąąjį́ damoo ná'ádleehjį́ . Atah halne’é áká’adoolwołígíí jóki, t’áadoo le’é t’áá hóhazaadjį́ hadilyąą’go, éí doodaii’ nááná lá ał’ąą ádaat’ehígíí bee hádadilyaa’go. Kojį́ hodiilnih **1-800-464-4000**, naadiin doo bibąą’ dį́ į́ ’ ahéé’iikeed tsosts’id yiskąąjį́ damoo ná’ádleehjį́ (Dahodiyin biniiyé e’e’aahgo éí da’deelkaal). TTY chodeeyoolínígíí kojį́ hodiilnih **711**.

Punjabi: ਬਿਨ ਾਂ ਬਿਸੀ ਲ ਗਤ ਦੇ, ਬਦਨ ਦੇ 24 ਘੰਟੇ, ਹਫਤੇ ਦੇ 7 ਬਦਨ, ਦ੍ਭ ਸੀਆ ਸੇਵ ਵ ਾਂ ਤ੍ਹ ਡੇ ਲਈ ਉਪਲਿਧ ਹੈ। ਤ੍ਸੀਂ ਇੱਿ ਦ੍ਭ ਸੀਏ ਦੀ ਮਦਦ ਲਈ, ਸਮੱਗਰੀਆਂ ਨ ੰ ਆਪਣੀ ਭ ਸ ਬਵੱਚ ਅਨ੍ਵ ਦ ਿਰਵ ਉਣ ਲਈ, ਜ ਾਂ ਬਿਸੇ ਵੱਖ ਫ ਰਮੈਟ ਬਵੱਚ ਪਰ ਪਤ ਿਰਨ ਲਈ ਿੇਨਤੀ ਿਰ ਸਿਦੇ ਹੋ। ਿਸ ਬਸਰਫ਼ ਸ ਨ ੰ **1-800-464-4000** ਤੇ, ਬਦਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਬਦਨ (ਛੁੱਟੀਆਂ ਵ ਲੇ ਬਦਨ ਿੰਦ ਰਬਹੰਦ ਹੈ) ਫ਼ੋਨ ਿਰੋ। TTY ਦ ਉਪਯੋਗ ਿਰਨ ਵ ਲੇ **711** ‘ਤੇ ਫ਼ੋਨ ਿਰਨ।

Russian: Мы бесплатно обеспечиваем Вас услугами перевода 24 часа в сутки, 7 дней в неделю. Вы можете воспользоваться помощью устного переводчика, запросить перевод материалов на свой язык или запросить их в одном из альтернативных форматов. Просто позвоните нам по телефону **1-800-464-4000**, который доступен 24 часа в сутки, 7 дней в неделю (кроме праздничных дней). Пользователи линии TTY могут звонить по номеру **711**.

Spanish: Contamos con asistencia de idiomas sin costo alguno para usted 24 horas al día, 7 días a la semana. Puede solicitar los servicios de un intérprete, que los materiales se traduzcan a su idioma o en formatos alternativos. Solo llame al **1-800-788-0616**, 24 horas al día, 7 días a la semana (cerrado los días festivos). Los usuarios de TTY, deben llamar al **711**.

Tagalog: May magagamit na tulong sa wika nang wala kang babayaran, 24 na oras bawat araw, 7 araw bawat linggo. Maaari kang humingi ng mga serbisyo ng tagasalin sa wika, mga babasahin na isinalin sa iyong wika o sa mga alternatibong format. Tawagan lamang kami sa **1-800-464-4000**, 24 na oras bawat araw, 7 araw bawat linggo (sarado sa mga pista opisyal). Ang mga gumagamit ng TTY ay maaaring tumawag sa **711**.

Thai: เรามีบริการล่ามฟรีส าหรับคุณตลอด 24 **ชั่วโมง ทุกวันตลอดชั่วโมงท าการของเราคุณสามารถขอให้ล่าม ช่วยตอบค าถามของคุณทีเกี่ยวกับความคุ้มครองการดูแลสุขภาพของเราและคุณยังสามารถขอให้มีการแปลเอกสารเป็นภาษาทีคุณใช้ได้โดยไม่มีการคิดค่าบริการเพียงโทร หาเราทีหมายเลข 1-800-464-4000 ตลอด** 24 **ชั่วโมงทุกวัน (ปิดให้บริการในวันหยุดราชการ) ผู้ใช้** TTY **โปรดโทรไปที่ 711**

Vietnamese: Dịch vụ thông dịch được cung cấp miễn phí cho quý vị 24 giờ mỗi ngày, 7 ngày trong tuần. Quý vị có thể yêu cầu dịch vụ thông dịch, tài liệu phiên dịch ra ngôn ngữ của quý vị hoặc tài liệu bằng nhiều hình thức khác. Quý vị chỉ cần gọi cho chúng tôi tại số **1-800-464-4000**, 24 giờ mỗi ngày, 7 ngày trong tuần (trừ các ngày lễ). Người dùng TTY xin gọi **711**.

Nondiscrimination Notice

Kaiser Permanente does not discriminate on the basis of age, race, ethnicity, color, national origin, cultural background, ancestry, religion, sex, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, source of payment, genetic information, citizenship, primary language, or immigration status.

Language assistance services are available from our Member Service Contact Center 24 hours a day, 7 days a week (except closed holidays). Interpreter services, including sign language, are available at no cost to you during all hours of operation. Auxiliary aids and services for individuals with disabilities are available at no cost to you during all hours of operation. We can also provide you, your family, and friends with any special assistance needed to access our facilities and services. You may request materials translated in your language at no cost to you. You may also request these materials in large text or in other formats to accommodate your needs at no cost to you. For more information, call **1-800-464-4000** (TTY **711**).

A grievance is any expression of dissatisfaction expressed by you or your authorized representative through the grievance process. For example, if you believe that we have discriminated against you, you can file a grievance. Please refer to your *Evidence of Coverage or Certificate of Insurance* or speak with a Member Services representative for the dispute-resolution options that apply to you.

You may submit a grievance in the following ways:

- **By phone:** Call member services at **1-800-464-4000** (TTY **711**) 24 hours a day, 7 days a week (except closed holidays).
- **By mail:** Call us at **1-800-464-4000** (TTY **711**) and ask to have a form sent to you.
- **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**

Please call our Member Service Contact Center if you need help submitting a grievance.

The Kaiser Permanente Civil Rights Coordinator will be notified of all grievances related to discrimination on the basis of race, color, national origin, sex, age, or disability. You may also contact the Kaiser Permanente Civil Rights Coordinator directly at:

Northern California
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California
Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at *ocrportal.hhs.gov/ocr/portal/lobby.jsf* or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TTY). Complaint forms are available at *hhs.gov/ocr/office/file/index.html*.

Aviso de no discriminación

Kaiser Permanente no discrimina a ninguna persona por su edad, raza, etnia, color, pals de origen, antecedentes culturales, ascendencia, religión, sexo, identidad de género, expresión de género, orientación sexual, estado civil, discapacidad flsica o mental, fuente de pago, información genética, ciudadanla, lengua materna o estado migratorio.

La Central de Llamadas de Servicio a los Miembros brinda servicios de asistencia con el idioma las 24 horas del dla, los 7 dlas de la semana (excepto los dlas festivos). Se ofrecen servicios de interpretación sin costo alguno para usted durante el horario de atención, incluido el lenguaje de señas. Se ofrecen aparatos y servicios auxiliares para personas con discapacidades sin costo alguno durante el horario de atención. También podemos ofrecerle a usted, a sus familiares y amigos cualquier ayuda especial que necesiten para acceder a nuestros centros de atención y servicios. Puede solicitar los materiales traducidos a su idioma sin costo para usted. También los puede solicitar con letra grande o en otros formatos que se adapten a sus necesidades sin costo para usted. Para obtener más información, llame al **1-800-788-0616** (TTY **711**).

Una queja es una expresión de inconformidad que manifiesta usted o su representante autorizado a través del proceso de quejas. Por ejemplo, si usted cree que ha sufrido discriminación de nuestra parte, puede presentar una queja. Consulte su *Evidencia de Cobertura (Evidence of Coverage)* o *Certificado de Seguro (Certificate of Insurance)*, o comunlquese con un representante de Servicio a los Miembros para conocer las opciones de resolución de disputas que le corresponden.

Puede presentar una queja de las siguientes maneras:

- **Por teléfono:** Llame a servicio a los miembros al **1-800-788-0616** (TTY **711**) las 24 horas del dla, los 7 dlas de la semana (excepto los dlas festivos).
- **Por correo postal:** Llámenos al **1-800-788-0616** (TTY **711**) y pida que se le envle un formulario.
- **En persona:** Llene un formulario de Queja Formal o Reclamo/Solicitud de Beneficios en una oficina de servicio a los miembros ubicada en un Centro de Atención del Plan (consulte su directorio de proveedores en **kp.org/facilities** [haga clic en “Español”] para obtener las direcciones).
- **En línea:** Use el formulario en llnea en nuestro sitio web en **kp.org/espanol**.

Llame a nuestra Central de Llamadas de Servicio a los Miembros si necesita ayuda para presentar una queja.

Se le informará al Coordinador de Derechos Civiles de Kaiser Permanente (Civil Rights Coordinator) de todas las quejas relacionadas con la discriminación por motivos de raza, color, pals de origen, género, edad o discapacidad. También puede comunicarse directamente con el coordinador de derechos civiles de Kaiser Permanente en:

Northern California
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California
Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

También puede presentar una queja formal de derechos civiles de forma electrónica ante la Oficina de Derechos Civiles (Office for Civil Rights) en el Departamento de Salud y Servicios Humanos de los Estados Unidos (U.S. Department of Health and Human Services) mediante el Portal de Quejas Formales de la Oficina de Derechos Civiles (Office for Civil Rights Complaint Portal), en *ocrportal.hhs.gov/ocr/portal/lobby.jsf* (en inglés) o por correo postal o por teléfono a: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TTY). Los formularios de queja formal están disponibles en *hhs.gov/ocr/office/file/index.html* (en inglés).

無歧視公告

Kaiser Permanente 禁止以年齡、人種、族裔、膚色、原國籍、文化背景、血統、宗教、性別、性別認同、性別表達、性取向、婚姻狀況、生理或心理殘障、付款來源、遺傳資訊、公民身份、主要語言或移民身份為由而歧視任何人。

會員服務聯絡中心每週 7 天每天 24 小時提供語言協助服務(節假日除外)。本機構在全部營業時間內免費為您提供口譯服務,包括手語服務,以及殘障人士輔助器材和服務。我們還可為您和您的親友提供使用本機構設施與服務所需要的任何特別協助。您可免費索取翻譯成您的語言的　　資料。您還可免費索取符合您需求的大號字體或其他格式的版本。若需更多資訊,請致電 **1-800-757-7585**(TTY **711**)。

申　　訴指任何您或您的授權代表透過申訴程序來表達不滿的做法。例如,如果您認為自己受到歧視,即可提出申訴。若需瞭解適用於自己的爭議解決選項,請參閱《承保範圍說明書》*(Evidence of Coverage)* 或《保險證明書》*(Certificate of Insurance)*,或諮詢會員服務代表。

您可透過以下方式提出申訴:

- **透過電話:**請致電 **1-800-757-7585**(TTY **711**)與會員服務部聯絡,服務時間為每週 7 天,每天 24 小時(節假日除外)。
- **透過郵件:**請致電 **1-800-757-7585**(TTY **711**)與我們聯絡並請我們將表格寄給您。
- **親自遞交:**在計劃設施的會員服務辦事處填寫投訴或福利理索賠/申請表(請參閱 **kp.org/facilities** 上的保健業者名錄以查看地址)
- **線上:**使用我們網站上的線上表格,網址為 **kp.org**

如果您在提交申訴時需要協助,請致電我們的會員服務聯絡中心。

涉及人種、膚色、原國籍、性別、年齡或殘障歧視的一切申訴都將通知 Kaiser Permanente 的民權事務協調員 (Civil Rights Coordinator)。您也可與 Kaiser Permanente 的民權事務協調員直接聯絡,地址:

Northern California
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California
Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

您還可以電子方式透過民權辦公室的投訴入口網站 (Office for Civil Rights Complaint Portal) 向美國　　衛生與民眾服務部 (U.S. Department of Health and Human Services) 民權辦公室 (Office for Civil Rights) 提出民權投訴,網址是 *ocrportal.hhs.gov/ocr/portal/lobby.jsf* 或者按照如下資訊採用郵寄或電話方式聯絡:U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, DC 20201, 1-800-368-1019, 1-800-537-7697 (TTY)。投訴表可從網站 *hhs.gov/ocr/office/file/index.html* 下載。

Thông Báo Không Kỳ Thị

Kaiser Permanente không phân biệt đối xử dựa trên tuổi tác, chủng tộc, sắc tộc, màu da, nguyên quán, hoàn cảnh văn hóa, tổ tiên, tôn giáo, giới tính, nhận dạng giới tính, cách thể hiện giới tính, khuynh hướng tình dục, gia cảnh, khuyết tật về thể chất hoặc tinh thần, nguồn tiền thanh toán, thông tin di truyền, quốc tịch, ngôn ngữ chính, hay tình trạng di trú.

Các dịch vụ trợ giúp ngôn ngữ hiện có từ Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi 24 giờ trong ngày, 7 ngày trong tuần (ngoại trừ ngày lễ). Dịch vụ thông dịch, kể cả ngôn ngữ ký hiệu, được cung cấp miễn phí cho quý vị trong giờ làm việc. Các phương tiện trợ giúp và dịch vụ bổ sung cho những người khuyết tật được cung cấp miễn phí cho quý vị trong giờ làm việc. Chúng tôi cũng có thể cung cấp cho quý vị, gia đình và bạn bè quý vị mọi hỗ trợ đặc biệt cần thiết để sử dụng cơ sở và dịch vụ của chúng tôi. Quý vị có thể yêu cầu miễn phí tài liệu được dịch ra ngôn ngữ của quý vị. Quý vị cũng có thể yêu cầu miễn phí các tài liệu này dưới dạng chữ lớn hoặc dưới các dạng khác để đáp ứng nhu cầu của quý vị. Để biết thêm thông tin, gọi **1-800-464-4000** (TTY **711**).

Một phàn nàn là bất cứ thể hiện bất mãn nào được quý vị hay vị đại diện được ủy quyền của quý vị trình bày qua thủ tục phàn nàn. Vì dụ, nếu quý vị tin rằng chúng tôi đã kỳ phân biệt đối xử với vị, quý vị có thể đệ đơn phàn nàn. Vui lòng tham khảo Chứng *Tie Belo Hiem (Evidence of Insurance)* hay *Ch'ing Nhan Belo Hiem (Certificate of Insurance)*, hoặc nói chuyện với một nhân viên ban Dịch Vụ Hội Viên để biết các lựa chọn giải quyết tranh chấp có thể áp dụng cho quý vị.

Quý vị có thể nộp đơn phàn nàn bằng các hình thức sau đây:

- **Qua điện thoại**: Gọi cho ban dịch vụ hội viên theo số **1-800-464-4000** (TTY **711**) 24 giờ trong ngày, 7 ngày trong tuần (ngoại trừ đóng cửa ngày lễ).
- **Qua bưu điện:** Gọi cho chúng tôi theo số **1-800-464-4000** (TTY **711**) và yêu cầu được gửi một mẫu đơn.
- **Trực tiếp:** Điền một mẫu đơn Than Phiền hay Yêu Cầu Quyền Lợi/Yêu Cầu tại một văn phòng ban dịch vụ hội viên tại một Cơ Sở Thuộc Chương Trình (xem danh mục nhà cung cấp của quý vị tại **kp.org/facilities** để biết địa chỉ)
- **Trực tuyến:** Sử dụng mẫu đơn trực tuyến trên trang mạng của chúng tôi tại **kp.org**

Xin gọi Trung Tâm Liên Lạc ban Dịch Vụ Hội Viên của chúng tôi nếu quý vị cần trợ giúp nộp đơn phàn nàn.

Điều Phối Viên Dân Quyền (Civil Rights Coordinator) Kaiser Permanente sẽ được thông báo về tất cả phàn nàn liên quan tới việc kỳ thị trên cơ sở chủng tộc, màu da, nguyên quán, giới tính, tuổi tác, hay tình trạng khuyết tật. Quý vị cũng có thể liên lạc trực tiếp với Điều Phối Viên Dân Quyền Kaiser Permanente tại:

Northern California
Civil Rights/ADA Coordinator
1800 Harrison St.
16th Floor
Oakland, CA 94612

Southern California
Civil Rights/ADA Coordinator
SCAL Compliance and Privacy
393 East Walnut St.,
Pasadena, CA 91188

Quý vị cũng có thể đệ đơn than phiền về dân quyền với Bộ Y Tế và Nhân Sinh Hoa Kỳ (U.S. Department of Health and Human Services), Phòng Dân Quyền (Office of Civil Rights) bằng đường điện tử thông qua Cổng Thông Tin Phòng Phụ Trách Khiếu Nại về Dân Quyền (Office for Civil Rights Complaint Portal), hiện có tại *ocrportal.hhs.gov/ocr/portal/lobby.jsf*, hay bằng đường bưu điện hoặc điện thoại tại: U.S. Department of Health and Human Services, 200 Independence Ave. SW, Room 509F, HHH Building, Washington, D.C. 20201, 1-800-368-1019, 1-800-537-7697 (TTY). Mẫu đơn than phiền hiện có tại *hhs.gov/ocr/office/file/index.html*.

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern California Region

A nonprofit corporation and a Medicare Advantage Organization

EOC #5 - Kaiser Permanente Senior Advantage (HMO) with Part D
Evidence of Coverage for
NORTHERN CALIF SOFT DRINK IND

Group ID: 24 Contract: 1 Version: 88 *EOC* Number: 5

January 1, 2022, through December 31, 2022

Member Service Contact Center
Seven days a week, 8 a.m.–8 p.m.
1-800-443-0815 (TTY users call **711**) **kp.org**

This document is available for free in Spanish. Please contact our Member Service Contact Center number at **1-800-443-0815** for additional information. (TTY users should call **711**.) Hours are 8 a.m. to 8 p.m., seven days a week.

*Esta documento está disponible de forma gratuita en español. Si desea información adicional, por favor llame al número de nuestra Central de Llamadas de Servicio a los Miembros al **1-800-443-0815** (los usuarios de la linea TTY deben llamar al **711**). El horario es de 8 a.m. a 8 p.m., los 7 días de la semana.*

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Benefit Highlights

Accumulation Period

The Accumulation Period for this plan is 1/1/22 through 12/31/22 (calendar year).

Plan Out-of-Pocket Maximum

For Services subject to the maximum, you will not pay any more Cost Share for the rest of the calendar year if the Copayments and Coinsurance you pay for those Services add up to the following amount:

For any one Member..... $1,500 per calendar year

Plan Deductible	None

Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$15 per visit
Most Physician Specialist Visits	$15 per visit
Annual Wellness visit and the "Welcome to Medicare" preventive visit	No charge
Routine physical exams	No charge
Routine eye exams with a Plan Optometrist	$15 per visit
Urgent care consultations, evaluations, and treatment	$15 per visit
Physical, occupational, and speech therapy	$15 per visit

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$15 per procedure
Allergy injections (including allergy serum)	$3 per visit
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	$15 per visit

Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge

Emergency Health Coverage	**You Pay**
Emergency Department visits	$50 per visit

Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the Emergency Department Cost Share (see "Hospitalization Services" for inpatient Cost Share).

Ambulance and Transportation Services	**You Pay**
Ambulance Services	No charge

Prescription Drug Coverage	**You Pay**
Covered outpatient items in accord with our drug formulary guidelines:	
Most generic items	$10 for up to a 100-day supply
Most brand-name items	$35 for up to a 100-day supply

Durable Medical Equipment (DME)	**You Pay**
Covered durable medical equipment for home use as described in this *EOC*	20 percent Coinsurance

Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	$15 per visit
Group outpatient mental health treatment	$7 per visit

Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment	$15 per visit
Group outpatient substance use disorder treatment	$5 per visit

Home Health Services	You Pay
Home health care (part-time, intermittent)	No charge

Other	You Pay
Eyeglasses or contact lenses every 24 months	Amount in excess of $150 Allowance
Skilled Nursing Facility care (up to 100 days per benefit period)	No charge
External prosthetic and orthotic devices as described in this *EOC*	20 percent Coinsurance
Ostomy, urological, and wound care supplies	20 percent Coinsurance
Meals delivered to your home immediately following discharge from a hospital due to congestive heart failure	No charge up to two meals per day in a consecutive four-week period, once per calendar year

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

Introduction

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

This contract provides Medicare Services (including Medicare Part D prescription drug coverage) through "Kaiser Permanente Senior Advantage (HMO) with Part D" (Senior Advantage), except for hospice care for Members with Medicare Part A, which is covered under Original Medicare. Enrollment in this Senior Advantage plan means that you are automatically enrolled in Medicare Part D. Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

This *Evidence of Coverage* (*"EOC")* describes our Senior Advantage health care coverage provided under the *Group Agreement (Agreement)* between Health Plan (Kaiser Foundation Health Plan, Inc.) and your Group (the entity with which Health Plan has entered into the *Agreement*). The *Agreement* contains additional terms such as Premiums, when coverage can change, the effective date of coverage, and the effective date of termination. The *Agreement* must be consulted to determine the exact terms of coverage. A copy of the *Agreement* is available from your Group.

For benefits provided under any other program, refer to that other plan's evidence of coverage. For benefits provided under any other program offered by your Group (for example, workers compensation benefits), refer to your Group's materials.

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

It is important to familiarize yourself with your coverage by reading this *EOC* completely, so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please carefully read the sections that apply to you.

About Kaiser Permanente

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOU MAY GET HEALTH CARE.

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

We provide covered Services to Members using Plan Providers located in our Service Area, which is described in the "Definitions" section. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Certain care when you visit the service area of another Region as described under "Receiving Care Outside of Your Home Region" in the "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Your Cost Share" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Your Cost Share" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section
- Routine Services associated with Medicare-approved clinical trials as described under "Services Associated with Clinical Trials" in the "Benefits and Your Cost Share" section

Term of this *EOC*

This *EOC* is for the period January 1, 2022, through December 31, 2022, unless amended. Benefits, Copayments, and Coinsurance may change on January 1 of each year and at other times in accord with your Group's *Agreement* with us. Your Group can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has been amended.

Definitions

Some terms have special meaning in this *EOC*. When we use a term with special meaning in only one section of this *EOC*, we define it in that section. The terms in this "Definitions" section have special meaning when capitalized and used in any section of this *EOC*.

Accumulation Period: A period of time no greater than 12 consecutive months for purposes of accumulating amounts toward any deductibles (if applicable) and out-of-pocket maximums. The Accumulation Period for this *EOC* is from 1/1/22 through 12/31/22.

Allowance: A specified amount that you can use toward the purchase price of an item. If the price of the items you select exceeds the Allowance, you will pay the amount in excess of the Allowance (and that payment will not apply toward any deductible or out-of-pocket maximum).

Catastrophic Coverage Stage: The stage in the Part D Drug Benefit where you pay a low Copayment or Coinsurance for your Part D drugs after you or other qualified parties on your behalf have spent $7,050 in covered Part D drugs during the covered year. Note: This amount may change every January 1 in accord with Medicare requirements.

Centers for Medicare & Medicaid Services (CMS): The federal agency that administers the Medicare program.

Ancillary Coverage: Optional benefits such as acupuncture, chiropractic, or dental coverage that may be available to Members enrolled under this *EOC*. If your plan includes Ancillary Coverage, this coverage will be described in an amendment to this *EOC* or a separate agreement from the issuer of the coverage.

Charges: "Charges" means the following:

- For Services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members
- For Services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan)
- For all other Services, the payments that Kaiser Permanente makes for the Services or, if Kaiser Permanente subtracts your Cost Share from its payment, the amount Kaiser Permanente would have paid if it did not subtract your Cost Share

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service under this *EOC*.

Complaint: The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance."

Comprehensive Formulary (Formulary or "Drug List"): A list of Medicare Part D prescription drugs covered by our plan. The drugs on this list are selected by us with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Comprehensive Outpatient Rehabilitation Facility (CORF): A facility that mainly provides rehabilitation Services after an illness or injury, and provides a variety of Services, including physician's Services, physical therapy, social or psychological Services, and outpatient rehabilitation.

Copayment: A specific dollar amount that you must pay when you receive a covered Service under this *EOC*. Note: The dollar amount of the Copayment can be $0 (no charge).

Cost Share: The amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible.

Coverage Determination: An initial determination we make about whether a Part D drug prescribed for you is covered under Part D and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription for a Part D drug to a Plan Pharmacy and the pharmacy tells you the prescription isn't covered by us, that isn't a Coverage Determination. You need to call or write us to ask for a formal decision about the coverage. Coverage Determinations are called "coverage decisions" in this *EOC*.

Dependent: A Member who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

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 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 any of the following:

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

A mental health condition is an emergency medical condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

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

Emergency Services: Covered Services that are (1) rendered by a provider qualified to furnish Emergency Services; and (2) needed to treat, evaluate, or Stabilize an Emergency Medical Condition such as:

- A medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services (such as imaging and laboratory Services) routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the hospital, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services you receive are Post Stabilization Care and not Emergency Services)

***EOC*:** This *Evidence of Coverage* document, including any amendments, which describes the health care coverage of "Kaiser Permanente Senior Advantage (HMO) with Part D" under Health Plan's *Agreement* with your Group.

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.

Grievance: A type of complaint you make about us, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Group: The entity with which Health Plan has entered into the *Agreement* that includes this *EOC*.

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. This *EOC* sometimes refers to Health Plan as "we" or "us."

Home Region: The Region where you enrolled (either the Northern California Region or the Southern California Region).

Initial Enrollment Period: When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, if you're eligible for 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.

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 will not pay a higher premium.

Kaiser Permanente: Kaiser Foundation Hospitals (a California nonprofit corporation), Health Plan, and the Medical Group.

Medical Group: The Permanente Medical Group, Inc., a for-profit professional corporation.

Medically Necessary: A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). A person enrolled in a Medicare Part D plan has Medicare

Part D by virtue of his or her enrollment in the Part D plan (this *EOC* is for a Part D plan).

Medicare Advantage Organization: A public or private entity organized and licensed by a state as a risk-bearing entity that has a contract with the Centers for Medicare & Medicaid Services to provide Services covered by Medicare, except for hospice care covered by Original Medicare. Kaiser Foundation Health Plan, Inc., is a Medicare Advantage Organization.

Medicare Advantage Plan: Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. Medicare Advantage Plans may also offer Medicare Part D (prescription drug coverage). This *EOC* is for a Medicare Part D plan.

Medicare Health Plan: A Medicare Health Plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage plans, Medicare Cost plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medigap (Medicare Supplement Insurance) Policy: Medicare supplement insurance sold by private insurance companies to fill "gaps" in the Original Medicare plan coverage. Medigap policies only work with the Original Medicare plan. (A Medicare Advantage Plan is not a Medigap policy.)

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

Non-Physician Specialist Visits: Consultations, evaluations, and treatment by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

Non–Plan Hospital: A hospital other than a Plan Hospital.

Non–Plan Pharmacy: A pharmacy other than a Plan Pharmacy. These pharmacies are also called "out-of-network pharmacies."

Non–Plan Physician: A physician other than a Plan Physician.

Non–Plan Provider: A provider other than a Plan Provider.

Non–Plan Psychiatrist: A psychiatrist who is not a Plan Physician.

Non–Plan Skilled Nursing Facility: A Skilled Nursing Facility other than a Plan Skilled Nursing Facility.

Organization Determination: An initial determination we make about whether we will cover or pay for Services that you believe you should receive. We also make an Organization Determination when we provide you with Services, or refer you to a Non–Plan Provider for Services. Organization Determinations are called "coverage decisions" in this *EOC.*

Original Medicare ("Traditional Medicare" or "Fee-for-Service Medicare"): The Original Medicare plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay a deductible. Medicare pays its share of the Medicare approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance), and is available everywhere in the United States and its territories.

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your health resulting from an unforeseen illness or an unforeseen injury if all of the following are true:

- You are temporarily outside our Service Area
- A reasonable person would have believed that your health would seriously deteriorate if you delayed treatment until you returned to our Service Area

Physician Specialist Visits: Consultations, evaluations, and treatment by physician specialists, including personal Plan Physicians who are not Primary Care Physicians.

Plan Deductible: The amount you must pay under this *EOC* in the calendar year for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that calendar year. Refer to the "Benefits and Your Cost Share" section to learn whether your coverage includes a Plan Deductible, the Services that are subject to the Plan Deductible, and the Plan Deductible amount.

Plan Facility: Any facility listed in the Provider Directory on our website at kp.org/facilities. Plan Facilities include Plan Hospitals, Plan Medical Offices, and other facilities that we designate in the directory. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call our Member Service Contact Center.

Plan Hospital: Any hospital listed in the Provider Directory on our website at kp.org/facilities. In the

directory, some Plan Hospitals are listed as Kaiser Permanente Medical Centers. The directory is updated periodically. The availability of Plan Hospitals may change. If you have questions, please call our Member Service Contact Center.

Plan Medical Office: Any medical office listed in the Provider Directory on our website at kp.org/facilities. In the directory, Kaiser Permanente Medical Centers may include Plan Medical Offices. The directory is updated periodically. The availability of Plan Medical Offices may change. If you have questions, please call our Member Service Contact Center.

Plan Optical Sales Office: An optical sales office owned and operated by Kaiser Permanente or another optical sales office that we designate. Refer to the Provider Directory on our website at kp.org/facilities for locations of Plan Optical Sales Offices. In the directory, Plan Optical Sales Offices may be called "Vision Essentials." The directory is updated periodically. The availability of Plan Optical Sales Offices may change. If you have questions, please call our Member Service Contact Center.

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Out-of-Pocket Maximum: The total amount of Cost Share you must pay under this *EOC* in the calendar year for certain covered Services that you receive in the same calendar year. Refer to the "Benefits and Your Cost Share" section to find your Plan Out-of-Pocket Maximum amount and to learn which Services apply to the Plan Out-of-Pocket Maximum.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Refer to the Provider Directory on our website at kp.org/facilities for locations of Plan Pharmacies. The directory is updated periodically. The availability of Plan Pharmacies may change. If you have questions, please call our Member Service Contact Center.

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

Plan Provider: A Plan Hospital, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other health care provider that Health Plan designates as a Plan Provider.

Plan Skilled Nursing Facility: A Skilled Nursing Facility approved by Health Plan.

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the Emergency Department) after your treating physician determines that this condition is Stabilized.

Premiums: The periodic amounts that your Group is responsible for paying for your membership under this *EOC*.

Preventive Services: Covered Services that prevent or detect illness and do one or more of the following:

- Protect against disease and disability or further progression of a disease
- Detect disease in its earliest stages before noticeable symptoms develop

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Refer to the Provider Directory on our website at kp.org for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call our Member Service Contact Center.

Primary Care Visits: Evaluations and treatment provided by Primary Care Physicians and primary care Plan Providers who are not physicians (such as nurse practitioners).

Provider Directory: A directory of Plan Physicians and Plan Facilities in your Home Region. This directory is available on our website at kp.org/directory. To obtain a printed copy, call our Member Service Contact Center. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call our Member Service Contact Center.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. Regions may change on January 1 of each year and are currently the District of Columbia and parts of Northern California, Southern California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For the current list of Region locations, please visit our website at kp.org or call our Member Service Contact Center.

Serious Emotional Disturbance of a Child Under Age 18: A condition identified as a "mental disorder" in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:

- As a result of the mental disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
- The child displays psychotic features, or risk of suicide or violence due to a mental disorder
- The child meets special education eligibility requirements under Section 5600.3(a)(2)(C) of the Welfare and Institutions Code

Service Area: The geographic area approved by the Centers for Medicare & Medicaid Services within which an eligible person may enroll in Senior Advantage. Note: Subject to approval by the Centers for Medicare & Medicaid Services, we may reduce or expand our Service Area effective any January 1. ZIP codes are subject to change by the U.S. Postal Service. The ZIP codes below for each county are in our Service Area:

- All ZIP codes in Alameda County are inside our Northern California Service Area: 94501–02, 94505, 94514, 94536–46, 94550–52, 94555, 94557, 94560, 94566, 94568, 94577–80, 94586–88, 94601–15, 94617–21, 94622–24, 94649, 94659–62, 94666, 94701–10, 94712, 94720, 95377, 95391
- The following ZIP codes in Amador County are inside our Northern California Service Area: 95640, 95669
- All ZIP codes in Contra Costa County are inside our Northern California Service Area: 94505–07, 94509, 94511, 94513–14, 94516–31, 94547–49, 94551, 94553, 94556, 94561, 94563–65, 94569–70, 94572, 94575, 94582–83, 94595–98, 94706–08, 94801–08, 94820, 94850
- The following ZIP codes in El Dorado County are inside our Northern California Service Area: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762
- The following ZIP codes in Fresno County are inside our Northern California Service Area: 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618–19, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701–12, 93714–18, 93720–30, 93737, 93740–41, 93744–45, 93747, 93750, 93755, 93760–61, 93764–65, 93771–79, 93786, 93790–94, 93844, 93888
- The following ZIP codes in Kings County are inside our Northern California Service Area: 93230, 93232, 93242, 93631, 93656
- The following ZIP codes in Madera County are inside our Northern California Service Area: 93601–02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, 93720
- All ZIP codes in Marin County are inside our Northern California Service Area: 94901, 94903–04, 94912–15, 94920, 94924–25, 94929–30, 94933, 94937–42, 94945–50, 94956–57, 94960, 94963–66, 94970–71, 94973–74, 94976–79
- The following ZIP codes in Mariposa County are inside our Northern California Service Area: 93601, 93623, 93653
- All ZIP codes in Napa County are inside our Northern California Service Area: 94503, 94508, 94515, 94558–59, 94562, 94567, 94573–74, 94576, 94581, 94599, 95476
- The following ZIP codes in Placer County are inside our Northern California Service Area: 95602–04, 95610, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95703, 95722, 95736, 95746–47, 95765
- All ZIP codes in Sacramento County are inside our Northern California Service Area: 94203–09, 94211, 94229–30, 94232, 94234–37, 94239–40, 94244–45, 94247–50, 94252, 94254, 94256–59, 94261–63, 94267–69, 94271, 94273–74, 94277–80, 94282–85, 94287–91, 94293–98, 94571, 95608–11, 95615, 95621, 95624, 95626, 95628, 95630, 95632, 95638–39, 95641, 95652, 95655, 95660, 95662, 95670–71, 95673, 95678, 95680, 95683, 95690, 95693, 95741–42, 95757–59, 95763, 95811–38, 95840–43, 95851–53, 95860, 95864–67, 95894, 95899
- All ZIP codes in San Francisco County are inside our Northern California Service Area: 94102–05, 94107–12, 94114–27, 94129–34, 94137, 94139–47, 94151, 94158–61, 94163–64, 94172, 94177, 94188
- All ZIP codes in San Joaquin County are inside our Northern California Service Area: 94514, 95201–15, 95219–20, 95227, 95230–31, 95234, 95236–37, 95240–42, 95253, 95258, 95267, 95269, 95296–97, 95304, 95320, 95330, 95336–37, 95361, 95366, 95376–78, 95385, 95391, 95632, 95686, 95690
- All ZIP codes in San Mateo County are inside our Northern California Service Area: 94002, 94005, 94010–11, 94014–21, 94025–28, 94030, 94037–38, 94044, 94060–66, 94070, 94074, 94080, 94083, 94128, 94303, 94401–04, 94497
- The following ZIP codes in Santa Clara County are inside our Northern California Service Area: 94022–

24, 94035, 94039–43, 94085–89, 94301–06, 94309, 94550, 95002, 95008–09, 95011, 95013–15, 95020–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95076, 95101, 95103, 95106, 95108–13, 95115–36, 95138–41, 95148, 95150–61, 95164, 95170, 95172–73, 95190–94, 95196

- All ZIP codes in Santa Cruz County are inside our Northern California Service Area: 95001, 95003, 95005–07, 95010, 95017–19, 95033, 95041, 95060–67, 95073, 95076–77
- All ZIP codes in Solano County are inside our Northern California Service Area: 94503, 94510, 94512, 94533–35, 94571, 94585, 94589–92, 95616, 95618, 95620, 95625, 95687–88, 95690, 95694, 95696
- The following ZIP codes in Sonoma County are inside our Northern California Service Area: 94515, 94922–23, 94926–28, 94931, 94951–55, 94972, 94975, 94999, 95401–07, 95409, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471–73, 95476, 95486–87, 95492
- All ZIP codes in Stanislaus County are inside our Northern California Service Area: 95230, 95304, 95307, 95313, 95316, 95319, 95322–23, 95326, 95328–29, 95350–58, 95360–61, 95363, 95367–68, 95380–82, 95385–87, 95397
- The following ZIP codes in Sutter County are inside our Northern California Service Area: 95626, 95645, 95659, 95668, 95674, 95676, 95692, 95837
- The following ZIP codes in Tulare County are inside our Northern California Service Area: 93238, 93261, 93618, 93631, 93646, 93654, 93666, 93673
- The following ZIP codes in Yolo County are inside our Northern California Service Area: 95605, 95607, 95612, 95615–18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99
- The following ZIP codes in Yuba County are inside our Northern California Service Area: 95692, 95903, 95961

For each ZIP code listed for a county, our 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 our 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 our Service Area, please call our Member Service Contact Center. 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.

Services: Health care services or items ("health care" includes both physical health care and mental health care) and services to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness.

Severe Mental Illness: The following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa.

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

Spouse: The person to whom the Subscriber is legally married under applicable law. For the purposes of this *EOC*, the term "Spouse" includes the Subscriber's domestic partner. "Domestic partners" are two people who are registered and legally recognized as domestic partners by California (if your Group allows enrollment of domestic partners not legally recognized as domestic partners by California, "Spouse" also includes the Subscriber's domestic partner who meets your Group's eligibility requirements for domestic partners).

Stabilize: To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

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

Telehealth Visits: Interactive video visits and scheduled telephone visits between you and your provider.

Urgent Care: Medically Necessary Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition.

Premiums, Eligibility, and Enrollment

Premiums

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

If you do not have Medicare Part A, you may be eligible to purchase Medicare Part A from Social Security. Please 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, please check with your Group's benefits administrator.

Medicare Premiums

Medicare Part D premium due to income

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.

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

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

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you will be disenrolled from Kaiser Permanente Senior Advantage and lose Part D prescription drug coverage.

Medicare Part D late enrollment penalty

The late enrollment penalty is an amount that is added to your Part D premium. You may owe a Part D late enrollment penalty if at any time after your Initial Enrollment Period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your Initial Enrollment Period or how many full calendar months you went without creditable prescription drug coverage (this *EOC* is for a Part D plan). You will have to pay this penalty for as long as you have Part D coverage. Your Group will inform you if the penalty applies to you.

If you disagree with your Part D late enrollment penalty, you can ask us to review the decision about your late enrollment penalty. Call our Member Service Contact Center at the number on the front of this booklet to find out more about how to do this.

Note: If you receive Extra Help from Medicare to pay for your Part D prescription drugs, you will not pay a late enrollment penalty.

Medicare's "Extra Help" Program

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

People with limited income and resources may qualify for "Extra Help." Some people automatically qualify for "Extra Help" and don't need to apply. Medicare mails a letter to people who automatically qualify for "Extra Help."

You may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week;
- The Social Security Office at **1-800-772-1213** (TTY users call **1-800-325-0778**), 7 a.m. to 7 p.m., Monday through Friday (applications); or
- Your state Medicaid office (applications). See the "Important Phone Numbers and Resources" section for contact information

If you qualify for "Extra Help," we will send you an *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*), that explains your costs as a Member of our plan. If the amount of your "Extra Help" changes during the year, we will also mail you an updated *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs.*

Who Is Eligible

To enroll and to continue enrollment, you must meet all of the eligibility requirements described in this "Who Is Eligible" section, including your Group's eligibility requirements and our Service Area eligibility requirements.

Group eligibility requirements

You must meet your Group's eligibility requirements. Your Group is required to inform Subscribers of its eligibility requirements.

Senior Advantage eligibility requirements

- You must have Medicare Part B
- You must be a United States citizen or lawfully present in the United States
- Your Medicare coverage must be primary and your Group's health care plan must be secondary
- You may not be enrolled in another Medicare Health Plan or Medicare prescription drug plan

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

Service Area eligibility requirements

You must live in our Service Area, unless you have been continuously enrolled in Senior Advantage since December 31, 1998, and lived outside our Service Area during that entire time. In which case, you may continue your membership unless you move and are still outside our Service Area. The "Definitions" section describes our Service Area and how it may change.

Moving outside our Service Area. If you permanently move outside our Service Area, or you are temporarily absent from our 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 *EOC.*

Send your notice to:

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

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

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Certain care when you visit the service area of another Region as described under "Receiving Care Outside of Your Home Region" in the "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Your Cost Share" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Your Cost Share" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section
- Routine Services associated with Medicare-approved clinical trials as described under "Services Associated with Clinical Trials" in the "Benefits and Your Cost Share" section

If you are not eligible to continue enrollment because you move to the service area of another Region, please contact your Group 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 your Group and that Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*.

For more information about the service areas of the other Regions, please call our Member Service Contact Center.

Eligibility as a Subscriber

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

- An employee of your Group
- A proprietor or partner of your Group
- Otherwise entitled to coverage under a trust agreement, retirement benefit program, or employment contract (unless the Internal Revenue Service considers you self-employed)

Eligibility as a Dependent

Dependent eligibility is subject to your Group's eligibility requirements, which are not described in this *EOC*. You can obtain your Group's eligibility requirements directly from your Group. If you are a Subscriber enrolled under this *EOC* or a subscriber enrolled in a non-Medicare plan offered by your Group, the following persons may be eligible to enroll as your Dependents under this *EOC* if they meet all of the other requirements described under "Group eligibility requirements," "Senior Advantage eligibility requirements," and "Service Area eligibility requirements" in this "Who Is Eligible" section:

- Your Spouse
- Your or your Spouse's Dependent children, who are under age 26, if they are any of the following:
  - sons, daughters, or stepchildren
  - adopted children
  - children placed with you for adoption, but not including children placed with you for foster care
  - children for whom you or your Spouse is the court-appointed guardian (or was when the child reached age 18)
- Children whose parent is a Dependent under your family coverage (including adopted children and children placed with your Dependent for adoption, but not including children placed with your Dependent for foster care) if they meet all of the following requirements:
  - they are not married and do not have a domestic partner (for the purposes of this requirement only, "domestic partner" means someone who is registered and legally recognized as a domestic partner by California)
  - they are under age 26
  - they receive all of their support and maintenance from you or your Spouse
  - they permanently reside with you or your Spouse
- Dependent children of the Subscriber or Spouse (including adopted children and children placed with you for adoption, but not including children placed with you for foster care) who reach the age limit may continue coverage under this *EOC* if all of the following conditions are met:
  - they meet all requirements to be a Dependent except for the age limit
  - your Group permits enrollment of Dependents
  - they are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred before they reached the age limit for Dependents
  - they receive 50 percent or more of their support and maintenance from you or your Spouse
  - you give us proof of their incapacity and dependency within 60 days after we request it (see "Disabled Dependent certification" below in this "Eligibility as a Dependent" section)

Disabled Dependent certification. One of the requirements for a Dependent to be eligible to continue coverage as a disabled Dependent is that the Subscriber must provide us documentation of the dependent's incapacity and dependency as follows:

- If the child is a Member, we will send the Subscriber a notice of the Dependent's membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. The Dependent's membership will terminate as described in our notice unless the Subscriber provides us documentation of the Dependent's incapacity and dependency within 60 days of receipt of our notice and we determine that the Dependent is eligible as a disabled dependent. If the Subscriber provides us this documentation in the specified time period and we do not make a determination about eligibility before the termination date, coverage will continue until we make a determination. If we determine that the Dependent does not meet the eligibility requirements as a disabled dependent, we will notify the Subscriber

that the Dependent is not eligible and let the Subscriber know the membership termination date. If we determine that the Dependent is eligible as a disabled dependent, there will be no lapse in coverage. Also, starting two years after the date that the Dependent reached the age limit, the Subscriber must provide us documentation of the Dependent's incapacity and dependency annually within 60 days after we request it so that we can determine if the Dependent continues to be eligible as a disabled dependent

- If the child is not a Member because you are changing coverage, you must give us proof, within 60 days after we request it, of the child's incapacity and dependency as well as proof of the child's coverage under your prior coverage. In the future, you must provide proof of the child's continued incapacity and dependency within 60 days after you receive our request, but not more frequently than annually

Dependents not eligible to enroll under a Senior Advantage plan. If you have dependents who do not have Medicare Part B coverage or for some other reason are not eligible to enroll under this *EOC*, you may be able to enroll them as your dependents under a non-Medicare plan offered by your Group. Please contact your Group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

How to Enroll and When Coverage Begins

Your Group is required to inform you when you are eligible to enroll and what your effective date of coverage is. If you are eligible to enroll as described under "Who Is Eligible" in this "Premiums, Eligibility, and Enrollment" section, enrollment is permitted as described below and membership begins at the beginning (12:00 a.m.) of the effective date of coverage indicated below, except that:

- Your Group may have additional requirements, which allow enrollment in other situations
- The effective date of your Senior Advantage coverage under this *EOC* must be confirmed by the Centers for Medicare & Medicaid Services, as described under "Effective date of Senior Advantage coverage" in this "How to Enroll and When Coverage Begins" section

If you are a Subscriber under this *EOC* and you have dependents who do not have Medicare Part B coverage or for some other reason are not eligible to enroll under this *EOC*, you may be able to enroll them as your dependents under a non-Medicare plan offered by your Group. Please contact your Group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

If you are eligible to be a Dependent under this *EOC* but the subscriber in your family is enrolled under a non-Medicare plan offered by your Group, the subscriber must follow the rules applicable to Subscribers who are enrolling Dependents in this "How to Enroll and When Coverage Begins" section.

Effective date of Senior Advantage coverage

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

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

New employees

When your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a Health Plan–approved enrollment application, and a Senior Advantage Election Form for each person, to your Group within 31 days.

Effective date of Senior Advantage coverage. The effective date of Senior Advantage coverage for new employees and their eligible family Dependents or newly acquired Dependents, is determined by your Group, subject to confirmation by the Centers for Medicare & Medicaid Services.

Group open enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan–approved enrollment application, and a Senior Advantage Election Form for each person to your Group during your Group's open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the effective date of coverage, which is subject to confirmation by the Centers for Medicare & Medicaid Services.

Special enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless one of the following is true:

- You become eligible because you experience a qualifying event (sometimes called a "triggering event") as described in this "Special enrollment" section
- You did not enroll in any coverage offered by your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future. Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person, from the Subscriber

Special enrollment due to new Dependents. You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, within 30 days after marriage, establishment of domestic partnership, birth, adoption, or placement for adoption by submitting to your Group a Health Plan–approved enrollment application, and a Senior Advantage Election Form for each person.

Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from marriage or establishment of domestic partnership is no later than the first day of the month following the date your Group receives an enrollment application, and a Senior Advantage Election Form for each person, from the Subscriber. Subject to confirmation by the Centers for Medicare & Medicaid Services, enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, date of adoption, or the date you or your Spouse have newly assumed a legal right to control health care in anticipation of adoption.

Special enrollment due to loss of other coverage. You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, if all of the following are true:

- The Subscriber or at least one of the Dependents had other coverage when they previously declined all coverage through your Group
- The loss of the other coverage is due to one of the following:
  - exhaustion of COBRA coverage
  - termination of employer contributions for non-COBRA coverage
  - loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, moving out of the plan's service area, reaching the age limit for dependent children, or the subscriber's death, termination of employment, or reduction in hours of employment
  - loss of eligibility (but not termination for cause) for coverage through Covered California, Medicaid coverage (known as Medi-Cal in California), Children's Health Insurance Program coverage, or Medi-Cal Access Program coverage
  - reaching a lifetime maximum on all benefits

Note: If you are enrolling yourself as a Subscriber along with at least one eligible Dependent, only one of you must meet the requirements stated above.

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person, to your Group within 30 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for coverage through Covered California, Medicaid, Children's Health Insurance Program, or Medi-Cal Access Program coverage. Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application, and Senior Advantage Election Form for each person, from the Subscriber.

Special enrollment due to court or administrative order. Within 31 days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or child as a Dependent by submitting to your Group a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person.

Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of coverage resulting from a court or administrative order is the first of the month following the date we receive the enrollment request, unless your Group specifies a different effective date (if your Group specifies a

different effective date, the effective date cannot be earlier than the date of the order).

Special enrollment due to eligibility for premium assistance. You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, if you or a dependent become eligible for premium assistance through the Medi-Cal program. Premium assistance is when the Medi-Cal program pays all or part of premiums for employer group coverage for a Medi-Cal beneficiary. To request enrollment in your Group's health care coverage, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person, to your Group within 60 days after you or a dependent become eligible for premium assistance. Please contact the California Department of Health Care Services to find out if premium assistance is available and the eligibility requirements.

Special enrollment due to reemployment after military service. If you terminated your health care coverage because you were called to active duty in the military service, you may be able to reenroll in your Group's health plan if required by state or federal law. Please ask your Group for more information.

How to Obtain Services

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

- Authorized referrals as described under "Getting a Referral" in this "How to Obtain Services" section
- Certain care when you visit the service area of another Region as described under "Receiving Care Outside of Your Home Region" in this "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Your Cost Share" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Your Cost Share" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section
- Routine Services associated with Medicare-approved clinical trials as described under "Services Associated with Clinical Trials" in the "Benefits and Your Cost Share" section

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

Routine Care

To request a non-urgent appointment, you can call your local Plan Facility or request the appointment online. For appointment phone numbers, refer to our Provider Directory or call our Member Service Contact Center. To request an appointment online, go to our website at kp.org.

Urgent Care

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call our Member Service Contact Center.

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

Our Advice Nurses

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

Your Personal Plan Physician

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

We encourage you to choose a personal Plan Physician. You may choose any available personal Plan Physician. Parents may choose a pediatrician as the personal Plan Physician for their child. Most personal Plan Physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians). Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal Plan Physicians. For example, some specialists in internal medicine and obstetrics/gynecology who are not designated as Primary Care Physicians may be available as personal Plan Physicians. However, if you choose a specialist who is not designated as a Primary Care Physician as your personal Plan Physician, the Cost Share for a Physician Specialist Visit will apply to all visits with the specialist except for Preventive Services listed in the "Benefits and Your Cost Share" section.

To learn how to select or change to a different personal Plan Physician, visit our website at kp.org, or call our Member Service Contact Center. Refer to our Provider Directory for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call our Member Service Contact Center. You can change your personal Plan Physician at any time for any reason.

Getting a Referral

Referrals to Plan Providers

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

- Your personal Plan Physician
- Generalists in internal medicine, pediatrics, and family practice
- Specialists in optometry, mental health Services, substance use disorder treatment, and obstetrics/gynecology

A Plan Physician must refer you before you can get care from a specialist in urology except that you do not need a referral to receive Services related to sexual or reproductive health, such as a vasectomy.

Although a referral or prior authorization is not required to receive most care from these providers, a referral may be required in the following situations:

- The provider may have to get prior authorization for certain Services in accord with "Medical Group authorization procedure for certain referrals" in this "Getting a Referral" section
- The provider may have to refer you to a specialist who has a clinical background related to your illness or condition

Standing referrals

If a Plan Physician refers you to a 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. For example, if you have a life-threatening, degenerative, or disabling condition, you can get a standing referral to a specialist if ongoing care from the specialist is required.

Medical Group authorization procedure for certain referrals

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

- Durable medical equipment
- Ostomy and urological supplies
- Services not available from Plan Providers
- Transplants

Utilization Management (UM) is a process that determines whether a Service recommended by your treating provider is Medically Necessary for you. Prior authorization is a UM process that determines whether the requested services are Medically Necessary before care is provided. If it is Medically Necessary, then you will receive authorization to obtain that care in a clinically appropriate place consistent with the terms of your health coverage. Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

For the complete list of Services that require prior authorization, and the criteria that are used to make authorization decisions, please visit our website at kp.org/UM or call our Member Service Contact Center to request a printed copy. Refer to "Post-Stabilization Care"

under "Emergency Services" in the "Emergency Services and Urgent Care" section for authorization requirements that apply to Post-Stabilization Care from Non–Plan Providers.

Additional information about prior authorization for 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 Plan Physicians and medical professionals with clinical expertise. The formulary guidelines are periodically updated to keep pace with changes in medical technology, Medicare guidelines, and clinical practice.

If your Plan Physician prescribes one of these items, they will submit a written referral in accord with the UM process described in this "Medical Group authorization procedure for certain referrals" section. If the formulary guidelines do not specify that the prescribed item is appropriate for your medical condition, the referral will be submitted to the Medical Group's designee Plan Physician, who will make an authorization decision as described under "Medical Group's decision time frames" in this "Medical Group authorization procedure for certain referrals" section.

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

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your physician will be informed of the scope of the authorized Services. If the Medical Group does not authorize all of the Services, Health Plan will send you a written decision and explanation within two business days after the decision is made. Any written criteria that the Medical Group uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request.

If the Medical Group does not authorize all of the Services requested and you want to appeal the decision, you can file a grievance as described in the "Coverage Decisions, Appeals, and Complaints" section.

Your Cost Share. For these referral Services, you pay **the Cost Share required for Services provided by a Plan Provider** as described in this *EOC*.

Travel and lodging for certain referrals

The following are examples of when we will arrange or provide reimbursement for certain travel and lodging expenses in accord with our Travel and Lodging Program Description:

- If Medical Group refers you to a provider that is more than 50 miles from where you live for certain specialty Services such as bariatric surgery, complex thoracic surgery, transplant nephrectomy, or inpatient chemotherapy for leukemia and lymphoma
- If Medical Group refers you to a provider that is outside our Service Area for certain specialty Services such as a transplant or transgender surgery

For the complete list of specialty Services for which we will arrange or provide reimbursement for travel and lodging expenses, the amount of reimbursement, limitations and exclusions, and how to request reimbursement, refer to the Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at kp.org/specialty-care/travel-reimbursements or by calling our Member Service Contact Center.

Second Opinions

If you want a second opinion, you can ask Member Services to help you arrange one with a Plan Physician who is an appropriately qualified medical professional for your condition. If there isn't a Plan Physician who is an appropriately qualified medical professional for your condition, Member Services will help you arrange a consultation with a Non–Plan Physician for a second opinion. For purposes of this "Second Opinions" provision, an "appropriately qualified medical professional" is a physician who is acting within their scope of practice and who possesses a clinical background, including training and expertise, related to the illness or condition associated with the request for a second medical opinion.

Here are some examples of when a second opinion may be provided or authorized:

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

Your Cost Share. For these referral Services, you pay **the Cost Share required for Services provided by a Plan Provider** as described in this *EOC*.

Contracts with Plan Providers

How Plan Providers are paid

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

Financial liability

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

Your Cost Share. When you are referred to a Plan Provider for covered Services, you pay **the Cost Share required for Services from that provider** as described in this *EOC*.

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

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

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

- Certain conditions that are either acute, or serious and chronic. We may cover these Services for up to 90 days, or longer, if necessary for a safe transfer of care to a Plan Physician or other contracting provider as determined by the Medical Group
- A high-risk pregnancy or a pregnancy in its second or third trimester. We may cover these Services through postpartum care related to the delivery, or longer if Medically Necessary for a safe transfer of care to a Plan Physician as determined by the Medical Group

The Services must be otherwise covered under this *EOC*. Also, the terminated provider must agree in writing to our contractual terms and conditions and comply with them for Services to be covered by us.

Your Cost Share. For the Services of a terminated provider, you pay **the Cost Share required for Services provided by a Plan Provider** as described in this *EOC*.

More information. For more information about this provision, or to request the Services, please call our Member Service Contact Center.

Receiving Care Outside of Your Home Region

If you have questions about your coverage when you are away from home, call the Away from Home Travel line at **1-951-268-3900** 24 hours a day, seven days a week (except closed holidays). For example, call this number for the following concerns:

- What you should do to prepare for your trip
- What Services are covered when you are outside our Service Area

- How to get care in another Region
- How to request reimbursement if you paid for covered Services outside our Service Area

You can also get information on our website at kp.org/travel.

Receiving Care in the Service Area of another Region

If you visit the service area of another Region temporarily, you can receive certain care covered under this *EOC* from designated providers in that service area.

Please call our Member Service Contact Center or our Away from Home Travel Line at **1-951-268-3900** (TTY users call **711)**, 24 hours a day, seven days a week except holidays, for more information about getting care when visiting another Kaiser Permanente Region's service area, including coverage information and facility locations in the service area of another Region.

Your ID Card

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

Your ID card is for identification only. To receive covered Services, you must be a current Member. Anyone who is not a Member will be billed as a non-Member for any Services they receive. If you let someone else use your ID card, we may keep your ID card and terminate your membership as described under "Termination for Cause" in the "Termination of Membership" section.

Your Medicare card

Do NOT use your red, white, and blue Medicare card for covered medical Services while you are 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 hospice services or participate in routine research studies.

Getting Assistance

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

Member Services

Member Services representatives can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain the following:

- Your Health Plan benefits
- How to make your first medical appointment
- What to do if you move
- How to replace your Kaiser Permanente ID card

Many Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, our Member Service Contact Center representatives are available to assist you seven days a week from 8 a.m. to 8 p.m. toll free at **1-800-443-0815** or **711** (TTY for the deaf, hard of hearing, or speech impaired). For your convenience, you can also contact us through our website at kp.org.

Cost Share estimates

For information about estimates, see "Getting an estimate of your Cost Share" under "Your Cost Share" in the "Benefits and Your Cost Share" section.

Plan Facilities

Plan Medical Offices and Plan Hospitals are listed in the Provider Directory for your Home Region. The directory describes the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services. This directory is available on our website at kp.org/facilities. To obtain a printed copy, call our Member Service Contact Center. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call our Member Service Contact Center.

At most of our Plan Facilities, you can usually receive all of the covered Services you need, including specialty care, pharmacy, and lab work. You are not restricted to a

particular Plan Facility, and we encourage you to use the facility that will be most convenient for you:

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Services are available from Plan Hospital Emergency Departments (for Emergency Department locations, refer to our Provider Directory or call our Member Service Contact Center)
- Same-day Urgent Care appointments are available at many locations (for Urgent Care locations, refer to our Provider Directory or call our Member Service Contact Center)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services Department (for locations, refer to our Provider Directory or call our Member Service Contact Center)
- Plan Pharmacies are located at most Plan Medical Offices (refer to *Kaiser Permanente Pharmacy Directory* for pharmacy locations)

Provider Directory

The *Provider Directory* lists our Plan Providers. It is subject to change and periodically updated. If you don't have our *Provider Directory*, you can get a copy by calling our Member Service Contact Center or by visiting our website at kp.org/directory.

Pharmacy Directory

The *Kaiser Permanente Pharmacy Directory* lists the locations of Plan Pharmacies, which are also called "network pharmacies." The pharmacy directory provides additional information about obtaining prescription drugs. It is subject to change and periodically updated. If you don't have the *Kaiser Permanente Pharmacy Directory*, you can get a copy by calling our Member Service Contact Center or by visiting our website at kp.org/directory.

Emergency Services and Urgent Care

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital Emergency Department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non–Plan Providers anywhere in the world.

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

Post-Stabilization Care

Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the Emergency Department) after your treating physician determines that your condition is Stabilized.

To request prior authorization, the Non–Plan Provider must call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card *before* you receive the care. We will discuss your condition with the Non–Plan Provider. If we determine that you require Post-Stabilization Care and that this care is part of your covered benefits, we will authorize your care from the Non–Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care with the treating physician's concurrence. If we decide to have a Plan Hospital, Plan Skilled Nursing Facility, or designated Non–Plan Provider provide your care, we may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered.

Be sure to ask the Non–Plan Provider to tell you what care (including any transportation) we have authorized because we will not cover unauthorized Post-Stabilization Care or related transportation provided by Non–Plan Providers. If you receive care from a Non– Plan Provider that we have not authorized, you may have to pay the full cost of that care if you are notified by the Non–Plan Provider or us about your potential liability.

Your Cost Share

Your Cost Share for covered Emergency Services and Post-Stabilization Care is described in the "Benefits and Your Cost Share" section. Your Cost Share is the same whether you receive the Services from a Plan Provider or a Non–Plan Provider. For example:

- If you receive Emergency Services in the Emergency Department of a Non–Plan Hospital, you pay the Cost Share for an Emergency Department visit as described under "Outpatient Care"
- If we gave prior authorization for inpatient Post-Stabilization Care in a Non–Plan Hospital, you pay the Cost Share for hospital inpatient care as described under "Hospital Inpatient Care"

Urgent Care

Inside the Service Area

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice number at a Plan Facility. For appointment and advice phone numbers, refer to our Provider Directory or call our Member Service Contact Center.

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

Out-of-Area Urgent Care

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

- You receive the Services from Non–Plan Providers while you are temporarily outside our Service Area
- A reasonable person would have believed that your health would seriously deteriorate if you delayed treatment until you returned to our Service Area

You do not need prior authorization for Out-of-Area Urgent Care. We cover Out-of-Area Urgent Care you receive from Non–Plan Providers if the Services would have been covered under this *EOC* if you had received them from Plan Providers.

We do not cover follow-up care from Non–Plan Providers after you no longer need Urgent Care. To obtain follow-up care from a Plan Provider, call the appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call our Member Service Contact Center.

Your Cost Share

Your Cost Share for covered Urgent Care is the Cost Share required for Services provided by Plan Providers as described in this *EOC*. For example:

- If you receive an Urgent Care evaluation as part of covered Out-of-Area Urgent Care from a Non–Plan Provider, you pay the Cost Share for Urgent Care consultations, evaluations, and treatment as described under "Outpatient Care"
- If the Out-of-Area Urgent Care you receive includes an X-ray, you pay the Cost Share for an X-ray as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services" in addition to the Cost Share for the Urgent Care evaluation
- Note: If you receive Urgent Care in an Emergency Department, you pay the Cost Share for an Emergency Department visit as described under "Outpatient Care."

Payment and Reimbursement

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

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

Benefits and Your Cost Share

- This section describes the Services that are covered under this *EOC*.
- Services are covered under this *EOC* as specifically described in this *EOC*. Services that are not specifically described in this *EOC* are not covered, except as required by federal law. Services are subject to exclusions and limitations described in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. Except as otherwise described in this *EOC*, all of the following conditions must be satisfied:

- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
  - Preventive Services
  - health care items and services for diagnosis, assessment, or treatment
  - health education covered under "Health Education" in this "Benefits and Your Cost Share" section
  - other health care items and services
  - other services to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except for:
  - certain care when you visit the service area of another Region, as described under "Receiving Care Outside of Your Home Region" in the "How to Obtain Services" section
  - drugs prescribed by dentists, as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section
  - emergency ambulance Services, as described under "Ambulance Services" in this "Benefits and Your Cost Share" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
  - eyeglasses and contact lenses prescribed by Non– Plan Providers, as described under "Vision Services" in this "Benefits and Your Cost Share" section
  - out-of-area dialysis care, as described under "Dialysis Care" in this "Benefits and Your Cost Share" section
  - routine Services associated with Medicare-approved clinical trials, as described under "Services Associated with Clinical Trials" in this "Benefits and Your Cost Share" section
- You receive the Services from Plan Providers inside our Service Area, except for:
  - authorized referrals, as described under "Getting a Referral" in the "How to Obtain Services" section
  - certain care when you visit the service area of another Region, as described under "Receiving Care Outside of Your Home Region" in the "How to Obtain Services" section
  - emergency ambulance Services, as described under "Ambulance Services" in this "Benefits and Your Cost Share" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
  - out-of-area dialysis care, as described under "Dialysis Care" in this "Benefits and Your Cost Share" section
  - prescription drugs from Non–Plan Pharmacies, as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section
  - routine Services associated with Medicare-approved clinical trials, as described under "Services Associated with Clinical Trials" in this "Benefits and Your Cost Share" section
- The Medical Group has given prior authorization for the Services, if required, as described under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

Please also refer to:

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

Your Cost Share

Your Cost Share is the amount you are required to pay for covered Services. The Cost Share for covered Services is listed in this *EOC*. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible.

General rules, examples, and exceptions

Your Cost Share for covered Services will be the Cost Share in effect on the date you receive the Services, except as follows:

- If you are receiving covered inpatient hospital Services on the effective date of this *EOC*, you pay the Cost Share in effect on your admission date until you are discharged if the Services were covered under your prior Health Plan evidence of coverage and there

has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Cost Share in effect on the date you receive the Services

- For items ordered in advance, you pay the Cost Share in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Share 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

Payment toward your Cost Share (and when you may be billed). In most cases, your provider will ask you to make a payment toward your Cost Share at the time you receive Services. If you receive more than one type of Services (such as primary care treatment and laboratory tests), you may be required to pay separate Cost Share for each of those Services. Keep in mind that your payment toward your Cost Share may cover only a portion of your total Cost Share for the Services you receive, and you will be billed for any additional amounts that are due. The following are examples of when you may be asked to pay (or you may be billed for) Cost Share amounts in addition to the amount you pay at check-in:

- You receive non-preventive Services during a preventive visit. For example, you go in for a routine physical exam, and at check-in you pay your Cost Share for the preventive exam (your Cost Share may be "no charge"). However, during your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional non-preventive diagnostic Services
- You receive diagnostic Services during a treatment visit. For example, you go in for treatment of an existing health condition, and at check-in you pay your Cost Share for a treatment visit. However, during the visit your provider finds a new problem with your health and performs or orders diagnostic Services (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional diagnostic Services
- You receive treatment Services during a diagnostic visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider confirms a problem with your health and performs treatment Services (such as an outpatient procedure). You may be asked to pay (or you will be billed for) your Cost Share for these additional treatment Services
- You receive Services from a second provider during your visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider requests a consultation with a specialist. You may be asked to pay (or you will be billed for) your Cost Share for the consultation with the specialist

In some cases, your provider will not ask you to make a payment at the time you receive Services, and you will be billed for your Cost Share (for example, some Laboratory Departments are not able to collect Cost Shares).

- When we send you a bill, it will list Charges for the Services you received, payments and credits applied to your account, and any amounts you still owe. Your current bill may not always reflect your most recent Charges and payments. Any Charges and payments that are not on the current bill will appear on a future bill. Sometimes, you may see a payment but not the related Charges for Services. That could be because your payment was recorded before the Charges for the Services were processed. If so, the Charges will appear on a future bill. Also, you may receive more than one bill for a single outpatient visit or inpatient stay. For example, you may receive a bill for physician services and a separate bill for hospital services. If you don't see all the Charges for Services on one bill, they will appear on a future bill. If we determine that you overpaid and are due a refund, then we will send a refund to you within four weeks after we make that determination. If you have questions about a bill, please call the phone number on the bill.

In some cases, a Non–Plan Provider may be involved in the provision of covered Services at a Plan Facility or a contracted facility where we have authorized you to receive care. You are not responsible for any amounts beyond your Cost Share for the covered Services you receive at Plan Facilities or at contracted facilities where we have authorized you to receive care. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Requests for Payment" section.

Primary Care Visits, Non-Physician Specialist Visits, and Physician Specialist Visits. The Cost Share for a Primary Care Visit applies to evaluations and treatment

provided by generalists in internal medicine, pediatrics, or family practice, and by specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Some physician specialists provide primary care in addition to specialty care but are not designated as Primary Care Physicians. If you receive Services from one of these specialists, the Cost Share for a Physician Specialist Visit will apply to all consultations, evaluations, and treatment provided by the specialist except for routine preventive counseling and exams listed under "Preventive Services" in this "Benefits and Your Cost Share" section. For example, if your personal Plan Physician is a specialist in internal medicine or obstetrics/gynecology who is not a Primary Care Physician, you will pay the Cost Share for a Physician Specialist Visit for all consultations, evaluations, and treatment by the specialist except routine preventive counseling and exams listed under "Preventive Services" in this "Benefits and Your Cost Share" section. The Non-Physician Specialist Visit Cost Share applies to consultations, evaluations, and treatment provided by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

Noncovered Services. If you receive Services that are not covered under this *EOC*, you may have to pay the full price of those Services. Payments you make for noncovered Services do not apply to any deductible or out-of-pocket maximum.

Getting an estimate of your Cost Share

If you have questions about the Cost Share for specific Services that you expect to receive or that your provider orders during a visit or procedure, please visit our website at kp.org/memberestimates to use our cost estimate tool or call our Member Service Contact Center.

- If you have a Plan Deductible and would like an estimate for Services that are subject to the Plan Deductible, please call **1-800-390-3507** (TTY users call **711**) Monday through Friday, 7 a.m. to 7 p.m.
- For all other Cost Share estimates, please call **1-800-443-0815**, 8 a.m. to 8 p.m., seven days a week (TTY users should call **711**)

Cost Share estimates are based on your benefits and the Services you expect to receive. They are a prediction of cost and not a guarantee of the final cost of Services. Your final cost may be higher or lower than the estimate since not everything about your care can be known in advance.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service, after you meet any applicable deductible, is described in this *EOC*.

Note: If Charges for Services are less than the Copayment described in this *EOC*, you will pay the lesser amount.

Plan Out-of-Pocket Maximum

There is a limit to the total amount of Cost Share you must pay under this *EOC* in the calendar year for covered Services that you receive in the same calendar year. The Services that apply to the Plan Out-of-Pocket Maximum are described under the "Payments that count toward the Plan Out-of-Pocket Maximum" section below. The limit is:

- **$1,500** per calendar year for any one Member

For Services subject to the Plan Out-of-Pocket Maximum, you will not pay any more Cost Share during the remainder of the calendar year, but every other Member in your Family must continue to pay Cost Share during the remainder of the calendar year until either he or she reaches the **$1,500** maximum for any one Member.

Payments that count toward the Plan Out-of-Pocket Maximum. Any amounts you pay for the following Services apply toward the out-of-pocket maximum:

- Covered in-network Medicare Part A and Part B Services
- Medicare Part B drugs
- Residential treatment program Services covered in the "Substance Use Disorder Treatment" and "Mental Health Services" sections

Copayments and Coinsurance you pay for Services that are not described above, do not apply to the out-of-pocket maximum. For these Services, you must pay Copayments or Coinsurance even if you have already reached the out-of-pocket maximum. In addition:

- If your plan includes supplemental chiropractic or acupuncture Services, or fitness benefit, described in an amendment to this *EOC*, those Services do not apply toward the maximum
- If your plan includes an Allowance for specific Services (such as eyeglasses, contact lenses, or hearing aids), any amounts you pay that exceed the Allowance do not apply toward the maximum

Outpatient Care

We cover the following outpatient care subject to the Cost Share indicated:

Office visits

- Primary Care Visits and Non-Physician Specialist Visits that are not described elsewhere in this *EOC*: **a $15 Copayment per visit**
- Physician Specialist Visits that are not described elsewhere in this *EOC*: **a $15 Copayment per visit**
- Outpatient visits that are available as group appointments that are not described elsewhere in this *EOC*: **a $7 Copayment per visit**
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician:
  - Primary Care Visits and Non-Physician Specialist Visits: **a $15 Copayment per visit**
  - Physician Specialist Visits: **a $15 Copayment per visit**
- Routine physical exams that are medically appropriate preventive care in accord with generally accepted professional standards of practice: **no charge**
- Family planning counseling, or internally implanted time-release contraceptives or intrauterine devices (IUDs) and office visits related to their administration and management: **a $15 Copayment per visit**
- After confirmation of pregnancy, the normal series of regularly scheduled preventive prenatal care exams and the first postpartum follow-up consultation and exam: **a $15 Copayment per visit**
- Voluntary termination of pregnancy: **a $15 Copayment per procedure**
- Physical, occupational, and speech therapy in accord with Medicare guidelines: **a $15 Copayment per visit**
- Group and individual physical therapy prescribed by a Plan Provider to prevent falls: **no charge**
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program in accord with Medicare guidelines: **a $15 Copayment per day**
- Manual manipulation of the spine to correct subluxation, in accord with Medicare guidelines, is covered when provided by a Plan Provider or a chiropractor when referred by a Plan Provider: **a $15 Copayment per visit**

Acupuncture Services

- Acupuncture for chronic low back pain up to 12 visits in 90 days, in accord with Medicare guidelines: **a $15 Copayment per visit**. Chronic low back pain is defined as follows:
  - lasting 12 weeks or longer
  - non-specific, in that it has no identifiable systemic cause (i.e. not associated with metastatic, inflammatory, infectious, etc. disease)
  - not associated with surgery or pregnancy
- An additional eight sessions are covered for those 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.
- Acupuncture not covered by Medicare (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain): **a $15 Copayment per visit**

Emergency and Urgent Care visits

- Urgent Care consultations, evaluations, and treatment: **a $15 Copayment per visit**
- Emergency Department visits: **a $50 Copayment per visit**
- **If you are admitted from the Emergency Department**. If you are admitted to the hospital as an inpatient for covered Services (either within 24 hours for the same condition or after an observation stay), then the Services you received in the Emergency Department and observation stay, if applicable, will be considered part of your inpatient hospital stay. For the Cost Share for inpatient care, refer to "Hospital Inpatient Care" in this "Benefits and Your Cost Share" section. However, the Emergency Department Cost Share does apply if you are admitted for observation but are not admitted as an inpatient.

Outpatient surgeries and procedures

- Outpatient surgery and outpatient procedures when provided in an outpatient 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: **a $15 Copayment per procedure**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a $15 Copayment per procedure**

- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Cost Share that would otherwise apply for the procedure** in this "Benefits and Your Cost Share" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Pre- and post-operative visits:
  - ♦ Primary Care Visits and Non-Physician Specialist Visits: **a $15 Copayment per visit**
  - ♦ Physician Specialist Visits: **a $15 Copayment per visit**

Administered drugs and products

Administered drugs and products are medications and products that require administration or observation by medical personnel. We cover these items when prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility or during home visits.

We cover the following Services and their administration in a Plan Facility at the Cost Share indicated:

- Whole blood, red blood cells, plasma, and platelets: **no charge**
- Allergy antigens (including administration): **a $3 Copayment per visit**
- Cancer chemotherapy drugs and adjuncts: **no charge**
- Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products ("biologics") derived from tissue, cells, or blood: **no charge**
- Tuberculosis skin tests: **no charge**
- All other administered drugs and products: **no charge**
- We cover drugs and products administered to you during a home visit at **no charge**.

Certain administered drugs are Preventive Services. Refer to "Preventive Services" for information on immunizations.

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

For the following Services, refer to these sections

- Bariatric Surgery
- Dental Services
- Dialysis Care
- Durable Medical Equipment ("DME") for Home Use
- Fertility Services
- Health Education
- Hearing Services
- Home Health Care
- Hospice Care
- Meals
- Mental Health Services
- Ostomy, Urological, and Wound Care Supplies
- Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services
- Outpatient Prescription Drugs, Supplies, and Supplements
- Preventive Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Substance Use Disorder Treatment
- Transplant Services
- Vision Services

Hospital Inpatient Care

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

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Plan Physicians, including consultation and treatment by specialists
- Anesthesia
- Drugs prescribed in accord with our drug formulary guidelines (for discharge drugs prescribed when you are released from the hospital, refer to "Outpatient

Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section)

- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and other diagnostic and treatment Services, including MRI, CT, and PET scans
- Whole blood, red blood cells, plasma, platelets, and their administration
- Obstetrical care and delivery (including cesarean section). Note: If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge (for visits after you are released from the hospital, please refer to "Outpatient Care" in this "Benefits and Your Cost Share" section)
- Physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program) in accord with Medicare guidelines
- Respiratory therapy
- Medical social services and discharge planning

Your Cost Share. We cover hospital inpatient Services at **no charge**.

For the following Services, refer to these sections

- Bariatric surgical procedures (refer to "Bariatric Surgery")
- Dental procedures (refer to "Dental Services")
- Dialysis care (refer to "Dialysis Care")
- Fertility Services related to diagnosis and treatment of infertility, artificial insemination, or assisted reproductive technology (refer to "Fertility Services")
- Hospice care (refer to "Hospice Care")
- Mental health Services (refer to "Mental Health Services")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Reconstructive surgery Services (refer to "Reconstructive Surgery")
- Services in connection with a clinical trial (refer to "Services in Connection with a Clinical Trial")
- Skilled inpatient Services in a Plan Skilled Nursing Facility (refer to "Skilled Nursing Facility Care")
- Substance use disorder treatment Services (refer to "Substance Use Disorder Treatment")
- Transplant Services (refer to "Transplant Services")

Ambulance Services

Emergency

We cover Services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) in the following situations:

- You reasonably believed that the medical condition was an Emergency Medical Condition which required ambulance Services
- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

If you receive emergency ambulance Services that are not ordered by a Plan Provider, you are not responsible for any amounts beyond your Cost Share for covered emergency ambulance Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Requests for Payment" section.

Nonemergency

Inside our Service Area, we cover nonemergency ambulance Services in accord with Medicare guidelines if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to and from qualifying locations as defined by Medicare guidelines.

Your Cost Share

You pay the following for covered ambulance Services:

- Emergency ambulance Services: **no charge**
- Nonemergency Services: **no charge**

Ambulance Services exclusions

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

Bariatric Surgery

We cover hospital inpatient care related to bariatric surgical procedures (including room and board, imaging, laboratory, 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

Your Cost Share. 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, see "Hospital Inpatient Care" in this "Benefits and Your Cost Share" section for the Cost Share that applies for hospital inpatient care.

For the following Services, refer to these sections

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

Dental Services

Dental Services for radiation treatment

We cover services in accord with Medicare guidelines, including dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist for those Services (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental Services for transplants

We cover dental services that are Medically Necessary to free the mouth from infection in order to prepare for a transplant covered under "Transplant Services" in this "Benefits" section, if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist for those Services (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental anesthesia

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

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

We do not cover any other Services related to the dental procedure, such as the dentist's Services, unless the Service is covered in accord with Medicare guidelines.

Your Cost Share

You pay the following for dental Services covered under this "Dental Services" section:

- Non-Physician Specialist Visits with dentists for Services covered under this "Dental Services" section: **a $15 Copayment per visit**
- Physician Specialist Visits for Services covered under this "Dental Services" section: **a $15 Copayment per visit**
- Outpatient surgery and outpatient procedures when provided in an outpatient 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: **a $15 Copayment per procedure**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a $15 Copayment per procedure**
- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Cost Share that would otherwise apply for the procedure** in this "Benefits and Your Cost Share" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Hospital inpatient care (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services): **no charge**

For the following Services, refer to these sections

- Office visits not described in this "Dental Services" section (refer to "Outpatient Care")
- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Dialysis Care

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

- You satisfy all medical criteria developed by the Medical Group
- The facility is certified by Medicare
- A Plan Physician provides a written referral for your dialysis treatment except for out-of-area dialysis care

We also cover hemodialysis and peritoneal home dialysis (including equipment, training, and medical supplies). Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or purchase the equipment and supplies, and we select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when we are no longer covering them.

Out-of-area dialysis care

We cover dialysis (kidney) Services that you get at a Medicare-certified dialysis facility when you are temporarily outside our Service Area. If possible, before you leave the Service Area, please let us know where you are going so we can help arrange for you to have maintenance dialysis while outside our Service Area.

The procedure for obtaining reimbursement for out-of-area dialysis care is described in the "Requests for Payment" section.

Your Cost Share. You pay the following for these covered Services related to dialysis:

- Equipment and supplies for home hemodialysis and home peritoneal dialysis: **no charge**
- One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, evaluation, or treatment: **no charge**
- Hemodialysis and peritoneal dialysis treatment: **no charge**
- Hospital inpatient care (including room and board, drugs, imaging, laboratory, and other diagnostic and treatment Services, and Plan Physician Services): **no charge**

For the following Services, refer to these sections

- Durable medical equipment for home use (refer to "Durable Medical Equipment ("DME") for Home Use")
- Hospital inpatient care (refer to "Hospital Inpatient Care")
- Office visits not described in this "Dialysis Care" section (refer to "Outpatient Care")
- Kidney disease education (refer to "Health Education")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")
- Telehealth Visits (refer to "Telehealth Visits") **Dialysis care exclusion(s)**
- Comfort, convenience, or luxury equipment, supplies and features
- Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel

Durable Medical Equipment ("DME") for Home Use

DME coverage rules

DME for home use is an item that meets the following criteria:

- The item is intended for repeated use
- The item is primarily and customarily used to serve a medical purpose
- The item is generally useful only to an individual with an illness or injury
- The item is appropriate for use in the home (or another location used as your home as defined by Medicare)

For a DME item to be covered, all of the following requirements must be met:

- Your *EOC* includes coverage for the requested DME item
- A Plan Physician has prescribed the DME item for your medical condition
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage 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.

DME for diabetes

We cover the following diabetes blood-testing supplies and equipment and insulin-administration devices if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met:

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

Your Cost Share. You pay the following for covered DME for diabetes (including repair or replacement of covered equipment):

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices): **no charge**
- Insulin pumps and supplies to operate the pump: **20 percent Coinsurance**

Base DME Items

We cover Base DME Items (including repair or replacement of covered equipment) if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met. "Base DME Items" means the following items:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Bone stimulator
- Canes (standard curved handle or quad) and replacement supplies
- Cervical traction (over door)
- Crutches (standard or forearm) and replacement supplies
- Dry pressure pad for a mattress
- Infusion pumps (such as insulin pumps) and supplies to operate the pump
- IV pole
- Nebulizer and supplies
- Phototherapy blankets for treatment of jaundice in newborns

Your Cost Share. You pay the following for covered Base DME Items: **20 percent Coinsurance**.

Other covered DME items

- If all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met, we cover the following other DME items (including repair or replacement of covered equipment):
- 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 preventing daily living activities
- Nontherapeutic continuous glucose monitoring devices and related supplies
- Peak flow meters
- Resuscitation bag if tracheostomy patient has significant secretion management problems, needing lavage and suction technique aided by deep breathing via resuscitation bag

Your Cost Share. You pay the following for other covered DME items: **20 percent Coinsurance**, except peak flow meters are covered at: **no charge**.

Outside our Service Area

We do not cover most DME for home use outside our Service Area. However, if you live outside our Service Area, we cover the following DME (subject to the Cost Share and all other coverage requirements that apply to DME for home use inside our Service Area) when the item is dispensed at a Plan Facility:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test

strips, lancets, and lancet devices) from a Plan Pharmacy

- Canes (standard curved handle)
- Crutches (standard)
- Nebulizers and their supplies for the treatment of pediatric asthma
- Peak flow meters from a Plan Pharmacy

For the following Services, refer to these sections

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

DME for home use exclusion(s)

- Comfort, convenience, or luxury equipment or features
- Dental appliances
- Items not intended for maintaining normal activities of daily living, such as exercise equipment (including devices intended to provide additional support for recreational or sports activities)
- Hygiene equipment
- Nonmedical items, such as sauna baths or elevators
- Modifications to your home or car, unless covered in accord with Medicare guidelines
- Devices for testing blood or other body substances (except diabetes blood glucose monitors and their supplies)
- Electronic monitors of the heart or lungs except infant apnea monitors
- Repair or replacement of equipment due to misuse

Fertility Services

"Fertility Services" means treatments and procedures to help you become pregnant.

Before starting or continuing a course of fertility Services, you may be required to pay initial and subsequent deposits toward your Cost Share for some or all of the entire course of Services, along with any past-due fertility-related Cost Share. Any unused portion of your deposit will be returned to you. When a deposit is not required, you must pay the Cost Share for the procedure, along with any past-due fertility-related Cost Share, before you can schedule a fertility procedure.

Diagnosis and treatment of infertility

For purposes of this "Diagnosis and treatment of infertility" section, "infertility" means not being able to get pregnant or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception or having a medical or other demonstrated condition that is recognized by a Plan Physician as a cause of infertility. We cover the following:

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

You pay the following for covered infertility Services:

- Office visits: **a $15 Copayment per visit**
- Most outpatient surgery and outpatient procedures when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or provided in any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort: **a $15 Copayment per procedure**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a $15 Copayment per procedure**
- Outpatient imaging: **no charge**
- Outpatient laboratory: **no charge**
- Outpatient diagnostic Services: **no charge**
- Outpatient administered drugs: **no charge**
- Hospital inpatient care (including room and board, imaging, laboratory, and other diagnostic and treatment Services, and Plan Physician Services): **no charge**
- Note: Administered drugs and products are medications and products that require administration or observation by medical personnel. We cover these items when they are prescribed by a Plan Provider, in

accord with our drug formulary guidelines, and they are administered to you in a Plan Facility.

For the following Services, refer to these sections

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

Fertility Services exclusion(s)

- Services to reverse voluntary, surgically induced infertility
- Semen and eggs (and Services related to their procurement and storage)
- Assisted reproductive technology Services, such as ovum transplants, gamete intrafallopian transfer (GIFT), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT)

Health Education

We cover a variety of health education counseling, programs, and materials that your personal Plan Physician or other Plan Providers provide during a visit covered under another part of this *EOC*.

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

For more information about our health education counseling, programs, and materials, please contact a Health Education Department or our Member Service Contact Center or go to our website at kp.org.

Note: Our Health Education Department offers a comprehensive self-management workshop to help members learn the best choices in exercise, diet, monitoring, and medications to manage and control diabetes. Members may also choose to receive diabetes self-management training from a program outside our Plan that is recognized by the American Diabetes Association (ADA) and approved by Medicare. Also, our Health Education Department offers education to teach kidney care and help members make informed decisions about their care.

Your Cost Share. You pay the following for these covered Services:

- Covered health education programs, which may include programs provided online and counseling over the phone: **no charge**
- Other covered individual counseling when the office visit is solely for health education: **a $15 Copayment per visit**
- Health education provided during an outpatient consultation or evaluation covered in another part of this *EOC*: **no additional Cost Share beyond the Cost Share required in that other part of this *EOC***
- Covered health education materials: **no charge**

Hearing Services

We cover the following:

- Hearing exams with an audiologist to determine the need for hearing correction: **a $15 Copayment per visit**
- Physician Specialist Visits to diagnose and treat hearing problems: **a $15 Copayment per visit**

For the following Services, refer to these sections

- Services related to the ear or hearing other than those described in this section, such as outpatient care to treat an ear infection or outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits and Your Cost Share" section)
- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")

Hearing Services exclusion(s)

- Hearing aids and tests to determine their efficacy, and hearing tests to determine an appropriate hearing aid

Home Health Care

"Home health care" means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists. We cover part-time or intermittent home health care in accord with Medicare guidelines. Home health care services are covered up to the number of visits and length of time that are determined to be medically necessary under the Member's home health treatment plan and no more than the limits established under Medicare guidelines, only if all of the following are true:

- You are substantially confined to your home

- Your condition requires the Services of a nurse, physical therapist, or speech therapist or continued need for an occupational therapist (home health aide Services are not covered unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide)
- A Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home and that the Services can be safely and effectively provided in your home
- The Services are provided inside our Service Area

Your Cost Share. We cover home health care Services at **no charge**.

For the following Services, refer to these sections

- Dialysis care (refer to "Dialysis Care")
- Durable medical equipment (refer to "Durable Medical Equipment ("DME") for Home Use")
- Ostomy, urological, and wound care supplies (refer to "Ostomy, Urological, and Wound Care Supplies")
- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient physical, occupational, and speech therapy visits (refer to "Outpatient Care")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Home health care exclusion(s)

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

Home Medical Care Not Covered by Medicare for Members Who Live in Contra Costa or Solano Counties (Advanced Care at Home)

We cover medical care in your home that is not otherwise covered by Medicare in certain situations 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

Medically Home is our network provider and 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 Medically Home's 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 Medically Home's command center if you are unable to get to a phone
- The following equipment necessary to ensure that you are 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 are receiving acute care in the home

In addition, for Medicare-covered services and items listed below, the Cost-Sharing indicated elsewhere in this *EOC* does not apply when the Services and items are prescribed as part of your home treatment plan:

- Durable medical equipment
- Medical supplies
- Ambulance transportation to and from network facilities when ambulance transport is Medically Necessary
- Physician assistant and nurse practitioner house calls or office visits
- The following Services at a Plan 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, ultrasounds, and EKGs

The cost-sharing indicated elsewhere in this *EOC* will apply to all other Services and items that are not part of your home treatment plan (for example, DME unrelated to your home treatment plan) or are part of your home treatment plan, but are not provided in your home except as listed above. Note: For prescription drug Cost-Sharing information, refer to the "Outpatient Prescription Drugs, Supplies, and Supplements" section.

Hospice Care

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

If you have Medicare Part A, you may receive care from any Medicare-certified hospice program. You are eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have six months or less to live if your illness runs its normal course. Your hospice doctor can be a Plan Provider or a Non–Plan Provider. Covered Services include:

- Drugs for symptom control and pain relief
- Short-term respite care
- Home care

For hospice services and services that are covered by Medicare Part A or B and are related to your terminal prognosis: Original Medicare (rather than our Plan) will pay for your hospice services and any Part A and Part B services related to your terminal condition. While you are in the hospice program, your hospice provider will bill Original Medicare for the services that Original Medicare pays for.

For services that are covered by Medicare Part A or B and are not related to your terminal prognosis: If you need nonemergency, non–urgently needed services that are covered under Medicare Part A or B and that are not related to your terminal condition, your cost for these services depends on whether you use a Plan Provider:

- If you obtain the covered services from a Plan Provider, you only pay the Plan Cost Share amount
- If you obtain the covered services from a Non–Plan Provider, you pay the cost sharing under Fee-for-Service Medicare (Original Medicare)

For services that are covered by our Plan but are not covered by Medicare Part A or B: We will continue to cover Plan-covered Services that are not covered under Part A or B whether or not they are related to your terminal condition. You pay your Plan Cost Share amount for these Services.

- **For drugs that may be covered by our plan's Part D benefit:** Drugs are never covered by both hospice and our plan at the same time. For more information, please see "What if you're in a Medicare-certified hospice" in the "Outpatient Prescription Drugs, Supplies, and Supplements" section.

Note: If you need non-hospice care (care that is not related to your terminal prognosis), you should contact us to arrange the services.

For more information about Original Medicare hospice coverage, visit https://www.medicare.gov, and under "Search Tools," choose "Find a Medicare Publication" to view or download the publication "Medicare Hospice Benefits." Or call **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048)**, 24 hours a day, seven days a week.

Special note if you do not have Medicare Part A

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

- You are not entitled to Medicare Part A
- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The Services are provided inside 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 Plan Provider
- A Plan Physician determines that the Services are necessary for the palliation and management of your terminal illness and related conditions

If all of the above requirements are met, we cover the following hospice Services, if necessary for your hospice care:

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, and 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 a Plan Pharmacy. Certain drugs are limited to a maximum 30-day supply in any 30-day period (please call our Member Service Contact Center for the current list of these drugs)
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling

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:

- 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

Meals

Immediately following discharge from a hospital as an inpatient due to congestive heart failure, we cover up to two meals per day in a consecutive four-week period, once per calendar year as follows:

- As part of the discharge process, someone from your care team will initiate a referral valid for 30 days. Once the referral is approved, the meal delivery vendor will contact you with meal options and arrange meal delivery. You can contact our Member Service Contact Center if you have any questions about your referral (unused referrals are not renewable)
- In addition to meals for general health, there are menus to support specific conditions and diets

Your Cost Share. We cover home-delivered meals at **no charge**.

Meals exclusions

- You are discharged to another facility that provides meals (for example, inpatient rehabilitation)
- The meals referral has expired

Mental Health Services

We cover Services specified in this "Mental Health Services" section only when the Services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, as amended in the most recently issued edition, *("DSM")* that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the *DSM* identifies as something other than a "mental disorder." For example, the *DSM* identifies relational problems as something other than a "mental disorder," so we do not cover services (such as couples counseling or family counseling) for relational problems.

"Mental Disorders" include the following conditions:

- Severe Mental Illness of a person of any age
- Serious Emotional Disturbance of a Child Under Age 18

In addition to the Services described in this Mental Health Services section, we also cover other Services that are Medically Necessary to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness, if the Medical Group authorizes a written referral (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Outpatient mental health Services

We cover the following Services when provided by Plan Physicians or other Plan Providers who are licensed

health care professionals acting within the scope of their license:

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

Intensive psychiatric treatment programs. We cover the following intensive psychiatric treatment programs at a Plan Facility:

- Partial hospitalization
- Multidisciplinary treatment in an intensive outpatient program
- Psychiatric observation for an acute psychiatric crisis

Your Cost Share. You pay the following for these covered Services:

- Individual mental health evaluation and treatment: **a $15 Copayment per visit**
- Group mental health treatment: **a $7 Copayment per visit**
- Partial hospitalization: **no charge**
- Other intensive psychiatric treatment programs: **no charge**

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized mental health treatment, the Services are generally and customarily provided by a mental health residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group mental health evaluation and treatment
- Medical services
- Medication monitoring
- Room and board
- Drugs prescribed by a Plan 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 (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section)
- Discharge planning

Your Cost Share. We cover residential mental health treatment Services at **no charge**.

Inpatient psychiatric hospitalization

We cover care for acute psychiatric conditions in a Medicare-certified psychiatric hospital.

Your Cost Share. We cover inpatient psychiatric hospital Services at **no charge**.

For the following Services, refer to these sections

- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Telehealth Visits (refer to "Telehealth Visits")

Opioid Treatment Program Services

Members with opioid use disorder (OUD) can receive 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 medication assisted treatment (MAT) medications and the dispensing and administration of such MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments
- Medicare Part B clinically administered drugs

Your Cost Share: You pay the following for these covered Services: **no charge**.

Ostomy, Urological, and Wound Care Supplies

We cover ostomy, urological, and wound care supplies if the following requirements are met:

- A Plan Physician has prescribed ostomy, urological, and wound care supplies for your medical condition

- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area
- Coverage 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.

Your Cost Share: You pay the following for covered ostomy, urological, and wound care supplies: **20 percent Coinsurance**.

Ostomy, urological, and wound care supplies exclusion(s)

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services

We cover the following Services at the Cost Share indicated only when part of care covered under other headings in this "Benefits and Your Cost Share" section. The Services must be prescribed by a Plan Provider:

- Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans: **no charge**
- Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds: **no charge**
- Nuclear medicine: **no charge**
- Routine preventive retinal photography screenings: **no charge**
- Routine laboratory tests to monitor the effectiveness of dialysis: **no charge**
- Hemoglobin (A1c) testing for diabetes, Low-Density Lipoprotein (LDL) testing for heart disease, International Normalized Ratio (INR) for persons with liver disease or certain blood disorders, and glucose quantitative blood tests not covered at $0 under Original Medicare: **no charge**
- All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available): **no charge**
- Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs and EEGs): **no charge**
- Radiation therapy: **no charge**
- Ultraviolet light treatments, including ultraviolet light therapy equipment for home use, if (1) the equipment has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section 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.): **no charge**

For the following Services, refer to these sections

- Outpatient imaging and laboratory Services that are Preventive Services, such as routine mammograms, bone density scans, and laboratory screening tests (refer to "Preventive Services")
- Outpatient procedures that include imaging and diagnostic Services (refer to "Outpatient surgeries and procedures")
- Services related to diagnosis and treatment of infertility, artificial insemination, or assisted reproductive technology ("ART") Services (refer to "Fertility Services")
- Ultraviolet light therapy comfort, convenience, or luxury equipment or features
- Repair or replacement of ultraviolet light therapy equipment due to loss, theft, or misuse

Outpatient Prescription Drugs, Supplies, and Supplements

We cover outpatient drugs, supplies, and supplements specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section when prescribed as follows:

- Items prescribed by providers, within the scope of their licensure and practice, and in accord with our drug formulary guidelines
- Items prescribed by the following Non–Plan Providers unless a Plan Physician determines that the item is not Medically Necessary or the drug is for a sexual dysfunction disorder:
  - ♦ dentists if the drug is for dental care

  - Non–Plan Physicians if the Medical Group authorizes a written referral to the Non–Plan Physician (in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section) and the drug, supply, or supplement is covered as part of that referral
  - Non–Plan Physicians if the prescription was obtained as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described in the "Requests for Payment" section)
- The item meets the requirements of our applicable drug formulary guidelines (our Medicare Part D formulary or our formulary applicable to non–Part D items)
- You obtain the item at a Plan Pharmacy or through our mail-order service, except as otherwise described under "Certain items from Non–Plan Pharmacies" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section. Refer to our *Kaiser Permanente Pharmacy Directory* for the locations of Plan Pharmacies in your area. Plan Pharmacies can change without notice and if a pharmacy is no longer a Plan Pharmacy, you must obtain covered items from another Plan Pharmacy, except as otherwise described under "Certain items from Non–Plan Pharmacies" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section
- Your prescriber must either accept Medicare or file documentation with the Centers for Medicare & Medicaid Services showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed

In addition to our plan's Part D and medical benefits coverage, if you have Medicare Part A, your drugs may be covered by Original Medicare if you are in Medicare hospice. For more information, please see "What if you're in a Medicare-certified hospice" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section.

Obtaining refills by mail

Most refills are available through our mail-order service, but there are some restrictions. A Plan Pharmacy, our *Kaiser Permanente Pharmacy Directory*, or our website at kp.org/refill can give you more information about obtaining refills through our mail-order service. Please check with your local Plan Pharmacy if you have a question about whether your prescription can be mailed. Items available through our mail-order service are subject to change at any time without notice.

Certain items from Non–Plan Pharmacies

Generally, we cover drugs filled at a Non–Plan Pharmacy only when you are not able to use a Plan Pharmacy. If you cannot use a Plan Pharmacy, here are the circumstances when we would cover prescriptions filled at a Non–Plan Pharmacy.

- The drug is related to covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section. Note: Prescription drugs prescribed and provided outside of the United States and its territories as part of covered Emergency Services or Urgent Care are covered up to a 30-day supply in a 30-day period. These drugs are covered under your medical benefits, and are not covered under Medicare Part D. Therefore, payments for these drugs do not count toward reaching the Part D Catastrophic Coverage Stage
- For Medicare Part D covered drugs, the following are additional situations when a Part D drug may be covered:
  - if you are traveling outside our Service Area, but in the United States and its territories, and you become ill or run out of your covered Part D prescription drugs. We will cover prescriptions that are filled at a Non–Plan Pharmacy according to our Medicare Part D formulary guidelines
  - if you are unable to obtain a covered drug in a timely manner inside our Service Area because there is no Plan Pharmacy within a reasonable driving distance that provides 24-hour service. We may not cover your prescription if a reasonable person could have purchased the drug at a Plan Pharmacy during normal business hours
  - if you are trying to fill a prescription for a drug that is not regularly stocked at an accessible Plan Pharmacy or available through our mail-order pharmacy (including high-cost drugs)
  - if you are not able to get your prescriptions from a Plan Pharmacy during a disaster

In these situations, please check first with our Member Service Contact Center to see if there is a Plan Pharmacy nearby. You may be required to pay the difference between what you pay for the drug at the Non–Plan Pharmacy and the cost that we would cover at Plan Pharmacy.

Payment and reimbursement. If you go to a Non–Plan Pharmacy for the reasons listed, you may have to pay the full cost (rather than paying just your Copayment or Coinsurance) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a request for reimbursement as described in the "Requests for Payment" section. If we pay for the drugs you obtained from a Non–Plan Pharmacy, you may still pay more for your drugs than what you would have paid if you had gone to a Plan Pharmacy because you may be responsible for paying the difference between Plan Pharmacy Charges and the price that the Non–Plan Pharmacy charged you.

What if you're in a Medicare-certified hospice

If you have Medicare Part A, drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication, or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive 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 receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. For more information about Medicare Part D coverage and what you pay, please see "Medicare Part D drugs" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section.

Medicare Part D drugs

Medicare Part D covers most outpatient prescription drugs if they are sold in the United States and approved for sale by the federal Food and Drug Administration. Our Part D formulary includes drugs that can be covered under Medicare Part D according to Medicare requirements. Refer to our "Medicare Part D drug formulary *(2022 Comprehensive Formulary)*" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section for more information about this formulary.

Cost Share for Medicare Part D drugs. Unless you reach the Catastrophic Coverage Stage in a calendar year, you will pay the following Cost Share for covered Medicare Part D drugs:

- Generic drugs: **a $10 Copayment for up to a 100-day supply**
- Brand-name and specialty drugs: **a $35 Copayment for up to a 100-day supply**
- Injectable Part D vaccines: **no charge**
- Emergency contraceptive pills: **no charge**
- The following insulin-administration devices at **a $10 Copayment** for up to a 100-day supply: needles, syringes, alcohol swabs, and gauze

Catastrophic Coverage Stage. All Medicare prescription drug plans include catastrophic coverage for people with high drug costs. In order to qualify for catastrophic coverage, you must spend **$7,050** out-of-pocket during 2022. When the total amount you have paid for your Cost Share reaches **$7,050**, you will pay the following for the remainder of 2022:

- **a $3 Copayment** per prescription for insulin administration devices and generic drugs
- **a $10 Copayment** per prescription for brand-name and specialty drugs
- Injectable Part D vaccines: **no charge**
- Emergency contraceptive pills: **no charge**

Note: Each year, effective on January 1, the Centers for Medicare & Medicaid Services may change coverage thresholds and catastrophic coverage Copayments that apply for the calendar year. We will notify you in advance of any change to your coverage.

These payments <u>are</u> included in your out-of-pocket costs. When you add up your out-of-pocket costs, you can include the payments listed below (as long as they are for Part D covered drugs and you followed the rules for drug coverage that are explained in this "Outpatient Prescription Drugs, Supplies, and Supplements" section):

- The amount you pay for drugs when you are in the Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare prescription drug plan before you joined our Plan

It matters who pays:

- If you make these payments yourself, they are included in your out-of-pocket costs
- These payments are also included if they are made on your behalf by certain other individuals or organizations. This includes payments for your drugs made by a friend or relative, by most charities, by AIDS drug assistance programs, or by the Indian Health Service. Payments made by Medicare's Extra Help Program are also included

These payments are not included in your out-of-pocket costs. When you add up your out-of-pocket costs, you are not allowed to include any of these types of payments for prescription drugs:

- The amount you contribute, if any, toward your group's Premium
- Drugs you buy outside the United States and its territories
- Drugs that are not covered by our Plan
- Drugs you get at an out-of-network pharmacy that do not meet our Plan's requirements for out-of-network coverage
- Prescription drugs covered by Part A or Part B
- Payments you make toward prescription drugs not normally covered in a Medicare prescription drug plan
- Payments for your drugs that are made or funded by group health plans, including employer health plans
- Payments for your drugs that are made by certain insurance plans and government-funded health programs such as TRICARE and Veterans Affairs
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)

Reminder: If any other organization such as the ones described above pays part or all of your out-of-pocket costs for Part D drugs, you are required to tell our Plan. Call our Member Service Contact Center to let us know (phone numbers are on the cover of this *EOC*).

Keeping track of Medicare Part D drugs. The *Part D Explanation of Benefits* is a document you will get for each month you use your Part D prescription drug coverage. The *Part D Explanation of Benefits* will tell you the total amount you, or others on your behalf, have spent on your prescription drugs and the total amount we have paid for your prescription drugs. A *Part D Explanation of Benefits* is also available upon request from our Member Service Contact Center.

Medicare's "Extra Help" Program

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

People with limited income and resources may qualify for "Extra Help." Some people automatically qualify for "Extra Help" and don't need to apply. Medicare mails a letter to people who automatically qualify for "Extra Help."

You may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week;
- The Social Security Office at **1-800-772-1213** (TTY users call **1-800-325-0778**), 7 a.m. to 7 p.m., Monday through Friday (applications); or
- Your state Medicaid office (applications). See the "Important Phone Numbers and Resources" section for contact information

If you believe you have qualified for "Extra Help" and you believe that you are paying an incorrect Cost Share amount when you get your prescription at a Plan Pharmacy, our plan has established a process that allows you either to request assistance in obtaining evidence of your proper Cost Share level, or, if you already have the evidence, to provide this evidence to us. If you aren't sure what evidence to provide us, please contact a Plan Pharmacy or our Member Service Contact Center. The evidence is often a letter from either your state Medicaid or Social Security office that confirms you are 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 Plan Pharmacy when obtaining covered Part D prescriptions so that we may charge you the appropriate Cost Share amount until the Centers for Medicare & Medicaid Services updates its records to reflect your current status. Once the Centers for Medicare & Medicaid Services updates its records, you will no longer need to present the evidence to the Plan Pharmacy. Please provide your evidence in one of the following ways so we can forward it to the Centers for Medicare & Medicaid Services for updating:

- Write to Kaiser Permanente at:
  California Service Center
  Attn: Best Available Evidence
  P.O. Box 232407
  San Diego, CA 92193-2407
- Fax it to **1-877-528-8579**
- Take it to a Plan Pharmacy or your local Member Services office at a Plan Facility

When we receive the evidence showing your Cost Share level, we will update our system so that you can pay the correct Cost Share when you get your next prescription at our Plan Pharmacy. If you overpay your Cost Share, we will reimburse you. Either we will forward a check to you in the amount of your overpayment or we will offset future Cost Share. If our Plan Pharmacy hasn't collected a Cost Share from you and is carrying your Cost Share as a debt owed by you, we may make the payment directly to our Plan Pharmacy. If a state paid on your behalf, we may make payment directly to the state. Please call our Member Service Contact Center if you have questions.

If you qualify for "Extra Help," we will send you an *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*), that explains your costs as a Member of our plan. If the amount of your "Extra Help" changes during the year, we will also mail you an updated *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs*.

Medicare Part D drug formulary *(2022 Comprehensive Formulary)*

Our Medicare Part D formulary is a list of covered drugs selected by our plan in consultation with a team of health care providers that represents the drug therapies believed to be a necessary part of a quality treatment program. Our formulary must meet requirements set by Medicare and is approved by Medicare. Our formulary includes drugs that can be covered under Medicare Part D according to Medicare requirements. For a complete, current listing of the Medicare Part D prescription drugs we cover, please visit our website at kp.org/seniorrx or call our Member Service Contact Center.

The presence of a drug on our formulary does not necessarily mean that your Plan Physician will prescribe it for a particular medical condition. Our drug formulary guidelines allow you to obtain Medicare Part D prescription drugs if a Plan Physician determines that they are Medically Necessary for your condition. If you disagree with your Plan Physician's determination, refer to "Your Part D Prescription Drugs: How to Ask for a Coverage Decision or Make an Appeal" in the "Coverage Decisions, Appeals, and Complaints" section.

Continuity drugs. If this *EOC* is amended to exclude a drug that we have been covering and providing to you under this *EOC*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the Federal Food and Drug Administration.

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.

Preferred generic and generic drugs listed in the formulary will be subject to the generic drug Copayment or Coinsurance listed under "Copayment and Coinsurance for Medicare Part D drugs" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section. Preferred and nonpreferred brand-name drugs and specialty tier drugs listed in the formulary will be subject to the brand-name Copayment or Coinsurance listed under "Copayment and Coinsurance for Medicare Part D drugs" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section. Please note that sometimes a drug may appear more than once on our *2022 Comprehensive Formulary*. This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

You can get updated information about the drugs our plan covers by visiting our website at kp.org/seniorrx. You may also call our Member Service Contact Center to find out if your drug is on the formulary or to request an updated copy of our formulary.

We may make certain changes to our formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. The kinds of formulary changes we may make include:

- Adding or removing drugs from the formulary
- Adding prior authorizations or other restrictions on a drug

If we remove drugs from the formulary or add prior authorizations or restrictions on a drug, and you are taking the drug affected by the change, you will be permitted to continue receiving that drug at the same level of Cost Share for the remainder of the calendar year. However, if a brand-name drug is replaced with a new generic drug, or our formulary is changed as a result of new information on a drug's safety or effectiveness, you may be affected by this change. We will notify you of the change at least 30 days before the date that the change becomes effective or provide you with at least a

month's supply at the Plan Pharmacy. This will give you an opportunity to work with your physician to switch to a different drug that we cover or request an exception. (If a drug is removed from our formulary because the drug has been recalled, we will not give 30 days' notice before removing the drug from the formulary. Instead, we will remove the drug immediately and notify members taking the drug about the change as soon as possible.)

If your drug isn't listed on your copy of our formulary, you should first check the formulary on our website, which we update when there is a change. In addition, you may call our Member Service Contact Center to be sure it isn't covered. If Member Services confirms that we don't cover your drug, you have two options:

- You may ask your Plan Physician if you can switch to another drug that is covered by us
- You or your Plan Physician may ask us to make an exception (a type of coverage determination) to cover your Medicare Part D drug. See the "Coverage Decisions, Complaints, and Appeals" section for more information on how to request an exception

Transition policy. If you recently joined our plan, you may be able to get a temporary supply of a Medicare Part D drug you were previously taking that may not be on our formulary or has other restrictions, during the first 90 days of your membership. Current members may also be affected by changes in our formulary from one year to the next. Members should talk to their Plan Physicians to decide if they should switch to a different drug that we cover or request a Part D formulary exception in order to get coverage for the drug. Refer to our formulary or our website, kp.org/seniorrx, for more information about our Part D transition coverage.

Medicare Part D exclusions (non–Part D drugs). By law, certain types of drugs are not covered by Medicare Part D. If a drug is not covered by Medicare Part D, any amounts you pay for that drug will not count toward reaching the Catastrophic Coverage Stage. A Medicare Prescription Drug Plan can't cover a drug under Medicare Part D in the following situations:

- The drug would be covered under Medicare Part A or Part B
- Drug purchased outside the United States and its territories
- Off-label uses (meaning for uses other than those indicated on a drug's label as approved by the federal Food and Drug Administration) of a prescription drug, except in cases where the use is supported by certain reference books. Congress specifically listed the reference books that list whether the off-label use would be permitted. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.) If the use is not supported by one of these references, known as compendia, then the drug is considered a non–Part D drug and cannot be covered under Medicare Part D coverage

In addition, by law, certain types of drugs or categories of drugs are not covered under Medicare Part D. These drugs include:

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

Note: In addition to the coverage provided under this Medicare Part D plan, you also have coverage for non–Part D drugs described under "Home infusion therapy," "Outpatient drugs covered by Medicare Part B," "Certain intravenous drugs, supplies, and supplements," and "Outpatient drugs, supplies, and supplements not covered by Medicare" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section. If a drug is not covered under Medicare Part D, refer to those headings for information about your non–Part D drug coverage.

Other prescription drug coverage. If you have additional health care or drug coverage from another plan, you must provide that information to our plan. The information you provide helps us calculate how much you and others have paid for your prescription drugs. In addition, if you lose or gain additional health care or prescription drug coverage, please call our Member Service Contact Center to update your membership records.

Home infusion therapy

We cover home infusion supplies and drugs at **no charge** 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

Outpatient drugs covered by Medicare Part B In addition to Medicare Part D drugs, we also cover the limited number of outpatient prescription drugs that are covered by Medicare Part B. The following are the types of drugs that Medicare Part B covers:

- Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services
- Drugs you take using durable medical equipment (such as nebulizers) that were prescribed by a Plan Physician
- Clotting factors you give yourself by injection if you have hemophilia
- Immunosuppressive drugs, if Medicare paid for the transplant (or a group plan was required to pay before Medicare paid for it)
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Antigens
- Certain oral anticancer drugs and antinausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when Medically Necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases

Your Cost Share for Medicare Part B drugs. You pay the following for Medicare Part B drugs:

- Generic drugs: **a $10 Copayment for up to a 100-day supply**
- Brand-name drugs, specialty drugs, and compounded products: **a $35 Copayment for up to a 100-day supply**

Certain intravenous drugs, supplies, and supplements

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

Outpatient drugs, supplies, and supplements not covered by Medicare

If a drug, supply, or supplement is not covered by Medicare Part B or D, we cover the following additional items in accord with our non–Part D drug formulary:

- Drugs for which a prescription is required by law that are not covered by Medicare Part B or D. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary applicable to non–Part D items
- Diaphragms, cervical caps, contraceptive rings, and contraceptive patches
- Disposable needles and syringes needed for injecting covered drugs, pen delivery devices, and visual aids required to ensure proper dosage (except eyewear), that are not covered by Medicare Part B or D
- Inhaler spacers needed to inhale covered drugs
- Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing
- FDA-approved medications for tobacco cessation, including over-the-counter medications when prescribed by a Plan Physician

Your Cost Share for other outpatient drugs, supplies, and supplements not covered by Medicare. Your Cost Share for these items is as follows:

- Generic items (that are not described elsewhere in this *EOC*): **a $10 Copayment for up to a 100-day supply**
- Brand-name items, specialty drugs, and compounded products (that are not described elsewhere in this *EOC*): **a $35 Copayment for up to a 100-day supply**
- Drugs prescribed for the treatment of sexual dysfunction disorders: **25 percent Coinsurance for up to a 100-day supply**
- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria) and elemental dietary enteral formula when used as a primary therapy for regional enteritis: **no charge** for up to a 30-day supply

- Diabetes urine-testing supplies: **no charge** for up to a 100-day supply
- Tobacco cessation drugs: **no charge**. For over-the-counter medications, we cover up to two 100-day supplies per calendar year

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

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, selects drugs for the drug formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature. The Pharmacy and Therapeutics Committee meets at least quarterly to consider additions and deletions based on new information or drugs that become available. To find out which drugs are on the formulary for your plan, please visit our website at kp.org/formulary. If you would like to request a copy of the non–Part D drug formulary for your plan, please call our Member Service Contact Center. Note: The presence of a drug on the drug formulary does not 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 the "Coverage Decisions, Appeals, and Complaints" section. Also, our non–Part D formulary guidelines may require you to participate in a behavioral intervention program approved by the Medical Group for specific conditions and you may be required to pay for the program.

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 "Outpatient drugs, supplies, and supplements not covered by Medicare" 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 does not cover the entire amount of your Cost Share for your prescription. Certain health plan coverages are not eligible for coupons. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at kp.org/rxcoupons.

Drug utilization review

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

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

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

Drug management program

We have a program that can help make sure our members safely use their prescription opioid medications, or other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide you are at risk for misusing or abusing your opioid or benzodiazepine medications, we may limit how you can get those medications. The limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one pharmacy.
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one doctor.

- Limiting the amount of opioid or benzodiazepine medications we will cover for you.

If we decide that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the terms of the limitations we think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use. If you think we made a mistake or you disagree with our determination that you are at-risk for prescription drug abuse or the limitation, you and your prescriber have the right to ask us for an appeal. See the "Coverage Decisions, Appeals, and Complaints" section for information about how to ask for an appeal.

The DMP may not apply to you if you have certain medical conditions, such as cancer, you are receiving hospice, palliative, or end-of-life care, or you live in a long-term care facility.

Medication therapy management program

We offer a medication therapy management program at no additional cost to Members who have multiple medical conditions, who are taking many prescription drugs, and who have high drug costs. This program was developed for us by a team of pharmacists and doctors. We use this medication therapy management program to help us provide better care for our members. For example, this program helps us make sure that you are using appropriate drugs to treat your medical conditions and help us identify possible medication errors.

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

ID card at Plan Pharmacies

You must present your Kaiser Permanente ID card when obtaining covered items from Plan Pharmacies, including those that are not owned and operated by Kaiser Permanente. If you do not have your ID card, the Plan Pharmacy may require you to pay Charges for your covered items, and you will have to file a claim for reimbursement as described in the "Requests for Payment" section.

Notes:

- If Charges for a covered item are less than the Copayment, you will pay the lesser amount
- Durable medical equipment used to administer drugs, such as diabetes insulin pumps (and their supplies) and diabetes blood-testing equipment (and their supplies) are not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section (instead, refer to "Durable Medical Equipment ("DME") for Home Use" in this "Benefits and Your Cost Share" section)
- Except for vaccines covered by Medicare Part D, drugs administered to you in a Plan Medical Office or during home visits are not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section (instead, refer to "Outpatient Care" in this "Benefits and Your Cost Share" section)
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility are not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section (instead, refer to "Hospital Inpatient Care" and "Skilled Nursing Facility Care" in this "Benefits and Your Cost Share" section)

Outpatient prescription drugs, supplies, and supplements limitations

Day supply limit. Plan Physicians determine the amount of a drug or other item that is Medically Necessary for a particular day supply for you. Upon payment of the Cost Share specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section, you will receive the supply prescribed up to a 100-day supply in a 100-day period. However, the Plan Pharmacy may reduce the day supply dispensed to a 30-day supply in any 30-day period at the Cost Share listed in this "Outpatient Prescription Drugs, Supplies, and Supplements" section if the Plan Pharmacy determines that the drug is in limited supply in the market or a 31-day supply in any 31-day period if the item is dispensed by a long term care facility's pharmacy. Plan Pharmacies may also limit the quantity dispensed as described under "Utilization management." If you wish to receive more than the covered day supply limit, then the additional amount is not covered and you must pay Charges for any prescribed quantities that exceed the day supply limit. The amount you pay for noncovered drugs does not count toward reaching the Catastrophic Coverage Stage.

Utilization management. For certain items, we have additional coverage requirements and limits that help promote effective drug use and help us control drug plan costs. Examples of these utilization management tools are:

- **Quantity limits:** The Plan Pharmacy may reduce the day supply dispensed at the Cost Share specified in this "Outpatient Drugs, Supplies, and Supplements" section to a 30-day supply or less in any 30-day period for specific drugs. Your Plan Pharmacy can tell you if a drug you take is one of these drugs. In addition, we cover episodic drugs prescribed for the

treatment of sexual dysfunction up to a maximum of eight doses in any 30-day period, up to 16 doses in any 60-day period, or up to 27 doses in any 100-day period. Also, when there is a shortage of a drug in the marketplace and the amount of available supplies, we may reduce the quantity of the drug dispensed accordingly and charge one cost share

- **Generic substitution:** When there is a generic version of a brand-name drug available, Plan Pharmacies will automatically give you the generic version, unless your Plan Physician has specifically requested a formulary exception because it is Medically Necessary for you to receive the brand-name drug instead of the formulary alternative

Outpatient prescription drugs, supplies, and supplements exclusions

- Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging
- Compounded products unless the active ingredient in the compounded product is listed on one of our drug formularies
- Drugs prescribed to shorten the duration of the common cold
- Prescription drugs for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the prescription drug). This exclusion does not 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

Preventive Services

We cover a variety of Preventive Services in accord with Medicare guidelines. The list of Preventive Services is subject to change by the Centers for Medicare & Medicaid Services. These Preventive Services are subject to all coverage requirements described in this "Benefits and Your Cost Share" section and all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. If you have questions about Preventive Services, please call our Member Service Contact Center.

Note: If you receive any other covered Services that are not Preventive Services during or subsequent to a visit that includes Preventive Services on the list, you will pay the applicable Cost Share for those other Services. For example, if laboratory tests or imaging Services ordered during a preventive office visit are not Preventive Services, you will pay the applicable Cost Share for those Services.

Your Cost Share. You pay the following for covered Preventive Services:

- Abdominal aortic aneurysm screening prescribed during the one-time "Welcome to Medicare" preventive visit: **no charge**
- Annual Wellness visit: **no charge**
- Bone mass measurement: **no charge**
- Breast cancer screening (mammograms): **no charge**
- Cardiovascular disease risk reduction visit (therapy for cardiovascular disease): **no charge**
- Cardiovascular disease testing: **no charge**
- Cervical and vaginal cancer screening: **no charge**
- Colorectal cancer screening, including flexible sigmoidoscopies, colonoscopies, and fecal occult blood tests: **no charge**
- Depression screening: **no charge**
- Diabetes screening, including fasting glucose tests: **no charge**
- Diabetes self-management training: **no charge**
- Glaucoma screening: **no charge**
- HIV screening: **no charge**
- Immunizations (including the vaccine) covered by Medicare Part B such as COVID-19, Hepatitis B, influenza, and pneumococcal vaccines that are administered to you in a Plan Medical Office: **no charge**
- Lung cancer screening: **no charge**
- Medical nutrition therapy for kidney disease and diabetes: **no charge**
- Medicare diabetes prevention program: **no charge**
- Obesity screening and therapy to promote sustained weight loss: **no charge**
- Prostate cancer screening exams, including digital rectal exams and Prostate Specific Antigens (PSA) tests: **no charge**
- Screening and counseling to reduce alcohol misuse: **no charge**
- Screening for sexually transmitted infections (STIs) and counseling to prevent STIs: **no charge**

- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use): **no charge**
- "Welcome to Medicare" preventive visit: **no charge**

Prosthetic and Orthotic Devices

Prosthetic and orthotic devices coverage rules

We cover the prosthetic and orthotic devices specified in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor that we select
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage includes fitting and adjustment of these devices, their repair or replacement, and Services to determine whether you need a prosthetic or orthotic device. If we cover a replacement device, then you pay the Cost Share that you would pay for obtaining that device.

Base prosthetic and orthotic devices

If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the items described in this "Base prosthetic and orthotic devices" section.

Internally implanted devices. We cover prosthetic and orthotic devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, in accord with Medicare guidelines, if they are implanted during a surgery that we are covering under another section of this "Benefits and Your Cost Share" section. We cover these devices at **no charge**.

External devices. We cover the following external prosthetic and orthotic devices at **20 percent Coinsurance**:

- Prosthetics and orthotics in accord with Medicare guidelines. These include, but are not limited to, braces, prosthetic shoes, artificial limbs, and therapeutic footwear for severe diabetes-related foot disease in accord with Medicare guidelines
- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- After Medically Necessary removal of all or part of a breast, prosthesis including custom-made prostheses when Medically Necessary
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Enteral pump and supplies
- Tracheostomy tube and supplies
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect

Other covered prosthetic and orthotic devices

- If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the following items described in this "Other covered prosthetic and orthotic devices" section:
- Prosthetic devices required to replace all or part of an organ or extremity, in accord with Medicare guidelines
- Vacuum erection device for sexual dysfunction
- Certain surgical boots following surgery when provided during an outpatient visit
- Orthotic devices required to support or correct a defective body part, in accord with Medicare guidelines

Your Cost Share. You pay the following for other covered prosthetic and orthotic devices: **20 percent Coinsurance**.

For the following Services, refer to these sections

- Eyeglasses and contact lenses, including contact lenses to treat aniridia or aphakia (refer to "Vision Services")

- Eyewear following cataract surgery (refer to "Vision Services")
- Hearing aids other than internally implanted devices described in this section (refer to "Hearing Services")
- Injectable implants (refer to "Administered drugs and products" under "Outpatient Care")

Prosthetic and orthotic devices exclusion(s)

- Dental appliances
- Nonrigid supplies not covered by Medicare, such as elastic stockings and wigs, except as otherwise described above in this "Prosthetic and Orthotic Devices" section and the "Ostomy, Urological, and Wound Care Supplies" section
- Comfort, convenience, or luxury equipment or features
- Repair or replacement of device due to misuse
- Shoes, shoe inserts, arch supports, or any other footwear, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications
- Prosthetic and orthotic devices not intended for maintaining normal activities of daily living (including devices intended to provide additional support for recreational or sports activities)
- Nonconventional intraocular lenses (IOLs) following cataract surgery (for example, presbyopia-correcting IOLs). You may request and we may provide insertion of presbyopia-correcting IOLs or astigmatism-correcting IOLs following cataract surgery in lieu of conventional IOLs. However, you must pay the difference between Charges for nonconventional IOLs and associated services and Charges for insertion of conventional IOLs following cataract surgery

Reconstructive Surgery

We cover the following reconstructive surgery Services:

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

Your Cost Share. You pay the following for covered reconstructive surgery Services:

- Outpatient surgery and outpatient procedures when provided in an outpatient 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: **a $15 Copayment per procedure**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a $15 Copayment per procedure**
- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Cost Share that would otherwise apply for the procedure** in this "Benefits and Your Cost Share" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Hospital inpatient care (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services): **no charge**

For the following Services, refer to these sections

- Office visits not described in this "Reconstructive Surgery" section (refer to "Outpatient Care")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Telehealth Visits (refer to "Telehealth Visits")

Reconstructive surgery exclusion(s)

- Surgery that, in the judgment of a Plan Physician specializing in reconstructive surgery, offers only a minimal improvement in appearance

Religious Nonmedical Health Care Institution Services

Care in a Medicare-certified Religious Nonmedical Health Care Institution (RNHCI) is covered by our Plan under certain conditions. Covered Services in an RNHCI are limited to nonreligious aspects of care. To be eligible for covered Services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital or Skilled Nursing Facility care. You may get Services furnished in the home, but only items and Services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "nonexcepted" medical treatment. ("Excepted" medical treatment is a Service or treatment that you receive involuntarily or that is required under federal, state, or local law. "Nonexcepted" medical treatment is any other Service or treatment.) Your stay in the RNHCI is not covered by us unless you obtain authorization (approval) in advance from us.

Note: Covered Services are subject to the same limitations and Cost Share required for Services provided by Plan Providers as described in this "Benefits and Your Cost Share" section.

Services Associated with Clinical Trials

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

If you want to participate in a Medicare-approved clinical trial, you don't need to get a referral from a Plan Provider, and the providers that deliver your care as part of the clinical trial don't need to be Plan Providers. Although you don't need to get a referral from a Plan Provider, you do need to tell us before you start participating in a clinical trial so we can keep track of your Services.

Once you join a Medicare-approved clinical trial, you are covered for routine Services you receive as part of the trial. Routine Services include room and board for a hospital stay that Medicare would pay for even if you weren't in a trial, an operation or other medical procedure if it is part of the trial, and treatment of side effects and complications arising from the new care.

Original Medicare pays most of the cost of the covered Services you receive as part of the trial. After Medicare has paid its share of the cost for these Services, we will pay the difference between the cost share of Original Medicare and your Cost Share as a Member of our plan. This means you will pay the same amount for the routine Services you receive as part of the trial as you would if you received these Services from our plan.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the trial and how much you owe. Please see the "Requests for Payment" section for more information about submitting requests for payment.

To learn more about joining a clinical trial, refer to the "Medicare and Clinical Research Studies" brochure. To get a free copy, call Medicare directly toll free at **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week, or visit https://www.medicare.gov on the Web.

Services associated with clinical trials exclusion(s)

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

- The new item or service that the study is testing, unless Medicare would cover the item or service even if you were not in a study
- Items or services provided only to collect data, and not used in your direct health care
- Services that are customarily provided by the research sponsors free of charge to enrollees in the clinical trial
- Items and services provided solely to determine trial eligibility

Skilled Nursing Facility Care

Inside our Service Area, we cover up to 100 days per benefit period of skilled inpatient Services in a Plan Skilled Nursing Facility and in accord with Medicare guidelines. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

A benefit period begins on the date you are admitted to a hospital or Skilled Nursing Facility at a skilled level of care (defined in accord with Medicare guidelines). A benefit period ends on the date you have not been an inpatient in a hospital or Skilled Nursing Facility,

receiving a skilled level of care, for 60 consecutive days. A new benefit period can begin only after any existing benefit period ends. A prior three-day stay in an acute care hospital is not required. Note: If your Cost Share changes during a benefit period, you will continue to pay the previous Cost Share amount until a new benefit period begins.

We cover the following Services:

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

Your Cost Share. We cover these Skilled Nursing Facility Services at **no charge**.

For the following Services, refer to these sections

- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")

Non–Plan Skilled Nursing Facility care

Generally, you will get your Skilled Nursing Facility care from Plan Facilities. However, under certain conditions listed below, you may be able to receive covered care from a non–Plan facility, if the facility accepts our Plan's amounts for payment.

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides Skilled Nursing Facility care)
- A Skilled Nursing Facility where your spouse is living at the time you leave the hospital

Substance Use Disorder Treatment

We cover Services specified in this "Substance Use Disorder Treatment" section only when the Services are for the diagnosis or treatment of Substance Use Disorders. A "Substance Use Disorder" is a condition identified as a "substance use disorder" in the most recently issued edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM").

Outpatient substance use disorder treatment

We cover the following Services for treatment of substance use disorders:

- Day-treatment programs
- Individual and group substance use disorder counseling
- Intensive outpatient programs
- Medical treatment for withdrawal symptoms

Your Cost Share. You pay the following for these covered Services:

- Individual substance use disorder evaluation and treatment: **a $15 Copayment per visit**
- Group substance use disorder treatment: **a $5 Copayment per visit**
- Intensive outpatient and day-treatment programs: **a $5 Copayment per day**

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized substance use disorder treatment, the Services are generally and customarily provided by a substance use disorder residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group substance use disorder counseling
- Medical services
- Medication monitoring
- Room and board
- Drugs prescribed by a Plan 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 (for discharge drugs prescribed when you

are released from the residential treatment facility, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section)

- Discharge planning

Your Cost Share. We cover residential substance use disorder treatment Services at **no charge**.

Inpatient detoxification

We cover hospitalization in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

Your Cost Share. We cover inpatient detoxification Services at **no charge**.

For the following Services, refer to these sections

- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient self-administered drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Telehealth Visits (refer to "Telehealth Visits")

Telehealth Visits

Telehealth Visits between you and your provider are intended to make it more convenient for you to receive covered Services, when a Plan Provider determines it is medically appropriate for your medical condition. You have the option of receiving these services either through an in-person visit or via telehealth. You may receive covered Services via Telehealth Visits, when available and if the Services would have been covered under this *EOC* if provided in person. If you choose to receive Services via telehealth, then you must use a Plan Provider that currently offers the service via telehealth. We offer the following telehealth Services:

- 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 for diagnosis, evaluation or treatment of symptoms of an acute stroke
- Virtual check-ins (for example, by phone or video chat) with your doctor for 5 to 10 minutes if all of the following are true:
  - you're not a new patient
  - the check-in isn't related to an office visit within the past 7 days
  - 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 (except weekends and holidays) if all of the following are true:
  - you're not a new patient
  - the check-in isn't related to an office visit within the past 7 days
  - the check-in 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—if you are an established patient

Your Cost Share. You pay the following types for Telehealth Visits with Primary Care Physicians, Non-Physician Specialists, and Physician Specialists:

- Interactive video visits: **no charge**
- Scheduled telephone visits: **no charge**

Transplant Services

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

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

- If either the Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will only cover Services you receive before that determination is made
- Health Plan, Plan Hospitals, the Medical Group, and Plan Physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with our guidelines for Services for living transplant donors, we provide certain donation-related Services for a donor, or an individual identified by the Medical Group as a potential donor, whether or not the donor is a Member. These Services must be directly related to a covered transplant for you, which may include certain Services for harvesting the organ, tissue, or bone marrow and for treatment of

complications. Please call our Member Service Contact Center for questions about donor Services

Your Cost Share. For covered transplant Services that you receive, you will pay the **Cost Share you would pay if the Services were not related to a transplant**. For example, see "Hospital Inpatient Care" in this "Benefits and Your Cost Share" section for the Cost Share that applies for hospital inpatient care.

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

For the following Services, refer to these sections

- Dental Services that are Medically Necessary to prepare for a transplant (refer to "Dental Services")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Vision Services

We cover the following:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction (including dilation Services when Medically Necessary) and to provide a prescription for eyeglass lenses: **a $15 Copayment per visit**
- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye: **a $15 Copayment per visit**
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye: **a $15 Copayment per visit**

Optical Services

We cover the Services described in this "Optical Services" section when received from Plan Medical Offices or Plan Optical Sales Offices.

The date we provide an Allowance toward (or otherwise cover) an item described in this "Optical Services" section is the date on which you order the item. For example, if we last provided an Allowance toward an item you ordered on May 1, 2020, and if we provide an Allowance not more than once every 24 months for that type of item, then we would not provide another Allowance toward that type of item until on or after May 1, 2022. You can use the Allowances under this "Optical Services" section only when you first order an item. If you use part but not all of an Allowance when you first order an item, you cannot use the rest of that Allowance later.

Eyeglasses and contact lenses following cataract surgery

We cover at **no charge** one pair of eyeglasses or contact lenses (including fitting or dispensing) following each cataract surgery that includes insertion of an intraocular lens at Plan Medical Offices or Plan Optical Sales Offices when prescribed by a physician or optometrist. When multiple cataract surgeries are needed, and you do not obtain eyeglasses or contact lenses between procedures, we will only cover one pair of eyeglasses or contact lenses after any surgery. If the eyewear you purchase costs more than what Medicare covers for someone who has Original Medicare (also known as "Fee-for-Service Medicare"), you pay the difference.

Special contact lenses

We cover the following:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist: **no charge**
- In accord with Medicare guidelines, we cover corrective lenses (including contact lens fitting and dispensing) and frames (and replacements) for Members who are aphakic (for example, who have had a cataract removed but do not have an implanted intraocular lens (IOL) or who have congenital absence of the lens): **no charge**
- For other specialty 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 (up to six months, including fitting and dispensing) in any 24 months at **no charge**

Eyeglasses and contact lenses

We provide a single **$150 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 Plan 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 Plan Provider puts two lenses (at least one of which must have refractive value) into the frame
- Contact lenses, fitting, and dispensing

We will not provide the Allowance if we have provided an Allowance toward (or otherwise covered) eyeglass lenses or frames within the previous 24 months.

Replacement lenses

If you have a change in prescription of at least .50 diopter in one or both eyes 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 will 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.

For the following Services, refer to these sections

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

Vision Services exclusion(s)

- Eyeglass or contact lens adornment, such as engraving, faceting, or jeweling
- Items that do not require a prescription by law (other than eyeglass frames), such as eyeglass holders, eyeglass cases, and repair kits
- Lenses and sunglasses without refractive value, except as described in this "Vision Services" section
- Low vision devices
- Replacement of lost, broken, or damaged contact lenses, eyeglass lenses, and frames

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this *EOC* regardless of whether the services are within the scope of a provider's license or certificate. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in this *EOC*. These exclusions or limitations do not apply to Services that are Medically Necessary to treat Severe Mental Illness or Serious Emotional Disturbance of a Child Under Age 18.

Certain exams and Services

Routine physical exams and other Services that are not Medically Necessary, such as when required (1) for obtaining or maintaining employment or participation in employee programs, (2) for insurance, credentialing or licensing, (3) for travel, or (4) by court order or for parole or probation.

Chiropractic Services

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

Cosmetic Services

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

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

Custodial care

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

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

Dental care

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

Disposable supplies

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

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

Experimental or investigational Services

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

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

Hair loss or growth treatment

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

Intermediate care

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

Items and services that are not health care items and services

For example, we do not cover:

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

Items and services to correct refractive defects of the eye

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

Massage therapy

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

Oral nutrition

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

This exclusion does not apply to any of the following:

- Amino acid–modified products and elemental dietary enteral formula covered under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section

☐ Enteral formula covered under "Prosthetic and Orthotic Devices" in the "Benefits and Your Cost Share" section

Residential care

Care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a Skilled Nursing Facility, inpatient respite care covered in the "Hospice Care" section for Members who do not have Part A, or residential treatment program Services covered in the "Substance Use Disorder Treatment" and "Mental Health Services" sections.

Routine foot care items and services

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

Services not approved by the federal Food and Drug Administration

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

Services and items not covered by Medicare

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

Services performed by unlicensed people

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

Services related to a noncovered Service

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

Surrogacy

Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. Refer to "Surrogacy arrangements" under "Reductions" in this "Exclusions, Limitations, Coordination of Benefits, and Reductions" section for information about your obligations to us in connection with a Surrogacy Arrangement, including your obligations to reimburse us for any Services we cover and to provide information about anyone who may be financially responsible for Services the baby (or babies) receive.

Travel and lodging expenses

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

Limitations

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

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

Coordination of Benefits

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

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

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

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

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

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

Reductions

Employer responsibility

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

Government agency responsibility

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

Injuries or illnesses alleged to be caused by third parties

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

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

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain against a third party that results in any settlement proceeds or judgment, from other types of coverage that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, 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:

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

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

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

Surrogacy arrangements

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

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

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

You must send this information to:

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

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy arrangements" section and to satisfy those rights. You may not agree to waive, release, or reduce our rights

under this "Surrogacy arrangements" section without our prior, written consent.

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

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

U.S. Department of Veterans Affairs

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

Workers' compensation or employer's liability benefits

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

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

Requests for Payment

Requests for Payment of Covered Services or Part D drugs

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

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

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

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

- **When you've received emergency, urgent, or dialysis care from a Non–Plan Provider.** You can receive emergency services from any provider, whether or not the provider is a Plan Provider. When you receive emergency, urgent, or dialysis care from a Non–Plan Provider, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill our plan for our share of the cost
  - if you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made
  - at times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made
  - if the provider is owed anything, we will pay the provider directly
  - if you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost

- **When a Plan Provider sends you a bill you think you should not pay.** Plan Providers should always bill us directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share
  - you only have to pay your Cost Share amount when you get Services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your Cost Share amount) applies even if we pay the provider less than the provider charges for a service, and even if there is a dispute and we don't pay certain provider charges
  - whenever you get a bill from a Plan Provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem
  - if you have already paid a bill to a Plan Provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan
- **If you are retroactively enrolled in our plan.** Sometimes a person's enrollment in our plan is retroactive. ("Retroactive" means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.) If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered Services or Part D drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement. Please call our Member Service Contact Center for additional information about how to ask us to pay you back and deadlines for making your request
- **When you use a Non–Plan Pharmacy to get a prescription filled.** If you go to a Non–Plan Pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. We cover prescriptions filled at Non–Plan Pharmacies only in a few special situations. Please see "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section to learn more
  - save your receipt and send a copy to us when you ask us to pay you back for our share of the cost
- **When you pay the full cost for a prescription because you don't have your plan membership card with you.** If you do not have your plan membership card with you, you can ask the pharmacy to call us or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself
  - save your receipt and send a copy to us when you ask us to pay you back for our share of the cost
- **When you pay the full cost for a prescription in other situations.** You may pay the full cost of the prescription because you find that the drug is not covered for some reason
  - for example, the drug may not be on our *2022 Comprehensive Formulary*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it
  - save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost
- **When you pay copayments under a drug manufacturer patient assistance program.** If you get help from, and pay copayments under, a drug manufacturer patient assistance program outside our plan's benefit, you may submit a paper claim to have your out-of-pocket expense count toward qualifying you for catastrophic coverage
  - save your receipt and send a copy to us

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

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

How and where to send us your request for payment

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

- As soon as possible, request our claim form by calling our Member Service Contact Center toll free at **1-800-443-0815** or **1-800-390-3510** (TTY users call **711**). One of our representatives will be happy to assist you if you need help completing our claim form
- If you have paid for services, you must send us your request for reimbursement. Please attach any bills and receipts from the Non–Plan Provider

- You must complete and return to us any information that we request to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled. For example, we may require documents such as travel documents or original travel tickets to validate your claim
- The completed claim form must be mailed to the following address as soon as possible, but no later than 15 months after receiving the care (or up to 27 months according to Medicare rules, in some cases). Please do not send any bills or claims to Medicare. Any additional information we request should also be mailed to this address:
  Kaiser Permanente
  Claims Administration - NCAL
  P.O. Box 12923
  Oakland, CA 94604-2923

Note: If you are requesting payment of a Part D drug that was prescribed by a Plan Provider and obtained from a Plan Pharmacy, write to:
Kaiser Foundation Health Plan, Inc.
Part D Unit
P.O. Box 23170
Oakland, CA 94623-0170

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

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

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

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

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

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

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

For the details about how to make this appeal, go to the "Coverage Decisions, Appeals, and Complaints" section. The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading "A Guide to the Basics of Coverage Decisions and Appeals" in the "Coverage Decisions, Appeals, and Complaints" section, which is an introductory section that explains the process for coverage decisions and appeals and gives you definitions of terms such as "appeal." Then, after you have read "A Guide to the Basics of Coverage Decisions and Appeals," you can go to the section in "Coverage Decisions, Appeals, and Complaints" that tells you what to do for your situation:

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

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

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

There are some situations when you should let us know about payments you have made for your covered Part D prescription drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket

costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

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

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

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

Your Rights and Responsibilities

We must honor your rights as a Member of our plan

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

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

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

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

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

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

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

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

As a Member of our plan, you have the right to choose a primary care provider (PCP) in our network to provide and arrange for your covered services (the "How to Obtain Services" section explains more about this). Call our Member Service Contact Center to learn which doctors are accepting new patients. You also have the right to go to a women's health specialist (such as a

gynecologist), a mental health services provider, and an optometrist without a referral, as well as other providers described in the "How to Obtain Services" section.

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

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

We must protect the privacy of your personal health information

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

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

How do we protect the privacy of your health information?

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

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

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

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

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

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

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

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

- **Information about our plan.** This includes, for example, information about our plan's financial condition. It also includes information about the number of appeals made by Members and our plan's performance ratings, including how it has been rated by Members and how it compares to other Medicare health plans
- **Information about our network providers, including our network pharmacies**
  - for example, you have the right to get information from us about the qualifications of the providers

and pharmacies in our network and how we pay the providers in our network
  - for a list of the providers in our network, see the *Provider Directory*
  - for a list of the pharmacies in our network, see the *Pharmacy Directory*
  - for more detailed information about our providers or pharmacies, you can call our Member Service Contact Center or visit our website at kp.org/directory
- **Information about your coverage and the rules you must follow when using your coverage**
  - in the "How to Obtain Services" and "Benefits and Your Cost Share" sections, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services
  - to get the details about your Part D prescription drug coverage, see "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section plus our plan's *Drug List.* That section, together with the *Drug List*, tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs
  - if you have questions about the rules or restrictions, please call our Member Service Contact Center
- **Information about why something is not covered and what you can do about it**
  - if a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or Part D drug from an out-of-network provider or pharmacy
  - if you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see the "Coverage Decisions, Appeals, and Complaints" section. It gives you the details about how to make an appeal if you want us to change our decision. (it also tells you about how to make a complaint about quality of care, waiting times, and other concerns)
  - if you want to ask us to pay our share of a bill you have received for medical care or a Part D drug, see the "Request for Payments" section

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

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

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

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

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself
Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to

happen if you are in this situation. This means that, if you want to, you can:

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

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

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

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

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

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

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

What if your instructions are not followed?

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

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

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

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

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

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

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

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

Is it about something else?

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

- You can call our Member Service Contact Center
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to the "Important Phone Numbers and Resources" section

- Or you can call Medicare at **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week

How to get more information about your rights

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

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

Information about new technology assessments

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

You can make suggestions about rights and responsibilities

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

You have some responsibilities as a Member of our plan

What are your responsibilities?

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

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this *EOC* booklet to learn what is covered for you and the rules you need to follow to get your covered services
  - the "How to Obtain Services" and "Benefits and Your Cost Share" sections give details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay
  - the "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section gives details about your coverage for Part D prescription drugs
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us**. Please call our Member Service Contact Center to let us know
  - we are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "coordination of benefits" because it involves coordinating the health and drug benefits you get from us with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to the "Exclusion, Limitations, Coordination of Benefits, and Reductions" section)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D drugs
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care**
  - to help your doctors and other health care providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon
  - make sure you understand your health problems and participate in developing mutually agreed upon treatment goals with your providers whenever possible
  - make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements
  - if you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices

- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - in order to be eligible for our plan, you must have Medicare Part B. Most plan Members must pay a premium for Medicare Part B to remain a Member of our plan
  - for most of your Services or Part D drugs covered by our plan, you must pay your share of the cost when you get the Service or Part D drug. This will be a Copayment (a fixed amount) or Coinsurance (a percentage of the total cost). The "Benefits and Your Cost Share" section tells you what you must pay for your Services and Part D drugs
  - if you get any medical services or Part D drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost
  - if you disagree with our decision to deny coverage for a service or Part D drug, you can make an appeal. Please see the "Coverage Decisions, Appeals, and Complaints" section for information about how to make an appeal
  - if you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage
  - if you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a Member of our plan
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call our Member Service Contact Center
  - if you move outside of our Service Area, you cannot remain a Member of our plan. (The "Definitions" section tells you about our Service Area.) We can help you figure out whether you are moving outside our Service Area.
  - if you move within our Service Area, we still need to know so we can keep your membership record up-to-date and know how to contact you
  - if you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in the "Important Phone Numbers and Resources" section
- **Call our Member Service Contact Center for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan
  - phone numbers and calling hours for our Member Service Contact Center
  - for more information about how to reach us, including our mailing address, please see the "Important Phone Numbers and Resources" section

Coverage Decisions, Appeals, and Complaints

What to Do if You Have a Problem or Concern

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

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

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

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

Hospice care

If you have Medicare Part A, your hospice care is covered by Original Medicare and it is not covered under this *EOC*. Therefore, any complaints related to the coverage of hospice care must be resolved directly with Medicare and not through any complaint or appeal procedure discussed in this *EOC*. Medicare complaint and appeal procedures are described in the Medicare handbook Medicare & You, which is available from your local Social Security office, at https://www.medicare.gov, or by calling toll free **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week. If you do not have Medicare Part A, Original Medicare does not cover hospice care. Instead, we will provide hospice care, and any complaints related to hospice care are subject to this "Coverage Decisions, Appeals, and Complaints" section.

What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this

"Coverage Decisions, Appeals, and Complaints" section. Many of these terms are unfamiliar to most people and can be hard to understand.

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

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

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

Where to get more information and personalized assistance

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

Get help from an independent government organization

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

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

You can also get help and information from Medicare

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

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

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

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

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

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

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

A Guide to the Basics of Coverage Decisions and Appeals

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

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

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or Part D drugs. For example,

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

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

Making an appeal

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

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

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

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

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

- You can call our Member Service Contact Center (phone numbers are on the cover of this *EOC*)
- To can get free help from your State Health Insurance Assistance Program (see the "Important Phone Numbers and Resources" section)
- Your doctor can make a request for you
  - for medical care or Medicare Part B prescription drugs, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative
  - for Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative
- You can ask someone to act on your behalf. If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal
  - there may be someone who is already legally authorized to act as your representative under state law
  - if you want a friend, relative, your doctor or other provider, or other person to be your representative, call our Member Service Contact Center and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at kp.org.) The form gives that person permission to act on your behalf. It must be signed by you and by the person whom you would like to act on your behalf. You must give us a copy of the signed form
- You also have the right to hire a lawyer to act for you. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision

Which section gives the details for your situation?

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

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

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

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

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

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

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

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

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

Which of these situations are you in?

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

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

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

How to request coverage for the medical care you want

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

Generally we use the standard deadlines for giving you our decision

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

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

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

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

information about the process for making complaints, including fast complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section)

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

Deadlines for a "fast coverage decision"

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer within 72 hours. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours
  - as explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug
  - if you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section)
  - if we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), or within 24 hours if your request is for a Medicare Part B prescription drug, you have the right to appeal. "Step-by-step: How to make a Level 1 Appeal" below tells you how to make an appeal
- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the medical care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision on your request for a medical item or service, we will authorize or provide the coverage by the end of that extended period
- If our answer is ***no*** to part or all of what you requested, we will send you a detailed written explanation as to why we said ***no***

Deadlines for a "standard coverage decision"

- Generally, for a standard coverage decision on your request for a medical item or service, we will give you our answer within 14 calendar days of receiving your request. If your request is for a Medicare Part B prescription drug, we will give you an answer within 72 hours of receiving your request
  - for a request for a medical item or service, we can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug
  - if you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section)
  - if we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), or within 72 hours if your request is for a Medicare Part B prescription drug, you have the right to appeal. "Step-by-step: How to make a Level 1 Appeal" below tells you how to make an appeal
- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the medical care coverage we have agreed to provide within 14 calendar days, or 72 hours if your request is for a Part B prescription drug, after we received your request. If we extended the time needed to make our coverage decision on your request for a medical item or service, we will authorize or provide the coverage by the end of that extended period
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said ***no***

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

- If we say ***no***, you have the right to ask us to reconsider, and perhaps change this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want

- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see "Step-by-step: How to make a Level 1 Appeal" below)

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

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

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

What to do:

- To start an appeal, you, your doctor, or your representative must contact us. For details about how to reach us for any purpose related to your appeal, go to "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care" in the "Important Phone Numbers and Resources" section
- If you are asking for a standard appeal, make your standard appeal in writing by submitting a request
  - if you have someone appealing our decision for you other than your doctor, your appeal must include an "Appointment of Representative" form authorizing this person to represent you. To get the form, call our Member Service Contact Center and ask for the "Appointment of Representative" form. It is also available on Medicare's website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at kp.org. While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal
- If you are asking for a fast appeal, make your appeal in writing or call us (see "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care" in the "Important Phone Numbers and Resources" section)
- You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal
- You can ask for a copy of the information regarding your medical decision and add more information to support your appeal
  - you have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you
  - if you wish, you and your doctor may give us additional information to support your appeal

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

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

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

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

Deadlines for a "fast appeal"

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

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

- if we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process

- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal
- If our answer is ***no*** to part or all of what you requested, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal

Deadlines for a "standard appeal"

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

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

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

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

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

Step 1: The Independent Review Organization reviews your appeal

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

- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal

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

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

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

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

Step 2: The Independent Review Organization gives you their answer

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

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

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

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

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

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

Asking for reimbursement is asking for a coverage decision from us

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

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

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

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

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

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

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

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

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

Your benefits as a Member of our plan include coverage for many prescription drugs. Refer to our *2022 Comprehensive Formulary*. To be covered, the Part D drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the federal Food and Drug Administration or supported by certain reference books.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time
- For details about what we mean by Part D drugs, the *2022 Comprehensive Formulary*, rules and restrictions on coverage, and cost information, see "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section

Part D coverage decisions and appeals

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

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

- You ask us to make an exception, including:
  - asking us to cover a Part D drug that is not on our *2022 Comprehensive Formulary*
  - asking us to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. For example, when your drug is on our *2022*

Comprehensive Formulary, but we require you to get approval from us before we will cover it for you

  - note: if your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment

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

Which of these situations are you in?

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

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

What is a Part D exception?

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

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

- **Covering a Part D drug for you that is not on our *2022 Comprehensive Formulary.*** (We call it the "*Drug List"* for short.) Asking for coverage of a drug that is not on the *Drug List* is sometimes called asking for a "formulary exception"
  - if we agree to make an exception and cover a drug that is not on the *Drug List*, you will need to pay the Cost Share amount that applies to drugs in the brand-name drug tier. You cannot ask for an exception to the Copayment or Coinsurance amount we require you to pay for the drug
  - you cannot ask for coverage of any "excluded drugs" or other non–Part D drugs that Medicare does not cover. (For more information about excluded drugs, see "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section)
- **Removing a restriction on our coverage for a covered Part D drug**. There are extra rules or restrictions that apply to certain drugs on our *2022 Comprehensive Formulary* (for more information, go to "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section). Asking for a removal of a restriction on coverage for a drug is sometimes called asking for a "formulary exception"
  - the extra rules and restrictions on coverage for certain drugs include 1) being required to use the generic version of a drug instead of the brand-name drug, and 2) getting **plan approval in advance** before we will agree to cover the drug for you. (This is sometimes called "prior authorization")
  - if we agree to make an exception and waive a restriction for you, you can ask for an exception to the Copayment or Coinsurance amount we require you to pay for the Part D drug

Important things to know about asking for a Part D exception

Your doctor must tell us the medical reasons

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

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug

you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception. If you ask us for a tiering exception, we will generally not approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

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

- If we approve your request for a Part D exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition
- If we say ***no*** to your request for a Part D exception, you can ask for a review of our decision by making an appeal. The "Step-by-step: How to make a Level 1 Appeal" section tells how to make an appeal if we say no

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

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

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

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

What to do:

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

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

A "fast coverage decision" is called an "expedited coverage determination."

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement
- To get a fast coverage decision, you must meet two requirements:
  - you can get a fast coverage decision only if you are asking for a drug you have not yet received. (You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you have already bought)
  - you can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function
- If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision
- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support),

we will decide whether your health requires that we give you a fast coverage decision

- if we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead)
- this letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision
- the letter will also tell you how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells you how to file a "fast complaint," which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section

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

Deadlines for a "fast coverage decision"

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

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

- If we are using the standard deadlines, we must give you our answer within 72 hours
  - generally, this means within 72 hours after we receive your request. If you are requesting a Part D exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to
  - if we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2
- If our answer is ***yes*** to part or all of what you requested:
  - if we approve your request for coverage, we must provide the coverage we have agreed to provide within 72 hours after we receive your request or doctor's statement supporting your request
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal

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

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

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

- If we say ***no***, you have the right to request an appeal. Requesting an appeal means asking us to

reconsider—and possibly change—the decision we made

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

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

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

What to do:

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

If your health requires it, ask for a "fast appeal"

A "fast appeal" is also called an "expedited redetermination."

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

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

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

Deadlines for a "fast appeal"

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

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we receive your appeal for a drug you have not received yet. We will give you our decision sooner if you have not received the drug yet and your health condition

requires us to do so. If you believe your health requires it, you should ask for a "fast appeal"

- if we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process

- If our answer is ***yes*** to part or all of what you requested:
  - if we approve a request for coverage, we must provide the coverage we have agreed to provide as quickly as your health requires, but no later than 7 calendar days after we receive your appeal
  - if we approve a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive your appeal request
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said ***no*** and how you can appeal our decision
- If you are requesting that we pay you back for a drug you have already bought, we must give you our answer within 14 calendar days after we receive your request
  - If we do not give you a decision within 14 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- If our answer is yes to part or all of what you requested, we are also required to make payment to you within 30 calendar days after we receive your request
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal our decision

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

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

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

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

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

Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case

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

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

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

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Organization for a fast appeal
- If the review organization agrees to give you a fast appeal, the review organization must give you an

answer to your Level 2 Appeal within 72 hours after it receives your appeal request

- If the Independent Review Organization says ***yes*** to part or all of what you requested, we must provide the drug coverage that was approved by the review organization within 24 hours after we receive the decision from the review organization

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal within 7 calendar days after it receives your appeal if it is for a drug you have not received yet. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal within 14 calendar days after it receives your request
- If the Independent Review Organization says ***yes*** to part or all of what you requested:
  - if the Independent Review Organization approves a request for coverage, we must provide the drug coverage that was approved by the review organization within 72 hours after we receive the decision from the review organization
  - if the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive the decision from the review organization

What if the review organization says no to your appeal?

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

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

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

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

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

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

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

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

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

During your covered hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call

our Member Service Contact Center. You can also call **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week.

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

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

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

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

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

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

What is the Quality Improvement Organization?

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

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name,

address, and phone number of the Quality Improvement Organization for your state in the "Important Phone Numbers and Resources" section)

Act quickly

- To make your appeal, you must contact the Quality Improvement Organization before you leave the hospital and no later than midnight the day of your discharge date. (Your "planned discharge date" is the date that has been set for you to leave the hospital)
  - if you meet this deadline, you are allowed to stay in the hospital after your discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization
  - if you do not meet this deadline, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you receive after your planned discharge date
- If you miss the deadline for contacting the Quality Improvement Organization and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see "What if you miss the deadline for making your Level 1 Appeal?"

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

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

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

What happens during this review?

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

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

What happens if the answer is yes?

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

What happens if the answer is no?

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

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

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

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

If the Quality Improvement Organization has turned down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the

decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

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

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

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

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

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

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

If the review organization says yes

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

If the review organization says no

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

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

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

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

You can appeal to us instead

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

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

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

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

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

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

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

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules

- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review

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

- If we say ***yes*** to your fast appeal, it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs, and there may be coverage limitations that apply)
- If we say ***no*** to your fast appeal, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end
- If you stayed in the hospital after your planned discharge date, then you may have to pay the full cost of hospital care you received after the planned discharge date

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

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

Step-by-step: Level 2 *Alternate* Appeal Process

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

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

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

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

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

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

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

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

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

This section is only about the following types of care:

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

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

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

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

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

- **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice
  - the written notice tells you the date when we will stop covering the care for you
  - the written notice also tells you what you can do if you want to ask us to change this decision about when to end your care, and keep covering it for a longer period of time
  - in telling you what you can do, the written notice is telling how you can request a "fast-track appeal." Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. "Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time" tells you how you can request a fast-track appeal
  - the written notice is called the *Notice of Medicare Non-Coverage*
- **You will be asked to sign the written notice to show that you received it**
  - you or someone who is acting on your behalf will be asked to sign the notice. ("A Guide to the Basics of Coverage Decisions and Appeals" in this "Coverage Decisions, Appeals, and Complaints" section tells you how you can give written permission to someone else to act as your representative.)
  - signing the notice shows only that you have received the information about when your coverage will stop. Signing it does not mean you agree with us that it's time to stop getting the care

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

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

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

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

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

What is the Quality Improvement Organization?

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

How can you contact this organization?

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

What should you ask for?

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

Your deadline for contacting this organization

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

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

What happens during this review?

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

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

What happens if the reviewers say yes to your appeal?

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

What happens if the reviewers say no to your appeal?

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

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

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

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

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

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

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

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

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

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

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

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

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

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

What happens if the review organization says no?

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

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

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

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

You can appeal to us instead

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

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

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

Here are the steps for a Level 1 Alternate Appeal:

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

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

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

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

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

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

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

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

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

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

Step-by-step: Level 2 *Alternate* Appeal Process

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

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

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

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

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

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

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

Taking Your Appeal to Level 3 and Beyond

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

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

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

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

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

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

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

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

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

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

- This is the last step of the appeals process

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

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

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

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

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

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

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

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

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

- This is the last step of the appeals process

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

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

What kinds of problems are handled by the complaint process?

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

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

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

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

- **Information you get from our plan**
  - do you believe we have not given you a notice that we are required to give?
  - do you think written information we have given you is hard to understand?

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

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

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

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

Step-by-step: Making a complaint

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

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

- Usually calling our Member Service Contact Center is the first step. If there is anything else you need to do, our Member Service Contact Center will let you know. Please call us at **1-800-443-0815** (TTY users call **711**), 8 a.m. to 8 p.m., seven days a week
- If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you put your complaint in writing, we will respond to you in writing. We will also respond in writing when you make a complaint by phone if you request a written response or your complaint is related to quality of care
- If you have a complaint, we will try to resolve your complaint over the phone. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. Your grievance must explain your concern, such as why you are dissatisfied with the services you received. Please see the "Important Phone Numbers and Resources" section for whom you should contact if you have a complaint
  - you must submit your grievance to us (orally or in writing) within 60 calendar days of the event or incident. We must address your grievance as quickly as your health requires, but no later than 30 calendar days after receiving your complaint. We may extend the time frame to make our decision by up to 14 calendar days if you ask for an extension, or if we justify a need for additional information and the delay is in your best interest
  - you can file a fast grievance about our decision not to expedite a coverage decision or appeal, or if we extend the time we need to make a decision about a coverage decision or appeal. We must respond to your fast grievance within 24 hours
- Whether you call or write, you should contact our Member Service Contact Center right away. The complaint must be made within 60 calendar days after you had the problem you want to complain about
- If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint." If you have a "fast complaint," it means we will give you an answer within 24 hours. What this section calls a "fast complaint" is also called an "expedited grievance"

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

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

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

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

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

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

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

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

You can also tell Medicare about your complaint

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

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

Additional Review

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

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

Binding Arbitration

For all claims subject to this "Binding Arbitration" provision, 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" provision applies to claims asserted by Kaiser Permanente Parties, it shall apply retroactively to all unresolved claims that accrued before the effective date of this *EOC*. Such retroactive application shall be binding only on the Kaiser Permanente Parties.

Scope of arbitration

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

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

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

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

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

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

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

"Kaiser Permanente Parties" include:

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

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

Rules of procedure

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

Initiating arbitration

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

Serving demand for arbitration

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

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

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

Filing fee

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

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

Number of arbitrators

The number of Arbitrators may affect the Claimant's responsibility for paying the neutral arbitrator's fees and expenses (see the Rules of Procedure).

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

determined by one neutral arbitrator, unless the parties otherwise agree in writing 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" provision, 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" provision, 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 section. In accord with the rule that applies under Sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this 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 another party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Termination of Membership

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2023, your last minute of coverage was at 11:59 p.m. on December 31, 2022). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *EOC* after your membership terminates, except:

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

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

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

Termination Due to Loss of Eligibility

If you meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership will end at 11:59 p.m. on the last day of that month. For example, if you become ineligible on December 5, 2022, your termination date is January 1, 2023, and your last minute of coverage is at 11:59 p.m. on December 31, 2022.

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

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

Note: If you lose eligibility for Senior Advantage due to any of these circumstances, you may be eligible to transfer your membership to another Kaiser Permanente plan offered by your Group. Please contact your Group for information.

Termination of *Agreement*

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

Disenrolling from Senior Advantage

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

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

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

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

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

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

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

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

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

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

Termination of Contract with the Centers for Medicare & Medicaid Services

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

Termination for Cause

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

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

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

Termination for Nonpayment of Premiums

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

Termination of a Product or all Products

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

Payments after Termination

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

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

Review of Membership Termination

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

Continuation of Membership

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

Continuation of Group Coverage

COBRA

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

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

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

Coverage for a disabling condition

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

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

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

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

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

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

Conversion from Group Membership to an Individual Plan

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

Kaiser Permanente Conversion Plan

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

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

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

Miscellaneous Provisions

Administration of Agreement

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

Amendment of *Agreement*

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

Applications and Statements

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

Assignment

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

Attorney and Advocate Fees and Expenses

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

Claims Review Authority

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

EOC Binding on Members

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

ERISA Notices

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

Newborns' and Mothers' Health Protection Act

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

Women's Health and Cancer Rights Act

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

Governing Law

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

Group and Members not our Agents

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

No Waiver

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

Notices Regarding Your Coverage

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

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

Notice about Medicare Secondary Payer Subrogation Rights

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

Overpayment Recovery

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

Public Policy Participation

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

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

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

Telephone Access (TTY)

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

Important Phone Numbers and Resources

Kaiser Permanente Senior Advantage

How to contact our plan's Member Services

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

Member Services – contact information

Call **1-800-443-0815**

Calls to this number are free.

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

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

TTY 711

Calls to this number are free.

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

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

Website kp.org

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

- A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services
- An appeal is a formal way of asking us to review and change a coverage decision we have made
- You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes

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

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

Call **1-800-443-0815**

Calls to this number are free.

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

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

TTY 711

Calls to this number are free.

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

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

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

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

- If your coverage decision, appeal, or complaint **qualifies for a fast decision**, write to:
  Kaiser 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 https://www.medicare.gov/MedicareComplaintForm/home.aspx.

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

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

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

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

Coverage decisions for Part D prescription drugs – contact information

Call **1-877-645-1282**

Calls to this number are free.

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

TTY 711

Calls to this number are free.

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

Fax **1-844-403-1028**

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

Website kp.org

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

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

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

Appeals for Part D prescription drugs – contact information

Call **1-866-206-2973**

Calls to this number are free.

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

TTY 711

Calls to this number are free.

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

Fax **1-866-206-2974**

- **Write** Kaiser Permanente
  CA Medicare PDU/MSU Operations
  P.O. Box 1809
  Pleasanton, CA 94566

Website kp.org

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

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

Complaints for Part D prescription drugs – contact information

Call **1-800-443-0815**

Calls to this number are free.

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

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

TTY 711

Calls to this number are free.

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

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

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

If your complaint **qualifies for a fast decision**, write to:
Kaiser Permanente
CA Medicare PDU/MSU Operations
P.O. Box 1809
Pleasanton, CA 94566

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

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

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

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

Payment Requests – contact information

Call **1-800-443-0815**

Calls to this number are free.

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

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

TTY 711

Calls to this number are free.

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

Write For medical care:

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

For Part D drugs:

If you are requesting payment of a Part D drug that was prescribed and provided by a Plan Provider, you can fax your request to 1-866-206-2974 or mail it to:

Kaiser Permanente
CA Medicare PDU/MSU Operations
P.O. Box 1809
Pleasanton, CA 94566

Website kp.org

Medicare

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

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

Medicare – contact information

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

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

TTY 1-877-486-2048

Calls to this number are free.

Website https://www.medicare.gov

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

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

Medicare Eligibility Tool: Provides Medicare eligibility status information.

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

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

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

If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to

you. You can call Medicare at **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**), 24 hours a day, 7 days a week.

State Health Insurance Assistance Program

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

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

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

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

Method to access SHIP and other resources:

- Visit www.medicare.gov**.**
- Click on "**Forms, Help, and Resources**" on far right of menu on top.
- In the drop down, click on "**Phone Numbers & Websites.**"
- You now have several options:
    - Option 1: You can have a live chat.
    - Option 2: You can click on any of the "Topics" in the menu on bottom.
    - Option 3: You can select your state from the dropdown menu and click "Go." This will take you to a page with phone numbers and resources specific to your state.

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

Call **1-800-434-0222**

Calls to this number are free.

TTY 711

Write Your HICAP office for your county.

Website www.aging.ca.gov/HICAP/

Quality Improvement Organization

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

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

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

You should contact Livanta in any of these situations:

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

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

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

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

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

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

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

Social Security

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

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

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

Social Security – contact information

Call **1-800-772-1213**

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

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

TTY 1-800-325-0778

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

Website https://www.ssa.gov

Medicaid

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

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

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

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

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

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

Call **1-800-541-5555**

Calls to this number are free. You can use Medi-Cal's automated telephone services and get recorded information 24 hours a day.

TTY 711

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

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

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

Railroad Retirement Board

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs

for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

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

Railroad Retirement Board – contact information

Call **1-877-772-5772**

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

If you press "1," you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.

TTY 1-312-751-4701

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.

Website rrb.gov/

Group Insurance or Other Health Insurance from an Employer

If you have any questions about your employer-sponsored Group plan, please contact your Group's benefits administrator. You can ask about your employer or retiree health benefits, any contributions toward the Group's premium, eligibility, and enrollment periods.

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact that group's benefits administrator. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

Notice of nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, call Member Services at **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., seven days a week.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

KAISER PERMANENTE®

Multi-language Interpreter Services

English
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-800-443-0815** (TTY: **711**).

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüistica. Llame al **1-800-443-0815** (TTY: **711**).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-443-0815**（TTY：**711**）。

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phi dành cho bạn. Gọi số **1-800-443-0815** (TTY: **711**).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-443-0815** (TTY: **711**).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-443-0815 (TTY: **711**)번으로 전화해 주십시오.

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-800-443-0815** (TTY (հեռատիպ)՝ **711**):

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-443-0815** (телетайп: **711**).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-443-0815**（TTY:**711**）まで、お電話にてご連絡ください。

Punjabi
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।
1-800-443-0815 (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

KAISER PERMANENTE®

Cambodian
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល
គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-800-443-0815** (TTY: **711**)។

Hmong
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj.
Hu rau **1-800-443-0815** (TTY: **711**).

Hindi
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-800-443-0815 (TTY: **711**) पर कॉल करें।

Thai
เรียน: ณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-443-**
(TTY: **711**).

Farsi
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می
باشد. با **1-800-443-0815** (TTY: **711**) تماس بگیرید.

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم -
1-800-344-008-5180 (رقم هاتف الصم والبكم: -**117**).

KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Northern California Region

A nonprofit corporation and a Medicare Advantage Organization

EOC #6 - Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage Evidence of Coverage for
NORTHERN CALIF SOFT DRINK IND

Group ID: 24 Contract: 1 Version: 88 *EOC* Number: 6

January 1, 2022, through December 31, 2022

Member Service Contact Center
Seven days a week, 8 a.m.–8 p.m.
1-800-443-0815 (TTY users call **711**)
kp.org

This document is available for free in Spanish. Please contact our Member Service Contact Center number at **1-800-443-0815** for additional information. (TTY users should call **711**.) Hours are 8 a.m. to 8 p.m., seven days a week.

*Esta documento está disponible de forma gratuita en español. Si desea información adicional, por favor llame al número de nuestra Central de Llamadas de Servicio a los Miembros al **1-800-443-0815** (los usuarios de la linea TTY deben llamar al **711**). El horario es de 8 a.m. a 8 p.m., los 7 días de la semana.*

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Benefit Highlights

Plan Deductible	None

Professional Services (Plan Provider office visits)	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	No charge
Most Physician Specialist Visits	No charge
Annual Wellness visit and the "Welcome to Medicare" preventive visit	No charge
Routine physical exams	No charge
Routine eye exams with a Plan Optometrist	No charge
Urgent care consultations, evaluations, and treatment	No charge
Physical, occupational, and speech therapy	No charge
Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	No charge
Allergy injections (including allergy serum)	No charge
Most immunizations (including the vaccine)	No charge
Most X-rays and laboratory tests	No charge
Manual manipulation of the spine	No charge
Hospitalization Services	**You Pay**
Room and board, surgery, anesthesia, X-rays, laboratory tests, and drugs	No charge
Emergency Health Coverage	**You Pay**
Emergency Department visits	No charge
Note: If you are admitted directly to the hospital as an inpatient for covered Services, you will pay the inpatient Cost Share instead of the Emergency Department Cost Share (see "Hospitalization Services" for inpatient Cost Share).	
Ambulance and Transportation Services	**You Pay**
Ambulance Services	No charge
Prescription Drug Coverage	**You Pay**
Most covered outpatient items in accord with our drug formulary guidelines	No charge for up to a 100-day supply
Durable Medical Equipment (DME)	**You Pay**
Covered durable medical equipment for home use as described in this *EOC*	No charge
Mental Health Services	**You Pay**
Inpatient psychiatric hospitalization	No charge
Individual outpatient mental health evaluation and treatment	No charge
Group outpatient mental health treatment	No charge
Substance Use Disorder Treatment	**You Pay**
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment	No charge
Group outpatient substance use disorder treatment	No charge
Home Health Services	**You Pay**
Home health care	No charge
Other	**You Pay**
Eyeglasses or contact lenses every 24 months	Amount in excess of $350 Allowance
Hearing aid(s) every 36 months	Amount in excess of $2,500 Allowance per aid
Skilled Nursing Facility care	No charge
External prosthetic and orthotic devices as described in this *EOC*	No charge

Other	You Pay
Ostomy, urological, and wound care supplies	No charge
Meals delivered to your home immediately following discharge from a hospital due to congestive heart failure	No charge up to two meals per day in a consecutive four-week period, once per calendar year

This is a summary of the most frequently asked-about benefits. This chart does not explain benefits, Cost Share, exclusions, or limitations, nor does it list all benefits and Cost Share amounts. For a complete explanation, refer to the "Benefits and Your Cost Share" and "Exclusions, Limitations, Coordination of Benefits, and Reductions" sections.

Introduction

Kaiser Foundation Health Plan, Inc. (Health Plan) has a contract with the Centers for Medicare & Medicaid Services as a Medicare Advantage Organization.

This contract provides Medicare Services (including Medicare Part D prescription drug coverage) through "Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage" (Senior Advantage), except for hospice care for Members with Medicare Part A, which is covered under Original Medicare. Enrollment in this Senior Advantage plan means that you are automatically enrolled in Medicare Part D. Kaiser Permanente is an HMO plan with a Medicare contract. Enrollment in Kaiser Permanente depends on contract renewal.

This *Evidence of Coverage* ("*EOC*") describes our Senior Advantage health care coverage (when Medicare is secondary coverage under federal law) provided under the *Group Agreement (Agreement)* between Health Plan (Kaiser Foundation Health Plan, Inc.) and your Group (the entity with which Health Plan has entered into the *Agreement*). The *Agreement* contains additional terms such as Premiums, when coverage can change, the effective date of coverage, and the effective date of termination. The *Agreement* must be consulted to determine the exact terms of coverage. A copy of the *Agreement* is available from your Group.

Members who have Medicare as their secondary coverage are entitled to the same group benefits under the same terms as Members who are not eligible for Medicare, as described in your Group's non-Medicare plan document. However, if you meet the eligibility requirements for this Kaiser Permanente Senior Advantage plan, you may also enroll in this Senior Advantage plan and receive benefits under the terms described in this *EOC*. You must continue to have primary coverage through your Group's non-Medicare plan in order to remain enrolled in this secondary Senior Advantage plan.

In this *EOC*, Health Plan is sometimes referred to as "we" or "us." Members are sometimes referred to as "you." Some capitalized terms have special meaning in this *EOC*; please see the "Definitions" section for terms you should know.

It is important to familiarize yourself with your coverage by reading this *EOC* and your Group's non-Medicare plan document completely, so that you can take full advantage of your Health Plan benefits. Also, if you have special health care needs, please carefully read the sections that apply to you.

As a Senior Advantage Member when Medicare is secondary, you must refer to both this *EOC* and your Group's non-Medicare plan document for the full description of your coverages, which are coordinated in accord with applicable law. Your non-Medicare plan document includes benefits not covered under this *EOC*, for example, state-mandated benefits and other terms that apply to non-Medicare plans. If you do not have your other (non-Medicare) plan document, please ask your Group for it.

About Kaiser Permanente

PLEASE READ THE FOLLOWING INFORMATION SO THAT YOU WILL KNOW FROM WHOM OR WHAT GROUP OF PROVIDERS YOU MAY GET HEALTH CARE.

Kaiser Permanente provides Services directly to our Members through an integrated medical care program. Health Plan, Plan Hospitals, and the Medical Group work together to provide our Members with quality care. Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital care, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in this *EOC*. Plus, our health education programs offer you great ways to protect and improve your health.

We provide covered Services to Members using Plan Providers located in our Service Area, which is described in the "Definitions" section. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Certain care when you visit the service area of another Region as described under "Receiving Care Outside of Your Home Region" in the "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Your Cost Share" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Your Cost Share" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs,

Supplies, and Supplements" in the "Benefits and Your Cost Share" section

- Routine Services associated with Medicare-approved clinical trials as described under "Services Associated with Clinical Trials" in the "Benefits and Your Cost Share" section

Term of this *EOC*

This *EOC* is for the period January 1, 2022, through December 31, 2022, unless amended. Benefits, Copayments, and Coinsurance may change on January 1 of each year and at other times in accord with your Group's *Agreement* with us. Your Group can tell you whether this *EOC* is still in effect and give you a current one if this *EOC* has been amended.

Definitions

Some terms have special meaning in this *EOC*. When we use a term with special meaning in only one section of this *EOC*, we define it in that section. The terms in this "Definitions" section have special meaning when capitalized and used in any section of this *EOC*.

Allowance: A specified amount that you can use toward the purchase price of an item. If the price of the items you select exceeds the Allowance, you will pay the amount in excess of the Allowance.

Note: Any Allowances in your Group's non-Medicare plan are coordinated with Allowances in this *EOC* and cannot be combined.

Catastrophic Coverage Stage: The stage in the Part D Drug Benefit where you pay a low Copayment or Coinsurance for your Part D drugs after you or other qualified parties on your behalf have spent $7,050 in covered Part D drugs during the covered year. Note: This amount may change every January 1 in accord with Medicare requirements.

Centers for Medicare & Medicaid Services (CMS): The federal agency that administers the Medicare program.

Ancillary Coverage: Optional benefits such as acupuncture, chiropractic, or dental coverage that may be available to Members enrolled under this *EOC*. If your plan includes Ancillary Coverage, this coverage will be described in an amendment to this *EOC* or a separate agreement from the issuer of the coverage.

Charges: "Charges" means the following:

- For Services provided by the Medical Group or Kaiser Foundation Hospitals, the charges in Health Plan's schedule of Medical Group and Kaiser Foundation Hospitals charges for Services provided to Members
- For Services for which a provider (other than the Medical Group or Kaiser Foundation Hospitals) is compensated on a capitation basis, the charges in the schedule of charges that Kaiser Permanente negotiates with the capitated provider
- For items obtained at a pharmacy owned and operated by Kaiser Permanente, the amount the pharmacy would charge a Member for the item if a Member's benefit plan did not cover the item (this amount is an estimate of: the cost of acquiring, storing, and dispensing drugs, the direct and indirect costs of providing Kaiser Permanente pharmacy Services to Members, and the pharmacy program's contribution to the net revenue requirements of Health Plan)
- For all other Services, the payments that Kaiser Permanente makes for the Services or, if Kaiser Permanente subtracts your Cost Share from its payment, the amount Kaiser Permanente would have paid if it did not subtract your Cost Share

Coinsurance: A percentage of Charges that you must pay when you receive a covered Service under this *EOC*.

Complaint: The formal name for "making a complaint" is "filing a grievance." The complaint process is used for certain types of problems only. This includes problems related to quality of care, waiting times, and the customer service you receive. See also "Grievance."

Comprehensive Formulary (Formulary or "Drug List"): A list of Medicare Part D prescription drugs covered by our plan. The drugs on this list are selected by us with the help of doctors and pharmacists. The list includes both brand-name and generic drugs.

Comprehensive Outpatient Rehabilitation Facility (CORF): A facility that mainly provides rehabilitation Services after an illness or injury, and provides a variety of Services, including physician's Services, physical therapy, social or psychological Services, and outpatient rehabilitation.

Copayment: A specific dollar amount that you must pay when you receive a covered Service under this *EOC*. Note: The dollar amount of the Copayment can be $0 (no charge).

Cost Share: The amount you are required to pay for covered Services. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible.

Coverage Determination: An initial determination we make about whether a Part D drug prescribed for you is covered under Part D and the amount, if any, you are required to pay for the prescription. In general, if you bring your prescription for a Part D drug to a Plan Pharmacy and the pharmacy tells you the prescription isn't covered by us, that isn't a Coverage Determination. You need to call or write us to ask for a formal decision about the coverage. Coverage Determinations are called "coverage decisions" in this *EOC*.

Dependent: A Member who meets the eligibility requirements as a Dependent (for Dependent eligibility requirements, see "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

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 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 any of the following:

- Serious jeopardy to the health of the individual or, in the case of a pregnant woman, the health of the woman or her unborn child
- Serious impairment to bodily functions
- Serious dysfunction of any bodily organ or part

A mental health condition is an emergency medical condition when it meets the requirements of the paragraph above, or when the condition manifests itself by acute symptoms of sufficient severity such that either of the following is true:

- The person is an immediate danger to themselves or to others
- The person is immediately unable to provide for, or use, food, shelter, or clothing, due to the mental disorder

Emergency Services: Covered Services that are (1) rendered by a provider qualified to furnish Emergency Services; and (2) needed to treat, evaluate, or Stabilize an Emergency Medical Condition such as:

- A medical screening exam that is within the capability of the emergency department of a hospital, including ancillary services (such as imaging and laboratory Services) routinely available to the emergency department to evaluate the Emergency Medical Condition
- Within the capabilities of the staff and facilities available at the hospital, Medically Necessary examination and treatment required to Stabilize the patient (once your condition is Stabilized, Services you receive are Post Stabilization Care and not Emergency Services)

***EOC*:** This *Evidence of Coverage* document, including any amendments, which describes the health care coverage of "Kaiser Permanente Senior Advantage (HMO) with Part D when Medicare is secondary coverage" under Health Plan's *Agreement* with your Group.

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.

Grievance: A type of complaint you make about us, including a complaint concerning the quality of your care. This type of complaint does not involve coverage or payment disputes.

Group: The entity with which Health Plan has entered into the *Agreement* that includes this *EOC*.

Health Plan: Kaiser Foundation Health Plan, Inc., a California nonprofit corporation. This *EOC* sometimes refers to Health Plan as "we" or "us."

Home Region: The Region where you enrolled (either the Northern California Region or the Southern California Region).

Initial Enrollment Period: When you are first eligible for Medicare, the period of time when you can sign up for Medicare Part B. For example, if you're eligible for 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.

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 will not pay a higher premium.

Kaiser Permanente: Kaiser Foundation Hospitals (a California nonprofit corporation), Health Plan, and the Medical Group.

Medical Group: The Permanente Medical Group, Inc., a for-profit professional corporation.

Medically Necessary: A Service is Medically Necessary if it is medically appropriate and required to prevent, diagnose, or treat your condition or clinical symptoms in accord with generally accepted professional standards of practice that are consistent with a standard of care in the medical community.

Medicare: The federal health insurance program for people 65 years of age or older, some people under age 65 with certain disabilities, and people with end-stage renal disease (generally those with permanent kidney failure who need dialysis or a kidney transplant). A person enrolled in a Medicare Part D plan has Medicare Part D by virtue of his or her enrollment in the Part D plan (this *EOC* is for a Part D plan).

Medicare Advantage Organization: A public or private entity organized and licensed by a state as a risk-bearing entity that has a contract with the Centers for Medicare & Medicaid Services to provide Services covered by Medicare, except for hospice care covered by Original Medicare. Kaiser Foundation Health Plan, Inc., is a Medicare Advantage Organization.

Medicare Advantage Plan: Sometimes called Medicare Part C. A plan offered by a private company that contracts with Medicare to provide you with all your Medicare Part A (Hospital) and Part B (Medical) benefits. When you are enrolled in a Medicare Advantage Plan, Medicare services are covered through the plan, and are not paid for under Original Medicare. Medicare Advantage Plans may also offer Medicare Part D (prescription drug coverage). This *EOC* is for a Medicare Part D plan.

Medicare Health Plan: A Medicare Health Plan is offered by a private company that contracts with Medicare to provide Part A and Part B benefits to people with Medicare who enroll in the plan. This term includes all Medicare Advantage plans, Medicare Cost plans, Demonstration/Pilot Programs, and Programs of All-inclusive Care for the Elderly (PACE).

Medigap (Medicare Supplement Insurance) Policy: Medicare supplement insurance sold by private insurance companies to fill "gaps" in the Original Medicare plan coverage. Medigap policies only work with the Original Medicare plan. (A Medicare Advantage Plan is not a Medigap policy.)

Member: A person who is eligible and enrolled under this *EOC*, and for whom we have received applicable Premiums. This *EOC* sometimes refers to a Member as "you."

Non-Physician Specialist Visits: Consultations, evaluations, and treatment by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

Non–Plan Hospital: A hospital other than a Plan Hospital.

Non–Plan Pharmacy: A pharmacy other than a Plan Pharmacy. These pharmacies are also called "out-of-network pharmacies."

Non–Plan Physician: A physician other than a Plan Physician.

Non–Plan Provider: A provider other than a Plan Provider.

Non–Plan Psychiatrist: A psychiatrist who is not a Plan Physician.

Non–Plan Skilled Nursing Facility: A Skilled Nursing Facility other than a Plan Skilled Nursing Facility.

Organization Determination: An initial determination we make about whether we will cover or pay for Services that you believe you should receive. We also make an Organization Determination when we provide you with Services, or refer you to a Non–Plan Provider for Services. Organization Determinations are called "coverage decisions" in this *EOC.*

Original Medicare ("Traditional Medicare" or "Fee-for-Service Medicare"): The Original Medicare plan is the way many people get their health care coverage. It is the national pay-per-visit program that lets you go to any doctor, hospital, or other health care provider that accepts Medicare. You must pay a deductible. Medicare pays its share of the Medicare approved amount, and you pay your share. Original Medicare has two parts: Part A (Hospital Insurance) and Part B (Medical Insurance), and is available everywhere in the United States and its territories.

Out-of-Area Urgent Care: Medically Necessary Services to prevent serious deterioration of your health resulting from an unforeseen illness or an unforeseen injury if all of the following are true:

- You are temporarily outside our Service Area
- A reasonable person would have believed that your health would seriously deteriorate if you delayed treatment until you returned to our Service Area

Physician Specialist Visits: Consultations, evaluations, and treatment by physician specialists, including personal Plan Physicians who are not Primary Care Physicians.

Plan Deductible: The amount you must pay under this *EOC* in the calendar year for certain Services before we will cover those Services at the applicable Copayment or Coinsurance in that calendar year. Refer to the "Benefits and Your Cost Share" section to learn whether your

coverage includes a Plan Deductible, the Services that are subject to the Plan Deductible, and the Plan Deductible amount.

Plan Facility: Any facility listed in the Provider Directory on our website at kp.org/facilities. Plan Facilities include Plan Hospitals, Plan Medical Offices, and other facilities that we designate in the directory. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call our Member Service Contact Center.

Plan Hospital: Any hospital listed in the Provider Directory on our website at kp.org/facilities. In the directory, some Plan Hospitals are listed as Kaiser Permanente Medical Centers. The directory is updated periodically. The availability of Plan Hospitals may change. If you have questions, please call our Member Service Contact Center.

Plan Medical Office: Any medical office listed in the Provider Directory on our website at kp.org/facilities. In the directory, Kaiser Permanente Medical Centers may include Plan Medical Offices. The directory is updated periodically. The availability of Plan Medical Offices may change. If you have questions, please call our Member Service Contact Center.

Plan Optical Sales Office: An optical sales office owned and operated by Kaiser Permanente or another optical sales office that we designate. Refer to the Provider Directory on our website at kp.org/facilities for locations of Plan Optical Sales Offices. In the directory, Plan Optical Sales Offices may be called "Vision Essentials." The directory is updated periodically. The availability of Plan Optical Sales Offices may change. If you have questions, please call our Member Service Contact Center.

Plan Optometrist: An optometrist who is a Plan Provider.

Plan Pharmacy: A pharmacy owned and operated by Kaiser Permanente or another pharmacy that we designate. Refer to the Provider Directory on our website at kp.org/facilities for locations of Plan Pharmacies. The directory is updated periodically. The availability of Plan Pharmacies may change. If you have questions, please call our Member Service Contact Center.

Plan Physician: Any licensed physician who is an employee of the Medical Group, or any licensed physician who contracts to provide Services to Members (but not including physicians who contract only to provide referral Services).

Plan Provider: A Plan Hospital, a Plan Physician, the Medical Group, a Plan Pharmacy, or any other health care provider that Health Plan designates as a Plan Provider.

Plan Skilled Nursing Facility: A Skilled Nursing Facility approved by Health Plan.

Post-Stabilization Care: Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the Emergency Department) after your treating physician determines that this condition is Stabilized.

Premiums: The periodic amounts that your Group is responsible for paying for your membership under this *EOC*.

Preventive Services: Covered Services that prevent or detect illness and do one or more of the following:

- Protect against disease and disability or further progression of a disease
- Detect disease in its earliest stages before noticeable symptoms develop

Primary Care Physicians: Generalists in internal medicine, pediatrics, and family practice, and specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Refer to the Provider Directory on our website at kp.org for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call our Member Service Contact Center.

Primary Care Visits: Evaluations and treatment provided by Primary Care Physicians and primary care Plan Providers who are not physicians (such as nurse practitioners).

Provider Directory: A directory of Plan Physicians and Plan Facilities in your Home Region. This directory is available on our website at kp.org/directory. To obtain a printed copy, call our Member Service Contact Center. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call our Member Service Contact Center.

Region: A Kaiser Foundation Health Plan organization or allied plan that conducts a direct-service health care program. Regions may change on January 1 of each year and are currently the District of Columbia and parts of Northern California, Southern California, Colorado, Georgia, Hawaii, Maryland, Oregon, Virginia, and Washington. For the current list of Region locations, please visit our website at kp.org or call our Member Service Contact Center.

Serious Emotional Disturbance of a Child Under Age 18: A condition identified as a "mental disorder" in the most recent edition of the *Diagnostic and Statistical Manual of Mental Disorders*, other than a primary

substance use disorder or developmental disorder, that results in behavior inappropriate to the child's age according to expected developmental norms, if the child also meets at least one of the following three criteria:

- As a result of the mental disorder, (1) the child has substantial impairment in at least two of the following areas: self-care, school functioning, family relationships, or ability to function in the community; and (2) either (a) the child is at risk of removal from the home or has already been removed from the home, or (b) the mental disorder and impairments have been present for more than six months or are likely to continue for more than one year without treatment
- The child displays psychotic features, or risk of suicide or violence due to a mental disorder
- The child meets special education eligibility requirements under Section 5600.3(a)(2)(C) of the Welfare and Institutions Code

Service Area: The geographic area approved by the Centers for Medicare & Medicaid Services within which an eligible person may enroll in Senior Advantage. Note: Subject to approval by the Centers for Medicare & Medicaid Services, we may reduce or expand our Service Area effective any January 1. ZIP codes are subject to change by the U.S. Postal Service. The ZIP codes below for each county are in our Service Area:

- All ZIP codes in Alameda County are inside our Northern California Service Area: 94501–02, 94505, 94514, 94536–46, 94550–52, 94555, 94557, 94560, 94566, 94568, 94577–80, 94586–88, 94601–15, 94617–21, 94622–24, 94649, 94659–62, 94666, 94701–10, 94712, 94720, 95377, 95391
- The following ZIP codes in Amador County are inside our Northern California Service Area: 95640, 95669
- All ZIP codes in Contra Costa County are inside our Northern California Service Area: 94505–07, 94509, 94511, 94513–14, 94516–31, 94547–49, 94551, 94553, 94556, 94561, 94563–65, 94569–70, 94572, 94575, 94582–83, 94595–98, 94706–08, 94801–08, 94820, 94850
- The following ZIP codes in El Dorado County are inside our Northern California Service Area: 95613–14, 95619, 95623, 95633–35, 95651, 95664, 95667, 95672, 95682, 95762
- The following ZIP codes in Fresno County are inside our Northern California Service Area: 93242, 93602, 93606–07, 93609, 93611–13, 93616, 93618–19, 93624–27, 93630–31, 93646, 93648–52, 93654, 93656–57, 93660, 93662, 93667–68, 93675, 93701–12, 93714–18, 93720–30, 93737, 93740–41, 93744–45, 93747, 93750, 93755, 93760–61, 93764–65, 93771–79, 93786, 93790–94, 93844, 93888
- The following ZIP codes in Kings County are inside our Northern California Service Area: 93230, 93232, 93242, 93631, 93656
- The following ZIP codes in Madera County are inside our Northern California Service Area: 93601–02, 93604, 93614, 93623, 93626, 93636–39, 93643–45, 93653, 93669, 93720
- All ZIP codes in Marin County are inside our Northern California Service Area: 94901, 94903–04, 94912–15, 94920, 94924–25, 94929–30, 94933, 94937–42, 94945–50, 94956–57, 94960, 94963–66, 94970–71, 94973–74, 94976–79
- The following ZIP codes in Mariposa County are inside our Northern California Service Area: 93601, 93623, 93653
- All ZIP codes in Napa County are inside our Northern California Service Area: 94503, 94508, 94515, 94558–59, 94562, 94567, 94573–74, 94576, 94581, 94599, 95476
- The following ZIP codes in Placer County are inside our Northern California Service Area: 95602–04, 95610, 95626, 95648, 95650, 95658, 95661, 95663, 95668, 95677–78, 95681, 95703, 95722, 95736, 95746–47, 95765
- All ZIP codes in Sacramento County are inside our Northern California Service Area: 94203–09, 94211, 94229–30, 94232, 94234–37, 94239–40, 94244–45, 94247–50, 94252, 94254, 94256–59, 94261–63, 94267–69, 94271, 94273–74, 94277–80, 94282–85, 94287–91, 94293–98, 94571, 95608–11, 95615, 95621, 95624, 95626, 95628, 95630, 95632, 95638–39, 95641, 95652, 95655, 95660, 95662, 95670–71, 95673, 95678, 95680, 95683, 95690, 95693, 95741–42, 95757–59, 95763, 95811–38, 95840–43, 95851–53, 95860, 95864–67, 95894, 95899
- All ZIP codes in San Francisco County are inside our Northern California Service Area: 94102–05, 94107–12, 94114–27, 94129–34, 94137, 94139–47, 94151, 94158–61, 94163–64, 94172, 94177, 94188
- All ZIP codes in San Joaquin County are inside our Northern California Service Area: 94514, 95201–15, 95219–20, 95227, 95230–31, 95234, 95236–37, 95240–42, 95253, 95258, 95267, 95269, 95296–97, 95304, 95320, 95330, 95336–37, 95361, 95366, 95376–78, 95385, 95391, 95632, 95686, 95690
- All ZIP codes in San Mateo County are inside our Northern California Service Area: 94002, 94005, 94010–11, 94014–21, 94025–28, 94030, 94037–38, 94044, 94060–66, 94070, 94074, 94080, 94083, 94128, 94303, 94401–04, 94497

- The following ZIP codes in Santa Clara County are inside our Northern California Service Area: 94022–24, 94035, 94039–43, 94085–89, 94301–06, 94309, 94550, 95002, 95008–09, 95011, 95013–15, 95020–21, 95026, 95030–33, 95035–38, 95042, 95044, 95046, 95050–56, 95070–71, 95076, 95101, 95103, 95106, 95108–13, 95115–36, 95138–41, 95148, 95150–61, 95164, 95170, 95172–73, 95190–94, 95196
- All ZIP codes in Santa Cruz County are inside our Northern California Service Area: 95001, 95003, 95005–07, 95010, 95017–19, 95033, 95041, 95060–67, 95073, 95076–77
- All ZIP codes in Solano County are inside our Northern California Service Area: 94503, 94510, 94512, 94533–35, 94571, 94585, 94589–92, 95616, 95618, 95620, 95625, 95687–88, 95690, 95694, 95696
- The following ZIP codes in Sonoma County are inside our Northern California Service Area: 94515, 94922–23, 94926–28, 94931, 94951–55, 94972, 94975, 94999, 95401–07, 95409, 95416, 95419, 95421, 95425, 95430–31, 95433, 95436, 95439, 95441–42, 95444, 95446, 95448, 95450, 95452, 95462, 95465, 95471–73, 95476, 95486–87, 95492
- All ZIP codes in Stanislaus County are inside our Northern California Service Area: 95230, 95304, 95307, 95313, 95316, 95319, 95322–23, 95326, 95328–29, 95350–58, 95360–61, 95363, 95367–68, 95380–82, 95385–87, 95397
- The following ZIP codes in Sutter County are inside our Northern California Service Area: 95626, 95645, 95659, 95668, 95674, 95676, 95692, 95837
- The following ZIP codes in Tulare County are inside our Northern California Service Area: 93238, 93261, 93618, 93631, 93646, 93654, 93666, 93673
- The following ZIP codes in Yolo County are inside our Northern California Service Area: 95605, 95607, 95612, 95615–18, 95645, 95691, 95694–95, 95697–98, 95776, 95798–99
- The following ZIP codes in Yuba County are inside our Northern California Service Area: 95692, 95903, 95961

For each ZIP code listed for a county, our 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 our 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 our Service Area, please call our Member Service Contact Center. 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.

Services: Health care services or items ("health care" includes both physical health care and mental health care) and services to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness.

Severe Mental Illness: The following mental disorders: schizophrenia, schizoaffective disorder, bipolar disorder (manic-depressive illness), major depressive disorders, panic disorder, obsessive-compulsive disorder, pervasive developmental disorder or autism, anorexia nervosa, or bulimia nervosa.

Skilled Nursing Facility: A facility that provides inpatient skilled nursing care, rehabilitation services, or other related health services and is licensed by the state of California. The facility's primary business must be the provision of 24-hour-a-day licensed skilled nursing care. The term "Skilled Nursing Facility" does not include convalescent nursing homes, rest facilities, or facilities for the aged, if those facilities furnish primarily custodial care, including training in routines of daily living. A "Skilled Nursing Facility" may also be a unit or section within another facility (for example, a hospital) as long as it continues to meet this definition.

Spouse: The person to whom the Subscriber is legally married under applicable law. For the purposes of this *EOC*, the term "Spouse" includes the Subscriber's domestic partner. "Domestic partners" are two people who are registered and legally recognized as domestic partners by California (if your Group allows enrollment of domestic partners not legally recognized as domestic partners by California, "Spouse" also includes the Subscriber's domestic partner who meets your Group's eligibility requirements for domestic partners).

Stabilize: To provide the medical treatment of the Emergency Medical Condition that is necessary to assure, within reasonable medical probability, that no material deterioration of the condition is likely to result from or occur during the transfer of the person from the facility. With respect to a pregnant woman who is having contractions, when there is inadequate time to safely transfer her to another hospital before delivery (or the transfer may pose a threat to the health or safety of the woman or unborn child), "Stabilize" means to deliver (including the placenta).

Subscriber: A Member who is eligible for membership on their own behalf and not by virtue of Dependent status and who meets the eligibility requirements as a Subscriber (for Subscriber eligibility requirements, see

"Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section).

Telehealth Visits: Interactive video visits and scheduled telephone visits between you and your provider.

Urgent Care: Medically Necessary Services for a condition that requires prompt medical attention but is not an Emergency Medical Condition.

Premiums, Eligibility, and Enrollment

Premiums

Your Group is responsible for paying Premiums. If you are 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 (through payroll deduction, for example). In addition to any amount you must pay your Group, you must also continue to pay Medicare your monthly Medicare premium.

Medicare Premiums

Medicare Part D premium due to income

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.

If you have to pay an extra amount, Social Security, not your Medicare plan, will send you a letter telling you what that extra amount will be and how to pay it. The extra amount will be withheld from your Social Security, Railroad Retirement Board, or Office of Personnel Management benefit check, no matter how you usually pay your plan premium, unless your monthly benefit isn't enough to cover the extra amount owed. If your benefit check isn't enough to cover the extra amount, you will get a bill from Medicare. The extra amount must be paid separately and cannot be paid with your monthly plan premium.

If you disagree about paying an extra amount because of your income, you can ask Social Security to review the decision. To find out more about how to do this, contact the Social Security Office at **1-800-772-1213** (TTY users call **1-800-325-0778**), 7 a.m. to 7 p.m., Monday through Friday.

The extra amount is paid directly to the government (not your Medicare plan) for your Medicare Part D coverage. If you are required to pay the extra amount and you do not pay it, you will be disenrolled from Kaiser Permanente Senior Advantage and lose Part D prescription drug coverage.

Medicare Part D late enrollment penalty

The late enrollment penalty is an amount that is added to your Part D premium. You may owe a Part D late enrollment penalty if at any time after your Initial Enrollment Period is over, there is a period of 63 days or more in a row when you did not have Part D or other creditable prescription drug coverage. ("Creditable prescription drug coverage" is coverage that meets Medicare's minimum standards since it is expected to pay, on average, at least as much as Medicare's standard prescription drug coverage.) The amount of the penalty depends on how long you waited to enroll in a creditable prescription drug coverage plan any time after the end of your Initial Enrollment Period or how many full calendar months you went without creditable prescription drug coverage (this *EOC* is for a Part D plan). You will have to pay this penalty for as long as you have Part D coverage. Your Group will inform you if the penalty applies to you.

If you disagree with your Part D late enrollment penalty, you can ask us to review the decision about your late enrollment penalty. Call our Member Service Contact Center at the number on the front of this booklet to find out more about how to do this.

Note: If you receive Extra Help from Medicare to pay for your Part D prescription drugs, you will not pay a late enrollment penalty.

Medicare's "Extra Help" Program

Medicare provides "Extra Help" to pay prescription drug costs for people who have limited income and resources. Resources include your savings and stocks, but not your home or car. If you qualify, you get help paying for any Medicare drug plan's monthly premium, and prescription Copayments. This "Extra Help" also counts toward your out-of-pocket costs.

People with limited income and resources may qualify for "Extra Help." Some people automatically qualify for "Extra Help" and don't need to apply. Medicare mails a letter to people who automatically qualify for "Extra Help."

You may be able to get "Extra Help" to pay for your prescription drug premiums and costs. To see if you qualify for getting "Extra Help," call:

- **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week;
- The Social Security Office at **1-800-772-1213** (TTY users call **1-800-325-0778**), 7 a.m. to 7 p.m., Monday through Friday (applications); or
- Your state Medicaid office (applications). See the "Important Phone Numbers and Resources" section for contact information

If you qualify for "Extra Help," we will send you an *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*), that explains your costs as a Member of our plan. If the amount of your "Extra Help" changes during the year, we will also mail you an updated *Evidence of Coverage Rider for People Who Get Extra Help Paying for Prescription Drugs.*

Who Is Eligible

To enroll and to continue enrollment, you must meet all of the eligibility requirements described in this "Who Is Eligible" section, including your Group's eligibility requirements and our Service Area eligibility requirements.

Group eligibility requirements

You must meet your Group's eligibility requirements such as the minimum number of hours that employees must work. Your Group is required to inform Subscribers of its eligibility requirements.

Senior Advantage eligibility requirements when Medicare is secondary

- You must have Medicare Part B
- You must be a United States citizen or lawfully present in the United States
- You must be simultaneously enrolled in your Group's non-Medicare plan as your primary coverage
- You must have Medicare as your secondary coverage in accord with federal law
- You may not be enrolled in another Medicare Health Plan or Medicare prescription drug plan

Note: If you are enrolled in a Medicare plan and lose Medicare eligibility, you may be able to enroll under your Group's non-Medicare plan *if* that is permitted by your Group (please ask your Group for details).

Service Area eligibility requirements

You must live in our Service Area, unless you have been continuously enrolled in Senior Advantage since December 31, 1998, and lived outside our Service Area during that entire time. In which case, you may continue your membership unless you move and are still outside our Service Area. The "Definitions" section describes our Service Area and how it may change.

Moving outside our Service Area. If you permanently move outside our Service Area, or you are temporarily absent from our 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 *EOC.*

Send your notice to:

Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 232400
San Diego, CA 92193

It is in your best interest to notify us as soon as possible because until your Senior Advantage coverage is officially terminated by the Centers for Medicare & Medicaid Services, you will not be covered by us or Original Medicare for any care you receive from Non–Plan Providers, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in the "How to Obtain Services" section
- Certain care when you visit the service area of another Region as described under "Receiving Care Outside of Your Home Region" in the "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Your Cost Share" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Your Cost Share" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section

- Routine Services associated with Medicare-approved clinical trials as described under "Services Associated with Clinical Trials" in the "Benefits and Your Cost Share" section

If you are not eligible to continue enrollment because you move to the service area of another Region, please contact your Group 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 your Group and that Region, but the plan, including coverage, premiums, and eligibility requirements, might not be the same as under this *EOC*.

For more information about the service areas of the other Regions, please call our Member Service Contact Center.

Eligibility as a Subscriber

You may be eligible to enroll and continue enrollment as a Subscriber if you are:

- An employee of your Group
- A proprietor or partner of your Group
- Otherwise entitled to coverage under a trust agreement or employment contract (unless the Internal Revenue Service considers you self-employed)

Eligibility as a Dependent

Dependent eligibility is subject to your Group's eligibility requirements, which are not described in this *EOC*. You can obtain your Group's eligibility requirements directly from your Group. If you are a Subscriber enrolled under this *EOC* or a subscriber enrolled in a non-Medicare plan offered by your Group, the following persons may be eligible to enroll as your Dependents under this *EOC* if they meet all of the other requirements described under "Group eligibility requirements," "Senior Advantage eligibility requirements when Medicare is secondary," and "Service Area eligibility requirements" in this "Who Is Eligible" section:

- Your Spouse
- Your or your Spouse's Dependent children, who are under age 26, if they are any of the following:
  - sons, daughters, or stepchildren
  - adopted children
  - children placed with you for adoption, but not including children placed with you for foster care
  - children for whom you or your Spouse is the court-appointed guardian (or was when the child reached age 18)
- Children whose parent is a Dependent under your family coverage (including adopted children and children placed with your Dependent for adoption, but not including children placed with your Dependent for foster care) if they meet all of the following requirements:
  - they are not married and do not have a domestic partner (for the purposes of this requirement only, "domestic partner" means someone who is registered and legally recognized as a domestic partner by California)
  - they are under age 26
  - they receive all of their support and maintenance from you or your Spouse
  - they permanently reside with you or your Spouse
- Dependent children of the Subscriber or Spouse (including adopted children and children placed with you for adoption, but not including children placed with you for foster care) who reach the age limit may continue coverage under this *EOC* if all of the following conditions are met:
  - they meet all requirements to be a Dependent except for the age limit
  - your Group permits enrollment of Dependents
  - they are incapable of self-sustaining employment because of a physically- or mentally-disabling injury, illness, or condition that occurred before they reached the age limit for Dependents
  - they receive 50 percent or more of their support and maintenance from you or your Spouse
  - you give us proof of their incapacity and dependency within 60 days after we request it (see "Disabled Dependent certification" below in this "Eligibility as a Dependent" section)

Disabled Dependent certification. One of the requirements for a Dependent to be eligible to continue coverage as a disabled Dependent is that the Subscriber must provide us documentation of the dependent's incapacity and dependency as follows:

- If the child is a Member, we will send the Subscriber a notice of the Dependent's membership termination due to loss of eligibility at least 90 days before the date coverage will end due to reaching the age limit. The Dependent's membership will terminate as described in our notice unless the Subscriber provides us documentation of the Dependent's incapacity and dependency within 60 days of receipt of our notice and we determine that the Dependent is eligible as a disabled dependent. If the Subscriber provides us this documentation in the specified time period and we do not make a determination about eligibility before the

termination date, coverage will continue until we make a determination. If we determine that the Dependent does not meet the eligibility requirements as a disabled dependent, we will notify the Subscriber that the Dependent is not eligible and let the Subscriber know the membership termination date. If we determine that the Dependent is eligible as a disabled dependent, there will be no lapse in coverage. Also, starting two years after the date that the Dependent reached the age limit, the Subscriber must provide us documentation of the Dependent's incapacity and dependency annually within 60 days after we request it so that we can determine if the Dependent continues to be eligible as a disabled dependent

- If the child is not a Member because you are changing coverage, you must give us proof, within 60 days after we request it, of the child's incapacity and dependency as well as proof of the child's coverage under your prior coverage. In the future, you must provide proof of the child's continued incapacity and dependency within 60 days after you receive our request, but not more frequently than annually

Dependents not eligible to enroll under a Senior Advantage plan. If you have dependents who do not have Medicare Part B coverage or for some other reason are not eligible to enroll under this *EOC*, you may be able to enroll them as your dependents under a non-Medicare plan offered by your Group. Please contact your Group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

How to Enroll and When Coverage Begins

Your Group is required to inform you when you are eligible to enroll and what your effective date of coverage is. If you are eligible to enroll as described under "Who Is Eligible" in this "Premiums, Eligibility, and Enrollment" section, enrollment is permitted as described below and membership begins at the beginning (12:00 a.m.) of the effective date of coverage indicated below, except that:

- Your Group may have additional requirements, which allow enrollment in other situations
- The effective date of your Senior Advantage coverage under this *EOC* must be confirmed by the Centers for Medicare & Medicaid Services, as described under "Effective date of Senior Advantage coverage" in this "How to Enroll and When Coverage Begins" section

If you are a Subscriber under this *EOC* and you have dependents who do not have Medicare Part B coverage or for some other reason are not eligible to enroll under this *EOC*, you may be able to enroll them as your dependents under a non-Medicare plan offered by your Group. Please contact your Group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

If you are eligible to be a Dependent under this *EOC* but the subscriber in your family is enrolled under a non-Medicare plan offered by your Group, the subscriber must follow the rules applicable to Subscribers who are enrolling Dependents in this "How to Enroll and When Coverage Begins" section.

Effective date of Senior Advantage coverage

After we receive your completed Senior Advantage Election Form, we will submit your enrollment request to the Centers for Medicare & Medicaid Services for confirmation and send you a notice indicating the proposed effective date of your Senior Advantage coverage under this *EOC*.

If the Centers for Medicare & Medicaid Services confirms your Senior Advantage enrollment and effective date, we will send you a notice that confirms your enrollment and effective date. If the Centers for Medicare & Medicaid Services tells us that you do not have Medicare Part B coverage, we will notify you that you will be disenrolled from Senior Advantage.

New employees

When your Group informs you that you are eligible to enroll as a Subscriber, you may enroll yourself and any eligible Dependents by submitting a Health Plan–approved enrollment application, and a Senior Advantage Election Form for each person, to your Group within 31 days.

Effective date of Senior Advantage coverage. The effective date of Senior Advantage coverage for new employees and their eligible family Dependents or newly acquired Dependents, is determined by your Group, subject to confirmation by the Centers for Medicare & Medicaid Services.

Group open enrollment

You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, by submitting a Health Plan–approved enrollment application, and a Senior Advantage Election Form for each person to your Group during your Group's open enrollment period. Your Group will let you know when the open enrollment period begins and ends and the

effective date of coverage, which is subject to confirmation by the Centers for Medicare & Medicaid Services.

Special enrollment

If you do not enroll when you are first eligible and later want to enroll, you can enroll only during open enrollment unless one of the following is true:

- You become eligible because you experience a qualifying event (sometimes called a "triggering event") as described in this "Special enrollment" section
- You did not enroll in any coverage offered by your Group when you were first eligible and your Group does not give us a written statement that verifies you signed a document that explained restrictions about enrolling in the future. Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from this provision is no later than the first day of the month following the date your Group receives a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person, from the Subscriber

Special enrollment due to new Dependents. You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, within 30 days after marriage, establishment of domestic partnership, birth, adoption, or placement for adoption by submitting to your Group a Health Plan–approved enrollment application, and a Senior Advantage Election Form for each person.

Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from marriage or establishment of domestic partnership is no later than the first day of the month following the date your Group receives an enrollment application, and a Senior Advantage Election Form for each person, from the Subscriber. Subject to confirmation by the Centers for Medicare & Medicaid Services, enrollments due to birth, adoption, or placement for adoption are effective on the date of birth, date of adoption, or the date you or your Spouse have newly assumed a legal right to control health care in anticipation of adoption.

Special enrollment due to loss of other coverage. You may enroll as a Subscriber (along with any eligible Dependents), and existing Subscribers may add eligible Dependents, if all of the following are true:

- The Subscriber or at least one of the Dependents had other coverage when they previously declined all coverage through your Group
- The loss of the other coverage is due to one of the following:
  - exhaustion of COBRA coverage
  - termination of employer contributions for non-COBRA coverage
  - loss of eligibility for non-COBRA coverage, but not termination for cause or termination from an individual (nongroup) plan for nonpayment. For example, this loss of eligibility may be due to legal separation or divorce, moving out of the plan's service area, reaching the age limit for dependent children, or the subscriber's death, termination of employment, or reduction in hours of employment
  - loss of eligibility (but not termination for cause) for coverage through Covered California, Medicaid coverage (known as Medi-Cal in California), Children's Health Insurance Program coverage, or Medi-Cal Access Program coverage
  - reaching a lifetime maximum on all benefits

Note: If you are enrolling yourself as a Subscriber along with at least one eligible Dependent, only one of you must meet the requirements stated above.

To request enrollment, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person, to your Group within 30 days after loss of other coverage, except that the timeframe for submitting the application is 60 days if you are requesting enrollment due to loss of eligibility for coverage through Covered California, Medicaid, Children's Health Insurance Program, or Medi-Cal Access Program coverage. Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of an enrollment resulting from loss of other coverage is no later than the first day of the month following the date your Group receives an enrollment or change of enrollment application, and Senior Advantage Election Form for each person, from the Subscriber.

Special enrollment due to court or administrative order. Within 31 days after the date of a court or administrative order requiring a Subscriber to provide health care coverage for a Spouse or child who meets the eligibility requirements as a Dependent, the Subscriber may add the Spouse or child as a Dependent by submitting to your Group a Health Plan–approved

enrollment or change of enrollment application, and a Senior Advantage Election Form for each person.

Subject to confirmation by the Centers for Medicare & Medicaid Services, the effective date of coverage resulting from a court or administrative order is the first of the month following the date we receive the enrollment request, unless your Group specifies a different effective date (if your Group specifies a different effective date, the effective date cannot be earlier than the date of the order).

Special enrollment due to eligibility for premium assistance. You may enroll as a Subscriber (along with eligible Dependents), and existing Subscribers may add eligible Dependents, if you or a dependent become eligible for premium assistance through the Medi-Cal program. Premium assistance is when the Medi-Cal program pays all or part of premiums for employer group coverage for a Medi-Cal beneficiary. To request enrollment in your Group's health care coverage, the Subscriber must submit a Health Plan–approved enrollment or change of enrollment application, and a Senior Advantage Election Form for each person, to your Group within 60 days after you or a dependent become eligible for premium assistance. Please contact the California Department of Health Care Services to find out if premium assistance is available and the eligibility requirements.

Special enrollment due to reemployment after military service. If you terminated your health care coverage because you were called to active duty in the military service, you may be able to reenroll in your Group's health plan if required by state or federal law. Please ask your Group for more information.

How to Obtain Services

As a Member, you are selecting our medical care program to provide your health care. You must receive all covered care from Plan Providers inside our Service Area, except as described in the sections listed below for the following Services:

- Authorized referrals as described under "Getting a Referral" in this "How to Obtain Services" section
- Certain care when you visit the service area of another Region as described under "Receiving Care Outside of Your Home Region" in this "How to Obtain Services" section
- Emergency ambulance Services as described under "Ambulance Services" in the "Benefits and Your Cost Share" section
- Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care as described in the "Emergency Services and Urgent Care" section
- Out-of-area dialysis care as described under "Dialysis Care" in the "Benefits and Your Cost Share" section
- Prescription drugs from Non–Plan Pharmacies as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section
- Routine Services associated with Medicare-approved clinical trials as described under "Services Associated with Clinical Trials" in the "Benefits and Your Cost Share" section

Our medical care program gives you access to all of the covered Services you may need, such as routine care with your own personal Plan Physician, hospital care, laboratory and pharmacy Services, Emergency Services, Urgent Care, and other benefits described in this *EOC*.

Routine Care

To request a non-urgent appointment, you can call your local Plan Facility or request the appointment online. For appointment phone numbers, refer to our Provider Directory or call our Member Service Contact Center. To request an appointment online, go to our website at kp.org.

Urgent Care

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call our Member Service Contact Center.

For information about Out-of-Area Urgent Care, refer to "Urgent Care" in the "Emergency Services and Urgent Care" section.

Our Advice Nurses

We know that sometimes it's difficult to know what type of care you need. That's why we have telephone advice nurses available to assist you. Our advice nurses are registered nurses specially trained to help assess medical symptoms and provide advice over the phone, when medically appropriate. Whether you are calling for advice or to make an appointment, you can speak to an advice nurse. They can often answer questions about a minor concern, tell you what to do if a Plan Medical

Office is closed, or advise you about what to do next, including making a same-day Urgent Care appointment for you if it's medically appropriate. To reach an advice nurse, refer to our Provider Directory or call our Member Service Contact Center.

Your Personal Plan Physician

Personal Plan Physicians provide primary care and play an important role in coordinating care, including hospital stays and referrals to specialists.

We encourage you to choose a personal Plan Physician. You may choose any available personal Plan Physician. Parents may choose a pediatrician as the personal Plan Physician for their child. Most personal Plan Physicians are Primary Care Physicians (generalists in internal medicine, pediatrics, or family practice, or specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians). Some specialists who are not designated as Primary Care Physicians but who also provide primary care may be available as personal Plan Physicians. For example, some specialists in internal medicine and obstetrics/gynecology who are not designated as Primary Care Physicians may be available as personal Plan Physicians. However, if you choose a specialist who is not designated as a Primary Care Physician as your personal Plan Physician, the Cost Share for a Physician Specialist Visit will apply to all visits with the specialist except for Preventive Services listed in the "Benefits and Your Cost Share" section.

To learn how to select or change to a different personal Plan Physician, visit our website at kp.org, or call our Member Service Contact Center. Refer to our Provider Directory for a list of physicians that are available as Primary Care Physicians. The directory is updated periodically. The availability of Primary Care Physicians may change. If you have questions, please call our Member Service Contact Center. You can change your personal Plan Physician at any time for any reason.

Getting a Referral

Referrals to Plan Providers

A Plan Physician must refer you before you can receive care from specialists, such as specialists in surgery, orthopedics, cardiology, oncology, dermatology, and physical, occupational, and speech therapies. However, you do not need a referral or prior authorization to receive most care from any of the following Plan Providers:

- Your personal Plan Physician
- Generalists in internal medicine, pediatrics, and family practice
- Specialists in optometry, mental health Services, substance use disorder treatment, and obstetrics/gynecology

A Plan Physician must refer you before you can get care from a specialist in urology except that you do not need a referral to receive Services related to sexual or reproductive health, such as a vasectomy.

Although a referral or prior authorization is not required to receive most care from these providers, a referral may be required in the following situations:

- The provider may have to get prior authorization for certain Services in accord with "Medical Group authorization procedure for certain referrals" in this "Getting a Referral" section
- The provider may have to refer you to a specialist who has a clinical background related to your illness or condition

Standing referrals

If a Plan Physician refers you to a 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. For example, if you have a life-threatening, degenerative, or disabling condition, you can get a standing referral to a specialist if ongoing care from the specialist is required.

Medical Group authorization procedure for certain referrals

The following are examples of Services that require prior authorization by the Medical Group for the Services to be covered ("prior authorization" means that the Medical Group must approve the Services in advance):

- Durable medical equipment
- Ostomy and urological supplies
- Services not available from Plan Providers
- Transplants

Utilization Management (UM) is a process that determines whether a Service recommended by your treating provider is Medically Necessary for you. Prior authorization is a UM process that determines whether the requested services are Medically Necessary before care is provided. If it is Medically Necessary, then you will receive authorization to obtain that care in a clinically appropriate place consistent with the terms of your health coverage. Decisions regarding requests for authorization will be made only by licensed physicians or other appropriately licensed medical professionals.

For the complete list of Services that require prior authorization, and the criteria that are used to make authorization decisions, please visit our website at kp.org/UM or call our Member Service Contact Center to request a printed copy. Refer to "Post-Stabilization Care" under "Emergency Services" in the "Emergency Services and Urgent Care" section for authorization requirements that apply to Post-Stabilization Care from Non–Plan Providers.

Additional information about prior authorization for 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 Plan Physicians and medical professionals with clinical expertise. The formulary guidelines are periodically updated to keep pace with changes in medical technology, Medicare guidelines, and clinical practice.

If your Plan Physician prescribes one of these items, they will submit a written referral in accord with the UM process described in this "Medical Group authorization procedure for certain referrals" section. If the formulary guidelines do not specify that the prescribed item is appropriate for your medical condition, the referral will be submitted to the Medical Group's designee Plan Physician, who will make an authorization decision as described under "Medical Group's decision time frames" in this "Medical Group authorization procedure for certain referrals" section.

Medical Group's decision time frames. The applicable Medical Group designee will make the authorization decision within the time frame appropriate for your condition, but no later than five business days after receiving all of the information (including additional examination and test results) reasonably necessary to make the decision, except that decisions about urgent Services will be made no later than 72 hours after receipt of the information reasonably necessary to make the decision. If the Medical Group needs more time to make the decision because it doesn't have information reasonably necessary to make the decision, or because it has requested consultation by a particular specialist, you and your treating physician will be informed about the additional information, testing, or specialist that is needed, and the date that the Medical Group expects to make a decision.

Your treating physician will be informed of the decision within 24 hours after the decision is made. If the Services are authorized, your physician will be informed of the scope of the authorized Services. If the Medical Group does not authorize all of the Services, Health Plan will send you a written decision and explanation within two business days after the decision is made. Any written criteria that the Medical Group uses to make the decision to authorize, modify, delay, or deny the request for authorization will be made available to you upon request.

If the Medical Group does not authorize all of the Services requested and you want to appeal the decision, you can file a grievance as described in the "Coverage Decisions, Appeals, and Complaints" section.

Your Cost Share. For these referral Services, you pay **the Cost Share required for Services provided by a Plan Provider** as described in this *EOC*.

Travel and lodging for certain referrals

The following are examples of when we will arrange or provide reimbursement for certain travel and lodging expenses in accord with our Travel and Lodging Program Description:

- If Medical Group refers you to a provider that is more than 50 miles from where you live for certain specialty Services such as bariatric surgery, complex thoracic surgery, transplant nephrectomy, or inpatient chemotherapy for leukemia and lymphoma
- If Medical Group refers you to a provider that is outside our Service Area for certain specialty Services such as a transplant or transgender surgery

For the complete list of specialty Services for which we will arrange or provide reimbursement for travel and lodging expenses, the amount of reimbursement, limitations and exclusions, and how to request reimbursement, refer to the Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at kp.org/specialty-care/travel-reimbursements or by calling our Member Service Contact Center.

Second Opinions

If you want a second opinion, you can ask Member Services to help you arrange one with a Plan Physician who is an appropriately qualified medical professional for your condition. If there isn't a Plan Physician who is an appropriately qualified medical professional for your condition, Member Services will help you arrange a consultation with a Non–Plan Physician for a second opinion. For purposes of this "Second Opinions" provision, an "appropriately qualified medical professional" is a physician who is acting within their scope of practice and who possesses a clinical

background, including training and expertise, related to the illness or condition associated with the request for a second medical opinion.

Here are some examples of when a second opinion may be provided or authorized:

- Your Plan Physician has recommended a procedure and you are unsure about whether the procedure is reasonable or necessary
- You question a diagnosis or plan of care for a condition that threatens substantial impairment or loss of life, limb, or bodily functions
- The clinical indications are not clear or are complex and confusing
- A diagnosis is in doubt due to conflicting test results
- The Plan Physician is unable to diagnose the condition
- The treatment plan in progress is not improving your medical condition within an appropriate period of time, given the diagnosis and plan of care
- You have concerns about the diagnosis or plan of care
- 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 in the "Coverage Decisions, Appeals, and Complaints" section.

Your Cost Share. For these referral Services, you pay **the Cost Share required for Services provided by a Plan Provider** as described in this *EOC*.

Contracts with Plan Providers

How Plan Providers are paid

Health Plan and Plan Providers are independent contractors. Plan Providers are paid in a number of ways, such as salary, capitation, per diem rates, case rates, fee for service, and incentive payments. To learn more about how Plan Physicians are paid to provide or arrange medical and hospital care for Members, please visit our website at kp.org or call our Member Service Contact Center.

Financial liability

Our contracts with Plan Providers provide that you are not liable for any amounts we owe. However, you may have to pay the full price of noncovered Services you obtain from Plan Providers or Non–Plan Providers.

Your Cost Share. When you are referred to a Plan Provider for covered Services, you pay **the Cost Share required for Services from that provider** as described in this *EOC*.

Termination of a Plan Provider's contract and completion of Services

If our contract with any Plan Provider terminates while you are under the care of that provider, we will retain financial responsibility for covered care you receive from that provider until we make arrangements for the Services to be provided by another Plan Provider and notify you of the arrangements.

Completion of Services. If you are undergoing treatment for specific conditions from a Plan Physician (or certain other providers) when the contract with him or her ends (for reasons other than medical disciplinary cause, criminal activity, or the provider's voluntary termination), you may be eligible to continue receiving covered care from the terminated provider for your condition. The conditions that are subject to this continuation of care provision are:

- Certain conditions that are either acute, or serious and chronic. We may cover these Services for up to 90 days, or longer, if necessary for a safe transfer of care to a Plan Physician or other contracting provider as determined by the Medical Group
- A high-risk pregnancy or a pregnancy in its second or third trimester. We may cover these Services through postpartum care related to the delivery, or longer if Medically Necessary for a safe transfer of care to a Plan Physician as determined by the Medical Group

The Services must be otherwise covered under this *EOC*. Also, the terminated provider must agree in writing to our contractual terms and conditions and comply with them for Services to be covered by us.

Your Cost Share. For the Services of a terminated provider, you pay **the Cost Share required for Services provided by a Plan Provider** as described in this *EOC*.

More information. For more information about this provision, or to request the Services, please call our Member Service Contact Center.

Receiving Care Outside of Your Home Region

If you have questions about your coverage when you are away from home, call the Away from Home Travel line at **1-951-268-3900** 24 hours a day, seven days a week

(except closed holidays). For example, call this number for the following concerns:

- What you should do to prepare for your trip
- What Services are covered when you are outside our Service Area
- How to get care in another Region
- How to request reimbursement if you paid for covered Services outside our Service Area

You can also get information on our website at kp.org/travel.

Receiving Care in the Service Area of another Region

If you visit the service area of another Region temporarily, you can receive certain care covered under this *EOC* from designated providers in that service area.

Please call our Member Service Contact Center or our Away from Home Travel Line at **1-951-268-3900** (TTY users call **711)**, 24 hours a day, seven days a week except holidays, for more information about getting care when visiting another Kaiser Permanente Region's service area, including coverage information and facility locations in the service area of another Region.

Your ID Card

Each Member's Kaiser Permanente ID card has a medical record number on it, which you will need when you call for advice, make an appointment, or go to a provider for covered care. When you get care, please bring your Kaiser Permanente ID card and a photo ID. Your medical record number is used to identify your medical records and membership information. Your medical record number should never change. Please call our Member Service Contact Center if we ever inadvertently issue you more than one medical record number or if you need to replace your Kaiser Permanente ID card.

Your ID card is for identification only. To receive covered Services, you must be a current Member. Anyone who is not a Member will be billed as a non-Member for any Services they receive. If you let someone else use your ID card, we may keep your ID card and terminate your membership as described under "Termination for Cause" in the "Termination of Membership" section.

Your Medicare card

Do NOT use your red, white, and blue Medicare card for covered medical Services while you are 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 hospice services or participate in routine research studies.

Getting Assistance

We want you to be satisfied with the health care you receive from Kaiser Permanente. If you have any questions or concerns, please discuss them with your personal Plan Physician or with other Plan Providers who are treating you. They are committed to your satisfaction and want to help you with your questions.

Member Services

Member Services representatives can answer any questions you have about your benefits, available Services, and the facilities where you can receive care. For example, they can explain the following:

- Your Health Plan benefits
- How to make your first medical appointment
- What to do if you move
- How to replace your Kaiser Permanente ID card

Many Plan Facilities have an office staffed with representatives who can provide assistance if you need help obtaining Services. At different locations, these offices may be called Member Services, Patient Assistance, or Customer Service. In addition, our Member Service Contact Center representatives are available to assist you seven days a week from 8 a.m. to 8 p.m. toll free at **1-800-443-0815** or **711** (TTY for the deaf, hard of hearing, or speech impaired). For your convenience, you can also contact us through our website at kp.org.

Cost Share estimates

For information about estimates, see "Getting an estimate of your Cost Share" under "Your Cost Share" in the "Benefits and Your Cost Share" section.

Plan Facilities

Plan Medical Offices and Plan Hospitals are listed in the Provider Directory for your Home Region. The directory describes the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services. This directory is available on our website at kp.org/facilities. To obtain a printed copy, call our Member Service Contact Center.

The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call our Member Service Contact Center.

At most of our Plan Facilities, you can usually receive all of the covered Services you need, including specialty care, pharmacy, and lab work. You are not restricted to a particular Plan Facility, and we encourage you to use the facility that will be most convenient for you:

- All Plan Hospitals provide inpatient Services and are open 24 hours a day, seven days a week
- Emergency Services are available from Plan Hospital Emergency Departments (for Emergency Department locations, refer to our Provider Directory or call our Member Service Contact Center)
- Same-day Urgent Care appointments are available at many locations (for Urgent Care locations, refer to our Provider Directory or call our Member Service Contact Center)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services Department (for locations, refer to our Provider Directory or call our Member Service Contact Center)
- Plan Pharmacies are located at most Plan Medical Offices (refer to *Kaiser Permanente Pharmacy Directory* for pharmacy locations)

Provider Directory

The *Provider Directory* lists our Plan Providers. It is subject to change and periodically updated. If you don't have our *Provider Directory*, you can get a copy by calling our Member Service Contact Center or by visiting our website at kp.org/directory.

Pharmacy Directory

The *Kaiser Permanente Pharmacy Directory* lists the locations of Plan Pharmacies, which are also called "network pharmacies." The pharmacy directory provides additional information about obtaining prescription drugs. It is subject to change and periodically updated. If you don't have the *Kaiser Permanente Pharmacy Directory*, you can get a copy by calling our Member Service Contact Center or by visiting our website at kp.org/directory.

Emergency Services and Urgent Care

Emergency Services

If you have an Emergency Medical Condition, call 911 (where available) or go to the nearest hospital Emergency Department. You do not need prior authorization for Emergency Services. When you have an Emergency Medical Condition, we cover Emergency Services you receive from Plan Providers or Non–Plan Providers anywhere in the world.

Emergency Services are available from Plan Hospital Emergency Departments 24 hours a day, seven days a week.

Post-Stabilization Care

Post-Stabilization Care is Medically Necessary Services related to your Emergency Medical Condition that you receive in a hospital (including the Emergency Department) after your treating physician determines that your condition is Stabilized.

To request prior authorization, the Non–Plan Provider must call **1-800-225-8883** or the notification phone number on your Kaiser Permanente ID card *before* you receive the care. We will discuss your condition with the Non–Plan Provider. If we determine that you require Post-Stabilization Care and that this care is part of your covered benefits, we will authorize your care from the Non–Plan Provider or arrange to have a Plan Provider (or other designated provider) provide the care with the treating physician's concurrence. If we decide to have a Plan Hospital, Plan Skilled Nursing Facility, or designated Non–Plan Provider provide your care, we may authorize special transportation services that are medically required to get you to the provider. This may include transportation that is otherwise not covered.

Be sure to ask the Non–Plan Provider to tell you what care (including any transportation) we have authorized because we will not cover unauthorized Post-Stabilization Care or related transportation provided by Non–Plan Providers. If you receive care from a Non– Plan Provider that we have not authorized, you may have to pay the full cost of that care if you are notified by the Non–Plan Provider or us about your potential liability.

Your Cost Share

Your Cost Share for covered Emergency Services and Post-Stabilization Care is described in the "Benefits and Your Cost Share" section. Your Cost Share is the same

whether you receive the Services from a Plan Provider or a Non–Plan Provider. For example:

- If you receive Emergency Services in the Emergency Department of a Non–Plan Hospital, you pay the Cost Share for an Emergency Department visit as described under "Outpatient Care"
- If we gave prior authorization for inpatient Post-Stabilization Care in a Non–Plan Hospital, you pay the Cost Share for hospital inpatient care as described under "Hospital Inpatient Care"

Urgent Care

Inside the Service Area

An Urgent Care need is one that requires prompt medical attention but is not an Emergency Medical Condition. If you think you may need Urgent Care, call the appropriate appointment or advice number at a Plan Facility. For appointment and advice phone numbers, refer to our Provider Directory or call our Member Service Contact Center.

In the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC* (such as a major disaster, epidemic, war, riot, and civil insurrection), we cover Urgent Care inside our Service Area from a Non–Plan Provider.

Out-of-Area Urgent Care

If you need Urgent Care due to an unforeseen illness or unforeseen injury, we cover Medically Necessary Services to prevent serious deterioration of your health from a Non–Plan Provider if all of the following are true:

- You receive the Services from Non–Plan Providers while you are temporarily outside our Service Area
- A reasonable person would have believed that your health would seriously deteriorate if you delayed treatment until you returned to our Service Area

You do not need prior authorization for Out-of-Area Urgent Care. We cover Out-of-Area Urgent Care you receive from Non–Plan Providers if the Services would have been covered under this *EOC* if you had received them from Plan Providers.

We do not cover follow-up care from Non–Plan Providers after you no longer need Urgent Care. To obtain follow-up care from a Plan Provider, call the appointment or advice phone number at a Plan Facility. For phone numbers, refer to our Provider Directory or call our Member Service Contact Center.

Your Cost Share

Your Cost Share for covered Urgent Care is the Cost Share required for Services provided by Plan Providers as described in this *EOC*. For example:

- If you receive an Urgent Care evaluation as part of covered Out-of-Area Urgent Care from a Non–Plan Provider, you pay the Cost Share for Urgent Care consultations, evaluations, and treatment as described under "Outpatient Care"
- If the Out-of-Area Urgent Care you receive includes an X-ray, you pay the Cost Share for an X-ray as described under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services" in addition to the Cost Share for the Urgent Care evaluation
- Note: If you receive Urgent Care in an Emergency Department, you pay the Cost Share for an Emergency Department visit as described under "Outpatient Care."

Payment and Reimbursement

If you receive Emergency Services, Post-Stabilization Care, or Urgent Care from a Non–Plan Provider as described in this "Emergency Services and Urgent Care" section, or emergency ambulance Services described under "Ambulance Services" in the "Benefits and Your Cost Share" section, ask the Non–Plan Provider to submit a claim to us within 60 days or as soon as possible, but no later than 15 months after receiving the care (or up to 27 months according to Medicare rules, in some cases). If the provider refuses to bill us, send us the unpaid bill with a claim form. Also, if you receive Services from a Plan Provider that are prescribed by a Non–Plan Provider as part of covered Emergency Services, Post-Stabilization Care, and Urgent Care (for example, drugs), you may be required to pay for the Services and file a claim. To request payment or reimbursement, you must file a claim as described in the "Requests for Payment" section.

We will reduce any payment we make to you or the Non–Plan Provider by the applicable Cost Share. Also, in accord with applicable law, we will reduce our payment by any amounts paid or payable (or that in the absence of this plan would have been payable) for the Services under any insurance policy, or any other contract or coverage, or any government program except Medicaid.

Benefits and Your Cost Share

- This section describes the Services that are covered under this *EOC*.
- Services are covered under this *EOC* as specifically described in this *EOC*. Services that are not specifically described in this *EOC* are not covered, except as required by federal law. Services are subject to exclusions and limitations described in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. Except as otherwise described in this *EOC*, all of the following conditions must be satisfied:
- You are a Member on the date that you receive the Services
- The Services are Medically Necessary
- The Services are one of the following:
  - Preventive Services
  - health care items and services for diagnosis, assessment, or treatment
  - health education covered under "Health Education" in this "Benefits and Your Cost Share" section
  - other health care items and services
  - other services to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness
- The Services are provided, prescribed, authorized, or directed by a Plan Physician except for:
  - certain care when you visit the service area of another Region, as described under "Receiving Care Outside of Your Home Region" in the "How to Obtain Services" section
  - drugs prescribed by dentists, as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section
  - emergency ambulance Services, as described under "Ambulance Services" in this "Benefits and Your Cost Share" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
  - eyeglasses and contact lenses prescribed by Non–Plan Providers, as described under "Vision Services" in this "Benefits and Your Cost Share" section
  - out-of-area dialysis care, as described under "Dialysis Care" in this "Benefits and Your Cost Share" section
  - routine Services associated with Medicare-approved clinical trials, as described under "Services Associated with Clinical Trials" in this "Benefits and Your Cost Share" section
- You receive the Services from Plan Providers inside our Service Area, except for:
  - authorized referrals, as described under "Getting a Referral" in the "How to Obtain Services" section
  - certain care when you visit the service area of another Region, as described under "Receiving Care Outside of Your Home Region" in the "How to Obtain Services" section
  - emergency ambulance Services, as described under "Ambulance Services" in this "Benefits and Your Cost Share" section
  - Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care, as described in the "Emergency Services and Urgent Care" section
  - out-of-area dialysis care, as described under "Dialysis Care" in this "Benefits and Your Cost Share" section
  - prescription drugs from Non–Plan Pharmacies, as described under "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section
  - routine Services associated with Medicare-approved clinical trials, as described under "Services Associated with Clinical Trials" in this "Benefits and Your Cost Share" section
- The Medical Group has given prior authorization for the Services, if required, as described under "Medical Group authorization procedure for certain referrals" in the "How to Obtain Services" section

Please also refer to:

- The "Emergency Services and Urgent Care" section for information about how to obtain covered Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care
- Our Provider Directory for the types of covered Services that are available from each Plan Facility, because some facilities provide only specific types of covered Services

Your Cost Share

Your Cost Share is the amount you are required to pay for covered Services. The Cost Share for covered Services is listed in this *EOC*. For example, your Cost Share may be a Copayment or Coinsurance. If your coverage includes a Plan Deductible and you receive

Services that are subject to the Plan Deductible, your Cost Share for those Services will be Charges until you reach the Plan Deductible.

General rules, examples, and exceptions

Your Cost Share for covered Services will be the Cost Share in effect on the date you receive the Services, except as follows:

- If you are receiving covered inpatient hospital Services on the effective date of this *EOC*, you pay the Cost Share in effect on your admission date until you are discharged if the Services were covered under your prior Health Plan evidence of coverage and there has been no break in coverage. However, if the Services were not covered under your prior Health Plan evidence of coverage, or if there has been a break in coverage, you pay the Cost Share in effect on the date you receive the Services
- For items ordered in advance, you pay the Cost Share in effect on the order date (although we will not cover the item unless you still have coverage for it on the date you receive it) and you may be required to pay the Cost Share 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

Payment toward your Cost Share (and when you may be billed). In most cases, your provider will ask you to make a payment toward your Cost Share at the time you receive Services. If you receive more than one type of Services (such as primary care treatment and laboratory tests), you may be required to pay separate Cost Share for each of those Services. Keep in mind that your payment toward your Cost Share may cover only a portion of your total Cost Share for the Services you receive, and you will be billed for any additional amounts that are due. The following are examples of when you may be asked to pay (or you may be billed for) Cost Share amounts in addition to the amount you pay at check-in:

- You receive non-preventive Services during a preventive visit. For example, you go in for a routine physical exam, and at check-in you pay your Cost Share for the preventive exam (your Cost Share may be "no charge"). However, during your preventive exam your provider finds a problem with your health and orders non-preventive Services to diagnose your problem (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional non-preventive diagnostic Services
- You receive diagnostic Services during a treatment visit. For example, you go in for treatment of an existing health condition, and at check-in you pay your Cost Share for a treatment visit. However, during the visit your provider finds a new problem with your health and performs or orders diagnostic Services (such as laboratory tests). You may be asked to pay (or you will be billed for) your Cost Share for these additional diagnostic Services
- You receive treatment Services during a diagnostic visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider confirms a problem with your health and performs treatment Services (such as an outpatient procedure). You may be asked to pay (or you will be billed for) your Cost Share for these additional treatment Services
- You receive Services from a second provider during your visit. For example, you go in for a diagnostic exam, and at check-in you pay your Cost Share for a diagnostic exam. However, during the diagnostic exam your provider requests a consultation with a specialist. You may be asked to pay (or you will be billed for) your Cost Share for the consultation with the specialist

In some cases, your provider will not ask you to make a payment at the time you receive Services, and you will be billed for your Cost Share (for example, some Laboratory Departments are not able to collect Cost Shares).

- When we send you a bill, it will list Charges for the Services you received, payments and credits applied to your account, and any amounts you still owe. Your current bill may not always reflect your most recent Charges and payments. Any Charges and payments that are not on the current bill will appear on a future bill. Sometimes, you may see a payment but not the related Charges for Services. That could be because your payment was recorded before the Charges for the Services were processed. If so, the Charges will appear on a future bill. Also, you may receive more than one bill for a single outpatient visit or inpatient stay. For example, you may receive a bill for physician services and a separate bill for hospital services. If you don't see all the Charges for Services on one bill, they will appear on a future bill. If we determine that you overpaid and are due a refund, then we will send a refund to you within four weeks after we make that determination. If you have questions about a bill, please call the phone number on the bill.

In some cases, a Non–Plan Provider may be involved in the provision of covered Services at a Plan Facility or a

contracted facility where we have authorized you to receive care. You are not responsible for any amounts beyond your Cost Share for the covered Services you receive at Plan Facilities or at contracted facilities where we have authorized you to receive care. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Requests for Payment" section.

Primary Care Visits, Non-Physician Specialist Visits, and Physician Specialist Visits. The Cost Share for a Primary Care Visit applies to evaluations and treatment provided by generalists in internal medicine, pediatrics, or family practice, and by specialists in obstetrics/gynecology whom the Medical Group designates as Primary Care Physicians. Some physician specialists provide primary care in addition to specialty care but are not designated as Primary Care Physicians. If you receive Services from one of these specialists, the Cost Share for a Physician Specialist Visit will apply to all consultations, evaluations, and treatment provided by the specialist except for routine preventive counseling and exams listed under "Preventive Services" in this "Benefits and Your Cost Share" section. For example, if your personal Plan Physician is a specialist in internal medicine or obstetrics/gynecology who is not a Primary Care Physician, you will pay the Cost Share for a Physician Specialist Visit for all consultations, evaluations, and treatment by the specialist except routine preventive counseling and exams listed under "Preventive Services" in this "Benefits and Your Cost Share" section. The Non-Physician Specialist Visit Cost Share applies to consultations, evaluations, and treatment provided by non-physician specialists (such as nurse practitioners, physician assistants, optometrists, podiatrists, and audiologists).

Noncovered Services. If you receive Services that are not covered under this *EOC*, you may have to pay the full price of those Services. Payments you make for noncovered Services do not apply to any deductible or out-of-pocket maximum.

Getting an estimate of your Cost Share

If you have questions about the Cost Share for specific Services that you expect to receive or that your provider orders during a visit or procedure, please visit our website at kp.org/memberestimates to use our cost estimate tool or call our Member Service Contact Center.

- If you have a Plan Deductible and would like an estimate for Services that are subject to the Plan Deductible, please call **1-800-390-3507** (TTY users call **711**) Monday through Friday, 7 a.m. to 7 p.m.
- For all other Cost Share estimates, please call **1-800443-0815**, 8 a.m. to 8 p.m., seven days a week (TTY users should call **711**)

Cost Share estimates are based on your benefits and the Services you expect to receive. They are a prediction of cost and not a guarantee of the final cost of Services. Your final cost may be higher or lower than the estimate since not everything about your care can be known in advance.

Copayments and Coinsurance

The Copayment or Coinsurance you must pay for each covered Service, after you meet any applicable deductible, is described in this *EOC*.

Note: If Charges for Services are less than the Copayment described in this *EOC*, you will pay the lesser amount.

Outpatient Care

We cover the following outpatient care subject to the Cost Share indicated:

Office visits

- Primary Care Visits and Non-Physician Specialist Visits that are not described elsewhere in this *EOC*: **no charge**
- Physician Specialist Visits that are not described elsewhere in this *EOC*: **no charge**
- House calls by a Plan Physician (or a Plan Provider who is a registered nurse) inside our Service Area when care can best be provided in your home as determined by a Plan Physician:
  - Primary Care Visits and Non-Physician Specialist Visits: **no charge**
  - Physician Specialist Visits: **no charge**
- Routine physical exams that are medically appropriate preventive care in accord with generally accepted professional standards of practice: **no charge**
- Family planning counseling, or internally implanted time-release contraceptives or intrauterine devices (IUDs) and office visits related to their administration and management: **no charge**
- After confirmation of pregnancy, the normal series of regularly scheduled preventive prenatal care exams and the first postpartum follow-up consultation and exam: **no charge**
- Voluntary termination of pregnancy: **no charge**

- Physical, occupational, and speech therapy in accord with Medicare guidelines: **no charge**
- Group and individual physical therapy prescribed by a Plan Provider to prevent falls: **no charge**
- Physical, occupational, and speech therapy provided in an organized, multidisciplinary rehabilitation day-treatment program in accord with Medicare guidelines: **no charge**
- Manual manipulation of the spine to correct subluxation, in accord with Medicare guidelines, is covered when provided by a Plan Provider or a chiropractor when referred by a Plan Provider: **no charge**

Acupuncture Services

- Acupuncture for chronic low back pain up to 12 visits in 90 days, in accord with Medicare guidelines: **no charge**. Chronic low back pain is defined as follows:
  - ♦ lasting 12 weeks or longer
  - ♦ non-specific, in that it has no identifiable systemic cause (i.e. not associated with metastatic, inflammatory, infectious, etc. disease)
  - ♦ not associated with surgery or pregnancy
- An additional eight sessions are covered for those 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.
- Acupuncture not covered by Medicare (typically provided only for the treatment of nausea or as part of a comprehensive pain management program for the treatment of chronic pain): **no charge**

Emergency and Urgent Care visits

- Urgent Care consultations, evaluations, and treatment: **no charge**
- Emergency Department visits: **no charge**
- **If you are admitted from the Emergency Department**. If you are admitted to the hospital as an inpatient for covered Services (either within 24 hours for the same condition or after an observation stay), then the Services you received in the Emergency Department and observation stay, if applicable, will be considered part of your inpatient hospital stay. For the Cost Share for inpatient care, refer to "Hospital Inpatient Care" in this "Benefits and Your Cost Share" section. However, the Emergency Department Cost Share does apply if you are admitted for observation but are not admitted as an inpatient.

Outpatient surgeries and procedures

- Outpatient surgery and outpatient procedures when provided in an outpatient 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: **no charge**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **no charge**
- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Cost Share that would otherwise apply for the procedure** in this "Benefits and Your Cost Share" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Pre- and post-operative visits:
  - ♦ Primary Care Visits and Non-Physician Specialist Visits: **no charge**
  - ♦ Physician Specialist Visits: **no charge**

Administered drugs and products

Administered drugs and products are medications and products that require administration or observation by medical personnel. We cover these items when prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility or during home visits.

We cover the following Services and their administration in a Plan Facility at the Cost Share indicated:

- Whole blood, red blood cells, plasma, and platelets: **no charge**
- Allergy antigens (including administration): **no charge**
- Cancer chemotherapy drugs and adjuncts: **no charge**
- Drugs and products that are administered via intravenous therapy or injection that are not for cancer chemotherapy, including blood factor products and biological products ("biologics") derived from tissue, cells, or blood: **no charge**
- Tuberculosis skin tests: **no charge**
- All other administered drugs and products: **no charge**

- We cover drugs and products administered to you during a home visit at **no charge**.

Certain administered drugs are Preventive Services. Refer to "Preventive Services" for information on immunizations.

Note: Vaccines covered by Medicare Part D are not covered under this "Outpatient Care" section (instead, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section).

For the following Services, refer to these sections

- Bariatric Surgery
- Dental Services
- Dialysis Care
- Durable Medical Equipment ("DME") for Home Use
- Fertility Services
- Health Education
- Hearing Services
- Home Health Care
- Hospice Care
- Meals
- Mental Health Services
- Ostomy, Urological, and Wound Care Supplies
- Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services
- Outpatient Prescription Drugs, Supplies, and Supplements
- Preventive Services
- Prosthetic and Orthotic Devices
- Reconstructive Surgery
- Services Associated with Clinical Trials
- Substance Use Disorder Treatment
- Transplant Services
- Vision Services

Hospital Inpatient Care

We cover the following inpatient Services in a Plan Hospital, when the Services are generally and customarily provided by acute care general hospitals inside our Service Area:

- Room and board, including a private room if Medically Necessary
- Specialized care and critical care units
- General and special nursing care
- Operating and recovery rooms
- Services of Plan Physicians, including consultation and treatment by specialists
- Anesthesia
- Drugs prescribed in accord with our drug formulary guidelines (for discharge drugs prescribed when you are released from the hospital, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section)
- Radioactive materials used for therapeutic purposes
- Durable medical equipment and medical supplies
- Imaging, laboratory, and other diagnostic and treatment Services, including MRI, CT, and PET scans
- Whole blood, red blood cells, plasma, platelets, and their administration
- Obstetrical care and delivery (including cesarean section). Note: If you are discharged within 48 hours after delivery (or within 96 hours if delivery is by cesarean section), your Plan Physician may order a follow-up visit for you and your newborn to take place within 48 hours after discharge (for visits after you are released from the hospital, please refer to "Outpatient Care" in this "Benefits and Your Cost Share" section)
- Physical, occupational, and speech therapy (including treatment in an organized, multidisciplinary rehabilitation program) in accord with Medicare guidelines
- Respiratory therapy
- Medical social services and discharge planning

Your Cost Share. We cover hospital inpatient Services at **no charge**.

For the following Services, refer to these sections

- Bariatric surgical procedures (refer to "Bariatric Surgery")
- Dental procedures (refer to "Dental Services")
- Dialysis care (refer to "Dialysis Care")
- Fertility Services related to diagnosis and treatment of infertility, artificial insemination, or assisted reproductive technology (refer to "Fertility Services")
- Hospice care (refer to "Hospice Care")
- Mental health Services (refer to "Mental Health Services")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")

- Reconstructive surgery Services (refer to "Reconstructive Surgery")
- Services in connection with a clinical trial (refer to "Services in Connection with a Clinical Trial")
- Skilled inpatient Services in a Plan Skilled Nursing Facility (refer to "Skilled Nursing Facility Care")
- Substance use disorder treatment Services (refer to "Substance Use Disorder Treatment")
- Transplant Services (refer to "Transplant Services")

Ambulance Services

Emergency

We cover Services of a licensed ambulance anywhere in the world without prior authorization (including transportation through the 911 emergency response system where available) in the following situations:

- You reasonably believed that the medical condition was an Emergency Medical Condition which required ambulance Services
- Your treating physician determines that you must be transported to another facility because your Emergency Medical Condition is not Stabilized and the care you need is not available at the treating facility

If you receive emergency ambulance Services that are not ordered by a Plan Provider, you are not responsible for any amounts beyond your Cost Share for covered emergency ambulance Services. However, if the provider does not agree to bill us, you may have to pay for the Services and file a claim for reimbursement. For information on how to file a claim, please see the "Requests for Payment" section.

Nonemergency

Inside our Service Area, we cover nonemergency ambulance Services in accord with Medicare guidelines if a Plan Physician determines that your condition requires the use of Services that only a licensed ambulance can provide and that the use of other means of transportation would endanger your health. These Services are covered only when the vehicle transports you to and from qualifying locations as defined by Medicare guidelines.

Your Cost Share

You pay the following for covered ambulance Services:

- Emergency ambulance Services: **no charge**
- Nonemergency Services: **no charge**

Ambulance Services exclusions

- Transportation by car, taxi, bus, gurney van, wheelchair van, and any other type of transportation (other than a licensed ambulance), even if it is the only way to travel to a Plan Provider

Bariatric Surgery

We cover hospital inpatient care related to bariatric surgical procedures (including room and board, imaging, laboratory, 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

Your Cost Share. 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, see "Hospital Inpatient Care" in this "Benefits and Your Cost Share" section for the Cost Share that applies for hospital inpatient care.

For the following Services, refer to these sections

- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Dental Services

Dental Services for radiation treatment

We cover services in accord with Medicare guidelines, including dental evaluation, X-rays, fluoride treatment, and extractions necessary to prepare your jaw for radiation therapy of cancer in your head or neck if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist for those Services (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental Services for transplants

We cover dental services that are Medically Necessary to free the mouth from infection in order to prepare for a transplant covered under "Transplant Services" in this "Benefits" section, if a Plan Physician provides the Services or if the Medical Group authorizes a referral to a dentist for those Services (as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Dental anesthesia

For dental procedures at a Plan Facility, we cover general anesthesia and the facility's Services associated with the anesthesia if all of the following are true:

- You are under age 7, or you are developmentally disabled, or your health is compromised
- Your clinical status or underlying medical condition requires that the dental procedure be provided in a hospital or outpatient surgery center
- The dental procedure would not ordinarily require general anesthesia

We do not cover any other Services related to the dental procedure, such as the dentist's Services, unless the Service is covered in accord with Medicare guidelines.

Your Cost Share

You pay the following for dental Services covered under this "Dental Services" section:

- Non-Physician Specialist Visits with dentists for Services covered under this "Dental Services" section: **no charge**
- Physician Specialist Visits for Services covered under this "Dental Services" section: **no charge**
- Outpatient surgery and outpatient procedures when provided in an outpatient 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: **no charge**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **no charge**
- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Cost Share that would otherwise apply for the procedure** in this "Benefits and Your Cost Share" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Hospital inpatient care (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services): **no charge**

For the following Services, refer to these sections

- Office visits not described in this "Dental Services" section (refer to "Outpatient Care")
- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Dialysis Care

We cover acute and chronic dialysis Services if all of the following requirements are met:

- You satisfy all medical criteria developed by the Medical Group
- The facility is certified by Medicare
- A Plan Physician provides a written referral for your dialysis treatment except for out-of-area dialysis care

We also cover hemodialysis and peritoneal home dialysis (including equipment, training, and medical supplies). Coverage is limited to the standard item of equipment or supplies that adequately meets your medical needs. We decide whether to rent or purchase the equipment and supplies, and we select the vendor. You must return the equipment and any unused supplies to us or pay us the fair market price of the equipment and any unused supply when we are no longer covering them.

Out-of-area dialysis care

We cover dialysis (kidney) Services that you get at a Medicare-certified dialysis facility when you are temporarily outside our Service Area. If possible, before you leave the Service Area, please let us know where you are going so we can help arrange for you to have maintenance dialysis while outside our Service Area.

The procedure for obtaining reimbursement for out-of-area dialysis care is described in the "Requests for Payment" section.

Your Cost Share. You pay the following for these covered Services related to dialysis:

- Equipment and supplies for home hemodialysis and home peritoneal dialysis: **no charge**
- One routine outpatient visit per month with the multidisciplinary nephrology team for a consultation, evaluation, or treatment: **no charge**
- Hemodialysis and peritoneal dialysis treatment: **no charge**
- Hospital inpatient care (including room and board, drugs, imaging, laboratory, and other diagnostic and treatment Services, and Plan Physician Services): **no charge**

For the following Services, refer to these sections

- Durable medical equipment for home use (refer to "Durable Medical Equipment ("DME") for Home Use")
- Hospital inpatient care (refer to "Hospital Inpatient Care")
- Office visits not described in this "Dialysis Care" section (refer to "Outpatient Care")
- Kidney disease education (refer to "Health Education")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")
- Telehealth Visits (refer to "Telehealth Visits")

Dialysis care exclusion(s)

- Comfort, convenience, or luxury equipment, supplies and features
- Nonmedical items, such as generators or accessories to make home dialysis equipment portable for travel

Durable Medical Equipment ("DME") for Home Use

DME coverage rules

DME for home use is an item that meets the following criteria:

- The item is intended for repeated use
- The item is primarily and customarily used to serve a medical purpose
- The item is generally useful only to an individual with an illness or injury
- The item is appropriate for use in the home (or another location used as your home as defined by Medicare)

For a DME item to be covered, all of the following requirements must be met:

- Your *EOC* includes coverage for the requested DME item
- A Plan Physician has prescribed the DME item for your medical condition
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage 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.

DME for diabetes

We cover the following diabetes blood-testing supplies and equipment and insulin-administration devices if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Insulin pumps and supplies to operate the pump

Your Cost Share. You pay the following for covered DME for diabetes (including repair or replacement of covered equipment):

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices): **no charge**
- Insulin pumps and supplies to operate the pump: **no charge**

Base DME Items

We cover Base DME Items (including repair or replacement of covered equipment) if all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home

Use" section are met. "Base DME Items" means the following items:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices)
- Bone stimulator
- Canes (standard curved handle or quad) and replacement supplies
- Cervical traction (over door)
- Crutches (standard or forearm) and replacement supplies
- Dry pressure pad for a mattress
- Infusion pumps (such as insulin pumps) and supplies to operate the pump
- IV pole
- Nebulizer and supplies
- Phototherapy blankets for treatment of jaundice in newborns

Your Cost Share. You pay the following for covered Base DME Items: **no charge**.

Other covered DME items

- If all of the requirements described under "DME coverage rules" in this "Durable Medical Equipment ("DME") for Home Use" section are met, we cover the following other DME items (including repair or replacement of covered equipment):
- 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 preventing daily living activities
- Nontherapeutic continuous glucose monitoring devices and related supplies
- Peak flow meters
- Resuscitation bag if tracheostomy patient has significant secretion management problems, needing lavage and suction technique aided by deep breathing via resuscitation bag

Your Cost Share. You pay the following for other covered DME items: **no charge**.

Outside our Service Area

We do not cover most DME for home use outside our Service Area. However, if you live outside our Service Area, we cover the following DME (subject to the Cost Share and all other coverage requirements that apply to DME for home use inside our Service Area) when the item is dispensed at a Plan Facility:

- Blood glucose monitors for diabetes blood testing and their supplies (such as blood glucose monitor test strips, lancets, and lancet devices) from a Plan Pharmacy
- Canes (standard curved handle)
- Crutches (standard)
- Nebulizers and their supplies for the treatment of pediatric asthma
- Peak flow meters from a Plan Pharmacy

For the following Services, refer to these sections

- Dialysis equipment and supplies required for home hemodialysis and home peritoneal dialysis (refer to "Dialysis Care")
- Diabetes urine testing supplies and insulin-administration devices other than insulin pumps (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Durable medical equipment related to the terminal illness for Members who are receiving covered hospice care (refer to "Hospice Care")
- Insulin and any other drugs administered with an infusion pump (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

DME for home use exclusion(s)

- Comfort, convenience, or luxury equipment or features
- Dental appliances
- Items not intended for maintaining normal activities of daily living, such as exercise equipment (including devices intended to provide additional support for recreational or sports activities)
- Hygiene equipment
- Nonmedical items, such as sauna baths or elevators
- Modifications to your home or car, unless covered in accord with Medicare guidelines
- Devices for testing blood or other body substances (except diabetes blood glucose monitors and their supplies)

- Electronic monitors of the heart or lungs except infant apnea monitors
- Repair or replacement of equipment due to misuse

Fertility Services

"Fertility Services" means treatments and procedures to help you become pregnant.

Diagnosis and treatment of infertility

For purposes of this "Diagnosis and treatment of infertility" section, "infertility" means not being able to get pregnant or carry a pregnancy to a live birth after a year or more of regular sexual relations without contraception or having a medical or other demonstrated condition that is recognized by a Plan Physician as a cause of infertility. We cover the following:

- Services for the diagnosis and treatment of infertility
- Artificial insemination

You pay the following for covered infertility Services:

- Office visits: **no charge**
- Most outpatient surgery and outpatient procedures when provided in an outpatient or ambulatory surgery center or in a hospital operating room, or provided in any setting where a licensed staff member monitors your vital signs as you regain sensation after receiving drugs to reduce sensation or to minimize discomfort: **no charge**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **no charge**
- Outpatient imaging: **no charge**
- Outpatient laboratory: **no charge**
- Outpatient diagnostic Services: **no charge**
- Outpatient administered drugs: **no charge**
- Hospital inpatient care (including room and board, imaging, laboratory, and other diagnostic and treatment Services, and Plan Physician Services): **no charge**
- Note: Administered drugs and products are medications and products that require administration or observation by medical personnel. We cover these items when they are prescribed by a Plan Provider, in accord with our drug formulary guidelines, and they are administered to you in a Plan Facility.

For the following Services, refer to these sections

- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

Fertility Services exclusion(s)

- Services to reverse voluntary, surgically induced infertility
- Semen and eggs (and Services related to their procurement and storage)
- Assisted reproductive technology Services, such as ovum transplants, gamete intrafallopian transfer (GIFT), in vitro fertilization (IVF), and zygote intrafallopian transfer (ZIFT)

Health Education

We cover a variety of health education counseling, programs, and materials that your personal Plan Physician or other Plan Providers provide during a visit covered under another part of this *EOC*.

We also cover a variety of health education counseling, programs, and materials to help you take an active role in protecting and improving your health, including programs for tobacco cessation, stress management, and chronic conditions (such as diabetes and asthma). Kaiser Permanente also offers health education counseling, programs, and materials that are not covered, and you may be required to pay a fee.

For more information about our health education counseling, programs, and materials, please contact a Health Education Department or our Member Service Contact Center or go to our website at kp.org.

Note: Our Health Education Department offers a comprehensive self-management workshop to help members learn the best choices in exercise, diet, monitoring, and medications to manage and control diabetes. Members may also choose to receive diabetes self-management training from a program outside our Plan that is recognized by the American Diabetes Association (ADA) and approved by Medicare. Also, our Health Education Department offers education to teach kidney care and help members make informed decisions about their care.

Your Cost Share. You pay the following for these covered Services:

- Covered health education programs, which may include programs provided online and counseling over the phone: **no charge**
- Other covered individual counseling when the office visit is solely for health education: **no charge**
- Health education provided during an outpatient consultation or evaluation covered in another part of this *EOC*: **no additional Cost Share beyond the Cost Share required in that other part of this *EOC***
- Covered health education materials: **no charge**

Hearing Services

We cover the following:

- Hearing exams with an audiologist to determine the need for hearing correction: **no charge**
- Physician Specialist Visits to diagnose and treat hearing problems: **no charge**

Hearing aids

We cover the following Services related to hearing aids:

- A **$2,500 Allowance** for each ear toward the purchase price of a hearing aid (including fitting, counseling, adjustment, cleaning, and inspection) every 36 months when prescribed by a Plan Physician or by a Plan Provider who is an audiologist. We will cover hearing aids for both ears only if both aids are required to provide significant improvement that is not obtainable with only one hearing aid. We will not provide the Allowance if we have provided an Allowance toward (or otherwise covered) a hearing aid within the previous 36 months. This also means that if your Group's non-Medicare plan includes coverage for hearing aids, the **$2,500 Allowance** reflects the coordination of the two coverages, thus they cannot be combined. Also, the Allowance can only be used at the initial point of sale. If you do not use all of your Allowance at the initial point of sale, you cannot use it later

We select the provider or vendor that will furnish the covered hearing aid(s). Coverage is limited to the types and models of hearing aids furnished by the provider or vendor.

For the following Services, refer to these sections

- Services related to the ear or hearing other than those described in this section, such as outpatient care to treat an ear infection or outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits and Your Cost Share" section)
- Cochlear implants and osseointegrated hearing devices (refer to "Prosthetic and Orthotic Devices")

Hearing Services exclusion(s)

- Internally implanted hearing aids
- Replacement parts and batteries, repair of hearing aids, and replacement of lost or broken hearing aids (the manufacturer warranty may cover some of these)

Home Health Care

"Home health care" means Services provided in the home by nurses, medical social workers, home health aides, and physical, occupational, and speech therapists. We cover home health care only if all of the following are true:

- You are substantially confined to your home
- Your condition requires the Services of a nurse, physical therapist, or speech therapist or continued need for an occupational therapist (home health aide Services are not covered unless you are also getting covered home health care from a nurse, physical therapist, occupational therapist, or speech therapist that only a licensed provider can provide)
- A Plan Physician determines that it is feasible to maintain effective supervision and control of your care in your home and that the Services can be safely and effectively provided in your home
- The Services are provided inside our Service Area

The Medical Group must authorize any home health nursing or other care of at least eight continuous hours, in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section (that authorization procedure does not apply to home health nursing or other care of less than eight continuous hours).

Your Cost Share. We cover home health care Services at **no charge**.

For the following Services, refer to these sections

- Dialysis care (refer to "Dialysis Care")
- Durable medical equipment (refer to "Durable Medical Equipment ("DME") for Home Use")
- Ostomy, urological, and wound care supplies (refer to "Ostomy, Urological, and Wound Care Supplies")

- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient physical, occupational, and speech therapy visits (refer to "Outpatient Care")
- Prosthetic and orthotic devices (refer to "Prosthetic and Orthotic Devices")

Home health care exclusion(s)

- Care in the home if the home is not a safe and effective treatment setting

Home Medical Care Not Covered by Medicare for Members Who Live in Contra Costa or Solano Counties (Advanced Care at Home)

We cover medical care in your home that is not otherwise covered by Medicare in certain situations 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

Medically Home is our network provider and 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 Medically Home's 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 Medically Home's command center if you are unable to get to a phone
- The following equipment necessary to ensure that you are 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 are receiving acute care in the home

In addition, for Medicare-covered services and items listed below, the Cost-Sharing indicated elsewhere in this *EOC* does not apply when the Services and items are prescribed as part of your home treatment plan:

- Durable medical equipment
- Medical supplies
- Ambulance transportation to and from network facilities when ambulance transport is Medically Necessary
- Physician assistant and nurse practitioner house calls or office visits
- The following Services at a Plan 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, ultrasounds, and EKGs

The cost-sharing indicated elsewhere in this *EOC* will apply to all other Services and items that are not part of your home treatment plan (for example, DME unrelated to your home treatment plan) or are part of your home treatment plan, but are not provided in your home except as listed above. Note: For prescription drug Cost-Sharing information, refer to the "Outpatient Prescription Drugs, Supplies, and Supplements" section.

Hospice Care

We cover the hospice Services listed below at **no charge** only if all of the following requirements are met:

- A Plan Physician has diagnosed you with a terminal illness and determines that your life expectancy is 12 months or less
- The Services are provided inside 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 Plan Provider

- A Plan Physician determines that the Services are necessary for the palliation and management of your terminal illness and related conditions

If all of the above requirements are met, we cover the following hospice Services, if necessary for your hospice care:

- Plan Physician Services
- Skilled nursing care, including assessment, evaluation, and case management of nursing needs, treatment for pain and symptom control, provision of emotional support to you and your family, and instruction to caregivers
- Physical, occupational, and 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 a Plan Pharmacy. Certain drugs are limited to a maximum 30-day supply in any 30-day period (please call our Member Service Contact Center for the current list of these drugs)
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient care limited to no more than five consecutive days at a time
- Counseling and bereavement services
- Dietary counseling

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:

- 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

Meals

Immediately following discharge from a hospital as an inpatient due to congestive heart failure, we cover up to two meals per day in a consecutive four-week period, once per calendar year as follows:

- As part of the discharge process, someone from your care team will initiate a referral valid for 30 days. Once the referral is approved, the meal delivery vendor will contact you with meal options and arrange meal delivery. You can contact our Member Service Contact Center if you have any questions about your referral (unused referrals are not renewable)
- In addition to meals for general health, there are menus to support specific conditions and diets

Your Cost Share. We cover home-delivered meals at **no charge**.

Meals exclusions

- You are discharged to another facility that provides meals (for example, inpatient rehabilitation)
- The meals referral has expired

Mental Health Services

We cover Services specified in this "Mental Health Services" section only when the Services are for the diagnosis or treatment of Mental Disorders. A "Mental Disorder" is a mental health condition identified as a "mental disorder" in the *Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision*, as amended in the most recently issued edition, *("DSM")* that results in clinically significant distress or impairment of mental, emotional, or behavioral functioning. We do not cover services for conditions that the *DSM* identifies as something other than a "mental disorder." For example, the *DSM* identifies relational problems as something other than a "mental disorder," so we do not cover services (such as couples counseling or family counseling) for relational problems.

"Mental Disorders" include the following conditions:

- Severe Mental Illness of a person of any age
- Serious Emotional Disturbance of a Child Under Age 18

In addition to the Services described in this Mental Health Services section, we also cover other Services that are Medically Necessary to treat Serious Emotional Disturbance of a Child Under Age 18 or Severe Mental Illness, if the Medical Group authorizes a written referral

(as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section).

Outpatient mental health Services

We cover the following Services when provided by Plan Physicians or other Plan Providers who are licensed health care professionals acting within the scope of their license:

- Individual and group mental health evaluation and treatment
- Psychological testing when necessary to evaluate a Mental Disorder
- Outpatient Services for the purpose of monitoring drug therapy

Intensive psychiatric treatment programs. We cover the following intensive psychiatric treatment programs at a Plan Facility:

- Partial hospitalization
- Multidisciplinary treatment in an intensive outpatient program
- Psychiatric observation for an acute psychiatric crisis

Your Cost Share. You pay the following for these covered Services:

- Individual mental health evaluation and treatment: **no charge**
- Group mental health treatment: **no charge**
- Partial hospitalization: **no charge**
- Other intensive psychiatric treatment programs: **no charge**

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized mental health treatment, the Services are generally and customarily provided by a mental health residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group mental health evaluation and treatment
- Medical services
- Medication monitoring
- Room and board
- Drugs prescribed by a Plan 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 (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section)
- Discharge planning

Your Cost Share. We cover residential mental health treatment Services at **no charge**.

Inpatient psychiatric hospitalization

We cover care for acute psychiatric conditions in a Medicare-certified psychiatric hospital.

Your Cost Share. We cover inpatient psychiatric hospital Services at **no charge**.

For the following Services, refer to these sections

- Outpatient drugs, supplies, and supplements (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Telehealth Visits (refer to "Telehealth Visits")

Opioid Treatment Program Services

Members with opioid use disorder (OUD) can receive 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 medication assisted treatment (MAT) medications and the dispensing and administration of such MAT medications (if applicable)
- Substance use counseling
- Individual and group therapy
- Toxicology testing
- Intake activities
- Periodic assessments
- Medicare Part B clinically administered drugs

Your Cost Share: You pay the following for these covered Services: **no charge**.

Ostomy, Urological, and Wound Care Supplies

We cover ostomy, urological, and wound care supplies if the following requirements are met:

- A Plan Physician has prescribed ostomy, urological, and wound care supplies for your medical condition
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area
- Coverage 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.

Your Cost Share: You pay the following for covered ostomy, urological, and wound care supplies: **no charge**.

Ostomy, urological, and wound care supplies exclusion(s)

- Comfort, convenience, or luxury equipment or features

Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services

We cover the following Services at the Cost Share indicated only when part of care covered under other headings in this "Benefits and Your Cost Share" section. The Services must be prescribed by a Plan Provider:

- Complex imaging (other than preventive) such as CT scans, MRIs, and PET scans: **no charge**
- Basic imaging Services, such as diagnostic and therapeutic X-rays, mammograms, and ultrasounds: **no charge**
- Nuclear medicine: **no charge**
- Routine preventive retinal photography screenings: **no charge**
- Routine laboratory tests to monitor the effectiveness of dialysis: **no charge**
- Hemoglobin (A1c) testing for diabetes, Low-Density Lipoprotein (LDL) testing for heart disease, International Normalized Ratio (INR) for persons with liver disease or certain blood disorders, and glucose quantitative blood tests not covered at $0 under Original Medicare: **no charge**
- All other laboratory tests (including tests for specific genetic disorders for which genetic counseling is available): **no charge**
- Diagnostic Services provided by Plan Providers who are not physicians (such as EKGs and EEGs): **no charge**
- Radiation therapy: **no charge**
- Ultraviolet light treatments, including ultraviolet light therapy equipment for home use, if (1) the equipment has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section 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.): **no charge**

For the following Services, refer to these sections

- Outpatient imaging and laboratory Services that are Preventive Services, such as routine mammograms, bone density scans, and laboratory screening tests (refer to "Preventive Services")
- Outpatient procedures that include imaging and diagnostic Services (refer to "Outpatient surgeries and procedures")
- Services related to diagnosis and treatment of infertility, artificial insemination, or assisted reproductive technology ("ART") Services (refer to "Fertility Services")
- Ultraviolet light therapy comfort, convenience, or luxury equipment or features
- Repair or replacement of ultraviolet light therapy equipment due to loss, theft, or misuse

Outpatient Prescription Drugs, Supplies, and Supplements

We cover outpatient drugs, supplies, and supplements specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section when prescribed as follows:

- Items prescribed by providers, within the scope of their licensure and practice, and in accord with our drug formulary guidelines

- Items prescribed by the following Non–Plan Providers unless a Plan Physician determines that the item is not Medically Necessary or the drug is for a sexual dysfunction disorder:
  - dentists if the drug is for dental care
  - Non–Plan Physicians if the Medical Group authorizes a written referral to the Non–Plan Physician (in accord with "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section) and the drug, supply, or supplement is covered as part of that referral
  - Non–Plan Physicians if the prescription was obtained as part of covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section (if you fill the prescription at a Plan Pharmacy, you may have to pay Charges for the item and file a claim for reimbursement as described in the "Requests for Payment" section)
- The item meets the requirements of our applicable drug formulary guidelines (our Medicare Part D formulary or our formulary applicable to non–Part D items)
- You obtain the item at a Plan Pharmacy or through our mail-order service, except as otherwise described under "Certain items from Non–Plan Pharmacies" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section. Refer to our *Kaiser Permanente Pharmacy Directory* for the locations of Plan Pharmacies in your area. Plan Pharmacies can change without notice and if a pharmacy is no longer a Plan Pharmacy, you must obtain covered items from another Plan Pharmacy, except as otherwise described under "Certain items from Non–Plan Pharmacies" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section
- Your prescriber must either accept Medicare or file documentation with the Centers for Medicare & Medicaid Services showing that he or she is qualified to write prescriptions, or your Part D claim will be denied. You should ask your prescribers the next time you call or visit if they meet this condition. If not, please be aware it takes time for your prescriber to submit the necessary paperwork to be processed

In addition to our plan's Part D and medical benefits coverage, if you have Medicare Part A, your drugs may be covered by Original Medicare if you are in Medicare hospice. For more information, please see "What if you're in a Medicare-certified hospice" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section.

Obtaining refills by mail

Most refills are available through our mail-order service, but there are some restrictions. A Plan Pharmacy, our *Kaiser Permanente Pharmacy Directory*, or our website at kp.org/refill can give you more information about obtaining refills through our mail-order service. Please check with your local Plan Pharmacy if you have a question about whether your prescription can be mailed. Items available through our mail-order service are subject to change at any time without notice.

Certain items from Non–Plan Pharmacies

Generally, we cover drugs filled at a Non–Plan Pharmacy only when you are not able to use a Plan Pharmacy. If you cannot use a Plan Pharmacy, here are the circumstances when we would cover prescriptions filled at a Non–Plan Pharmacy.

- The drug is related to covered Emergency Services, Post-Stabilization Care, or Out-of-Area Urgent Care described in the "Emergency Services and Urgent Care" section. Note: Prescription drugs prescribed and provided outside of the United States and its territories as part of covered Emergency Services or Urgent Care are covered up to a 30-day supply in a 30-day period. These drugs are covered under your medical benefits, and are not covered under Medicare Part D. Therefore, payments for these drugs do not count toward reaching the Part D Catastrophic Coverage Stage
- For Medicare Part D covered drugs, the following are additional situations when a Part D drug may be covered:
  - if you are traveling outside our Service Area, but in the United States and its territories, and you become ill or run out of your covered Part D prescription drugs. We will cover prescriptions that are filled at a Non–Plan Pharmacy according to our Medicare Part D formulary guidelines
  - if you are unable to obtain a covered drug in a timely manner inside our Service Area because there is no Plan Pharmacy within a reasonable driving distance that provides 24-hour service. We may not cover your prescription if a reasonable person could have purchased the drug at a Plan Pharmacy during normal business hours
  - if you are trying to fill a prescription for a drug that is not regularly stocked at an accessible Plan Pharmacy or available through our mail-order pharmacy (including high-cost drugs)
  - if you are not able to get your prescriptions from a Plan Pharmacy during a disaster

In these situations, please check first with our Member Service Contact Center to see if there is a

Plan Pharmacy nearby. You may be required to pay the difference between what you pay for the drug at the Non–Plan Pharmacy and the cost that we would cover at Plan Pharmacy.

Payment and reimbursement. If you go to a Non–Plan Pharmacy for the reasons listed, you may have to pay the full cost (rather than paying just your Copayment or Coinsurance) when you fill your prescription. You may ask us to reimburse you for our share of the cost by submitting a request for reimbursement as described in the "Requests for Payment" section. If we pay for the drugs you obtained from a Non–Plan Pharmacy, you may still pay more for your drugs than what you would have paid if you had gone to a Plan Pharmacy because you may be responsible for paying the difference between Plan Pharmacy Charges and the price that the Non–Plan Pharmacy charged you.

What if you're in a Medicare-certified hospice

If you have Medicare Part A, drugs are never covered by both hospice and our plan at the same time. If you are enrolled in Medicare hospice and require an anti-nausea, laxative, pain medication, or antianxiety drug that is not covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must receive 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 receiving any unrelated drugs that should be covered by our plan, you can ask your hospice provider or prescriber to make sure we have the notification that the drug is unrelated before you ask a pharmacy to fill your prescription.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover all your drugs. To prevent any delays at a pharmacy when your Medicare hospice benefit ends, you should bring documentation to the pharmacy to verify your revocation or discharge. For more information about Medicare Part D coverage and what you pay, please see "Medicare Part D drugs" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section.

Medicare Part D drugs

Medicare Part D covers most outpatient prescription drugs if they are sold in the United States and approved for sale by the federal Food and Drug Administration. Our Part D formulary includes drugs that can be covered under Medicare Part D according to Medicare requirements and certain insulin administration devices (needles, syringes, alcohol swabs, and gauze) at **no charge** for up to a 100-day supply. Refer to our "Medicare Part D drug formulary *(2022 Comprehensive Formulary)*" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section for more information about this formulary.

Keeping track of Medicare Part D drugs. The *Part D Explanation of Benefits* is a document you will get for each month you use your Part D prescription drug coverage. The *Part D Explanation of Benefits* will tell you the total amount you, or others on your behalf, have spent on your prescription drugs and the total amount we have paid for your prescription drugs. A *Part D Explanation of Benefits* is also available upon request from our Member Service Contact Center.

Medicare Part D drug formulary *(2022 Comprehensive Formulary)*

Our Medicare Part D formulary is a list of covered drugs selected by our plan in consultation with a team of health care providers that represents the drug therapies believed to be a necessary part of a quality treatment program. Our formulary must meet requirements set by Medicare and is approved by Medicare. Our formulary includes drugs that can be covered under Medicare Part D according to Medicare requirements. For a complete, current listing of the Medicare Part D prescription drugs we cover, please visit our website at kp.org/seniorrx or call our Member Service Contact Center.

The presence of a drug on our formulary does not necessarily mean that your Plan Physician will prescribe it for a particular medical condition. Our drug formulary guidelines allow you to obtain Medicare Part D prescription drugs if a Plan Physician determines that they are Medically Necessary for your condition. If you disagree with your Plan Physician's determination, refer to "Your Part D Prescription Drugs: How to Ask for a Coverage Decision or Make an Appeal" in the "Coverage Decisions, Appeals, and Complaints" section.

Continuity drugs. If this *EOC* is amended to exclude a drug that we have been covering and providing to you under this *EOC*, we will continue to provide the drug if a prescription is required by law and a Plan Physician continues to prescribe the drug for the same condition and for a use approved by the Federal Food and Drug Administration.

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.

The references in the formulary to preferred generic and generic or brand-name drugs and specialty tier drugs do not apply to you. All the drugs in the formulary are covered the same without regard for whether they are generic, brand, or specialty tier drugs. Please note that sometimes a drug may appear more than once on our *2022 Comprehensive Formulary*. This is because different restrictions or cost-sharing may apply based on factors such as the strength, amount, or form of the drug prescribed by your health care provider (for instance, 10 mg versus 100 mg; one per day versus two per day; tablet versus liquid).

You can get updated information about the drugs our plan covers by visiting our website at kp.org/seniorrx. You may also call our Member Service Contact Center to find out if your drug is on the formulary or to request an updated copy of our formulary.

We may make certain changes to our formulary during the year. Changes in the formulary may affect which drugs are covered and how much you will pay when filling your prescription. The kinds of formulary changes we may make include:

- Adding or removing drugs from the formulary
- Adding prior authorizations or other restrictions on a drug

If we remove drugs from the formulary or add prior authorizations or restrictions on a drug, and you are taking the drug affected by the change, you will be permitted to continue receiving that drug at the same level of Cost Share for the remainder of the calendar year. However, if a brand-name drug is replaced with a new generic drug, or our formulary is changed as a result of new information on a drug's safety or effectiveness, you may be affected by this change. We will notify you of the change at least 30 days before the date that the change becomes effective or provide you with at least a month's supply at the Plan Pharmacy. This will give you an opportunity to work with your physician to switch to a different drug that we cover or request an exception. (If a drug is removed from our formulary because the drug has been recalled, we will not give 30 days' notice before removing the drug from the formulary. Instead, we will remove the drug immediately and notify members taking the drug about the change as soon as possible.)

If your drug isn't listed on your copy of our formulary, you should first check the formulary on our website, which we update when there is a change. In addition, you may call our Member Service Contact Center to be sure it isn't covered. If Member Services confirms that we don't cover your drug, you have two options:

- You may ask your Plan Physician if you can switch to another drug that is covered by us
- You or your Plan Physician may ask us to make an exception (a type of coverage determination) to cover your Medicare Part D drug. See the "Coverage Decisions, Complaints, and Appeals" section for more information on how to request an exception

Transition policy. If you recently joined our plan, you may be able to get a temporary supply of a Medicare Part D drug you were previously taking that may not be on our formulary or has other restrictions, during the first 90 days of your membership. Current members may also be affected by changes in our formulary from one year to the next. Members should talk to their Plan Physicians to decide if they should switch to a different drug that we cover or request a Part D formulary exception in order to get coverage for the drug. Refer to our formulary or our website, kp.org/seniorrx, for more information about our Part D transition coverage.

Medicare Part D exclusions (non–Part D drugs). By law, certain types of drugs are not covered by Medicare Part D. A Medicare Prescription Drug Plan can't cover a drug under Medicare Part D in the following situations:

- The drug would be covered under Medicare Part A or Part B
- Drug purchased outside the United States and its territories
- Off-label uses (meaning for uses other than those indicated on a drug's label as approved by the federal Food and Drug Administration) of a prescription drug, except in cases where the use is supported by certain reference books. Congress specifically listed the reference books that list whether the off-label use would be permitted. (These reference books are the American Hospital Formulary Service Drug Information and the DRUGDEX Information System.) If the use is not supported by one of these references, known as compendia, then the drug is considered a non–Part D drug and cannot be covered under Medicare Part D coverage

In addition, by law, certain types of drugs or categories of drugs are not covered under Medicare Part D. These drugs include:

- Nonprescription drugs (also called over-the-counter drugs)
- Drugs when used to promote fertility
- Drugs when used for the relief of cough or cold symptoms

- Drugs when used for cosmetic purposes or to promote hair growth
- Prescription vitamins and mineral products, except prenatal vitamins and fluoride preparations
- Drugs when used for the treatment of sexual or erectile dysfunction
- Drugs when used for treatment of anorexia, weight loss, or weight gain
- Outpatient drugs for which the manufacturer seeks to require that associated tests or monitoring services be purchased exclusively from the manufacturer as a condition of sale

Note: In addition to the coverage provided under this Medicare Part D plan, you also have coverage for non–Part D drugs described under "Home infusion therapy," "Outpatient drugs covered by Medicare Part B," "Certain intravenous drugs, supplies, and supplements," and "Outpatient drugs, supplies, and supplements not covered by Medicare" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section. If a drug is not covered under Medicare Part D, refer to those headings for information about your non–Part D drug coverage.

Other prescription drug coverage. If you have additional health care or drug coverage from another plan besides your Group's non-Medicare plan, you must provide that information to our plan. The information you provide helps us calculate how much you and others have paid for your prescription drugs. In addition, if you lose or gain additional health care or prescription drug coverage, please call our Member Service Contact Center to update your membership records.

Home infusion therapy

We cover home infusion supplies and drugs at **no charge** 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

Outpatient drugs covered by Medicare Part B

In addition to Medicare Part D drugs, we also cover the limited number of outpatient prescription drugs that are covered by Medicare Part B at **no charge for up to a 100-day supply** (except that certain self-administered intravenous drugs are provided up to a 30-day supply).

The following are the types of drugs that Medicare Part B covers:

- Drugs that usually aren't self-administered by the patient and are injected or infused while you are getting physician, hospital outpatient, or ambulatory surgical center services
- Drugs you take using durable medical equipment (such as nebulizers) that were prescribed by a Plan Physician
- Clotting factors you give yourself by injection if you have hemophilia
- Immunosuppressive drugs, if Medicare paid for the transplant (or a group plan was required to pay before Medicare paid for it)
- Injectable osteoporosis drugs, if you are homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and cannot self-administer the drug
- Antigens
- Certain oral anticancer drugs and antinausea drugs
- Certain drugs for home dialysis, including heparin, the antidote for heparin when Medically Necessary, topical anesthetics, and erythropoiesis-stimulating agents (such as Epogen®, Procrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases

Certain intravenous drugs, supplies, and supplements

We cover certain self-administered intravenous drugs, fluids, additives, and nutrients that require specific types of parenteral-infusion (such as an intravenous or intraspinal-infusion) at **no charge** for up to a 30-day supply. In addition, we cover the supplies and equipment required for the administration of these drugs at **no charge**.

Outpatient drugs, supplies, and supplements not covered by Medicare

If a drug, supply, or supplement is not covered by Medicare Part B or D, we cover the following additional items in accord with our non–Part D drug formulary:

- Drugs for which a prescription is required by law that are not covered by Medicare Part B or D. We also cover certain drugs that do not require a prescription by law if they are listed on our drug formulary applicable to non–Part D items
- Diaphragms, cervical caps, contraceptive rings, and contraceptive patches

- Disposable needles and syringes needed for injecting covered drugs, pen delivery devices, and visual aids required to ensure proper dosage (except eyewear), that are not covered by Medicare Part B or D
- Inhaler spacers needed to inhale covered drugs
- Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing
- FDA-approved medications for tobacco cessation, including over-the-counter medications when prescribed by a Plan Physician

Your Cost Share for other outpatient drugs, supplies, and supplements not covered by Medicare. Your Cost Share for these items is as follows:

- Items (that are not described elsewhere in this *EOC*) **no charge for up to a 100-day supply**
- Amino acid–modified products used to treat congenital errors of amino acid metabolism (such as phenylketonuria) and elemental dietary enteral formula when used as a primary therapy for regional enteritis: **no charge** for up to a 30-day supply
- Tobacco cessation drugs: **no charge**

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, selects drugs for the drug formulary based on a number of factors, including safety and effectiveness as determined from a review of medical literature. The Pharmacy and Therapeutics Committee meets at least quarterly to consider additions and deletions based on new information or drugs that become available. To find out which drugs are on the formulary for your plan, please visit our website at kp.org/formulary. If you would like to request a copy of the non–Part D drug formulary for your plan, please call our Member Service Contact Center. Note: The presence of a drug on the drug formulary does not 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 the "Coverage Decisions, Appeals, and Complaints" section. Also, our non–Part D formulary guidelines may require you to participate in a behavioral intervention program approved by the Medical Group for specific conditions and you may be required to pay for the program.

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 "Outpatient drugs, supplies, and supplements not covered by Medicare" 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 does not cover the entire amount of your Cost Share for your prescription. Certain health plan coverages are not eligible for coupons. You can get more information regarding the Kaiser Permanente coupon program rules and limitations at kp.org/rxcoupons.

Drug utilization review

We conduct drug utilization reviews to make sure that you are getting safe and appropriate care. These reviews are especially important if you have more than one doctor who prescribes your medications. We conduct drug utilization reviews each time you fill a prescription and on a regular basis by reviewing our records. During these reviews, we look for medication problems such as:

- Possible medication errors
- Duplicate drugs that are unnecessary because you are taking another drug to treat the same medical condition
- Drugs that are inappropriate because of your age or gender
- Possible harmful interactions between drugs you are taking
- Drug allergies
- Drug dosage errors
- Unsafe amounts of opioid pain medications

If we identify a medication problem during our drug utilization review, we will work with your doctor to correct the problem.

Drug management program

We have a program that can help make sure our members safely use their prescription opioid medications, or other medications that are frequently abused. This program is called a Drug Management Program (DMP). If you use opioid medications that you get from several doctors or pharmacies, we may talk to your doctors to make sure your use is appropriate and medically necessary. Working with your doctors, if we decide you are at risk for misusing or abusing your opioid or benzodiazepine medications, we may limit how you can get those medications. The limitations may be:

- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one pharmacy.
- Requiring you to get all your prescriptions for opioid or benzodiazepine medications from one doctor.
- Limiting the amount of opioid or benzodiazepine medications we will cover for you.

If we decide that one or more of these limitations should apply to you, we will send you a letter in advance. The letter will have information explaining the terms of the limitations we think should apply to you. You will also have an opportunity to tell us which doctors or pharmacies you prefer to use. If you think we made a mistake or you disagree with our determination that you are at-risk for prescription drug abuse or the limitation, you and your prescriber have the right to ask us for an appeal. See the "Coverage Decisions, Appeals, and Complaints" section for information about how to ask for an appeal.

The DMP may not apply to you if you have certain medical conditions, such as cancer, you are receiving hospice, palliative, or end-of-life care, or you live in a long-term care facility.

Medication therapy management program

We offer a medication therapy management program at no additional cost to Members who have multiple medical conditions, who are taking many prescription drugs, and who have high drug costs. This program was developed for us by a team of pharmacists and doctors. We use this medication therapy management program to help us provide better care for our members. For example, this program helps us make sure that you are using appropriate drugs to treat your medical conditions and help us identify possible medication errors.

If you are selected to join a medication therapy management program, we will send you information about the specific program, including information about how to access the program.

ID card at Plan Pharmacies

You must present your Kaiser Permanente ID card when obtaining covered items from Plan Pharmacies, including those that are not owned and operated by Kaiser Permanente. If you do not have your ID card, the Plan Pharmacy may require you to pay Charges for your covered items, and you will have to file a claim for reimbursement as described in the "Requests for Payment" section.

Notes:

- If Charges for a covered item are less than the Copayment, you will pay the lesser amount
- Durable medical equipment used to administer drugs, such as diabetes insulin pumps (and their supplies) and diabetes blood-testing equipment (and their supplies) are not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section (instead, refer to "Durable Medical Equipment ("DME") for Home Use" in this "Benefits and Your Cost Share" section)
- Except for vaccines covered by Medicare Part D, drugs administered to you in a Plan Medical Office or during home visits are not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section (instead, refer to "Outpatient Care" in this "Benefits and Your Cost Share" section)
- Drugs covered during a covered stay in a Plan Hospital or Skilled Nursing Facility are not covered under this "Outpatient Prescription Drugs, Supplies, and Supplements" section (instead, refer to "Hospital Inpatient Care" and "Skilled Nursing Facility Care" in this "Benefits and Your Cost Share" section)

Outpatient prescription drugs, supplies, and supplements limitations

Day supply limit. Plan Physicians determine the amount of a drug or other item that is Medically Necessary for a particular day supply for you. Upon payment of the Cost Share specified in this "Outpatient Prescription Drugs, Supplies, and Supplements" section, you will receive the supply prescribed up to a 100-day supply in a 100-day period. However, the Plan Pharmacy may reduce the day supply dispensed to a 30-day supply in any 30-day period at the Cost Share listed in this "Outpatient Prescription Drugs, Supplies, and Supplements" section if the Plan Pharmacy determines that the drug is in limited supply in the market or a 31-day supply in any 31-day period if the item is dispensed by a long term care facility's pharmacy. Plan Pharmacies may also limit the quantity dispensed as described under "Utilization management." If you wish to receive more than the covered day supply limit, then the additional amount is

not covered and you must pay Charges for any prescribed quantities that exceed the day supply limit.

Utilization management. For certain items, we have additional coverage requirements and limits that help promote effective drug use and help us control drug plan costs. Examples of these utilization management tools are:

- **Quantity limits:** The Plan Pharmacy may reduce the day supply dispensed at the Cost Share specified in this "Outpatient Drugs, Supplies, and Supplements" section to a 30-day supply or less in any 30-day period for specific drugs. Your Plan Pharmacy can tell you if a drug you take is one of these drugs. In addition, we cover episodic drugs prescribed for the treatment of sexual dysfunction up to a maximum of eight doses in any 30-day period, up to 16 doses in any 60-day period, or up to 27 doses in any 100-day period. Also, when there is a shortage of a drug in the marketplace and the amount of available supplies, we may reduce the quantity of the drug dispensed accordingly and charge one cost share
- **Generic substitution:** When there is a generic version of a brand-name drug available, Plan Pharmacies will automatically give you the generic version, unless your Plan Physician has specifically requested a formulary exception because it is Medically Necessary for you to receive the brand-name drug instead of the formulary alternative

Outpatient prescription drugs, supplies, and supplements exclusions

- Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging
- Compounded products unless the active ingredient in the compounded product is listed on one of our drug formularies
- Drugs prescribed to shorten the duration of the common cold
- Prescription drugs for which there is an over-the-counter equivalent (the same active ingredient, strength, and dosage form as the prescription drug). This exclusion does not 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

Preventive Services

We cover a variety of Preventive Services in accord with Medicare guidelines. The list of Preventive Services is subject to change by the Centers for Medicare & Medicaid Services. These Preventive Services are subject to all coverage requirements described in this "Benefits and Your Cost Share" section and all provisions in the "Exclusions, Limitations, Coordination of Benefits, and Reductions" section. If you have questions about Preventive Services, please call our Member Service Contact Center.

Note: If you receive any other covered Services that are not Preventive Services during or subsequent to a visit that includes Preventive Services on the list, you will pay the applicable Cost Share for those other Services. For example, if laboratory tests or imaging Services ordered during a preventive office visit are not Preventive Services, you will pay the applicable Cost Share for those Services.

Your Cost Share. You pay the following for covered Preventive Services:

- Abdominal aortic aneurysm screening prescribed during the one-time "Welcome to Medicare" preventive visit: **no charge**
- Annual Wellness visit: **no charge**
- Bone mass measurement: **no charge**
- Breast cancer screening (mammograms): **no charge**
- Cardiovascular disease risk reduction visit (therapy for cardiovascular disease): **no charge**
- Cardiovascular disease testing: **no charge**
- Cervical and vaginal cancer screening: **no charge**
- Colorectal cancer screening, including flexible sigmoidoscopies, colonoscopies, and fecal occult blood tests: **no charge**
- Depression screening: **no charge**
- Diabetes screening, including fasting glucose tests: **no charge**
- Diabetes self-management training: **no charge**
- Glaucoma screening: **no charge**
- HIV screening: **no charge**
- Immunizations (including the vaccine) covered by Medicare Part B such as COVID-19, Hepatitis B, influenza, and pneumococcal vaccines that are administered to you in a Plan Medical Office: **no charge**
- Lung cancer screening: **no charge**

- Medical nutrition therapy for kidney disease and diabetes: **no charge**
- Medicare diabetes prevention program: **no charge**
- Obesity screening and therapy to promote sustained weight loss: **no charge**
- Prostate cancer screening exams, including digital rectal exams and Prostate Specific Antigens (PSA) tests: **no charge**
- Screening and counseling to reduce alcohol misuse: **no charge**
- Screening for sexually transmitted infections (STIs) and counseling to prevent STIs: **no charge**
- Smoking and tobacco use cessation (counseling to stop smoking or tobacco use): **no charge**
- "Welcome to Medicare" preventive visit: **no charge**

Prosthetic and Orthotic Devices

Prosthetic and orthotic devices coverage rules

We cover the prosthetic and orthotic devices specified in this "Prosthetic and Orthotic Devices" section if all of the following requirements are met:

- The device is in general use, intended for repeated use, and primarily and customarily used for medical purposes
- The device is the standard device that adequately meets your medical needs
- You receive the device from the provider or vendor that we select
- The item has been approved for you through the Plan's prior authorization process, as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section
- The Services are provided inside our Service Area

Coverage includes fitting and adjustment of these devices, their repair or replacement, and Services to determine whether you need a prosthetic or orthotic device. If we cover a replacement device, then you pay the Cost Share that you would pay for obtaining that device.

Base prosthetic and orthotic devices

If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the items described in this "Base prosthetic and orthotic devices" section.

Internally implanted devices. We cover prosthetic and orthotic devices such as pacemakers, intraocular lenses, cochlear implants, osseointegrated hearing devices, and hip joints, in accord with Medicare guidelines, if they are implanted during a surgery that we are covering under another section of this "Benefits and Your Cost Share" section. We cover these devices at **no charge**.

External devices. We cover the following external prosthetic and orthotic devices at **no charge**:

- Prosthetics and orthotics in accord with Medicare guidelines. These include, but are not limited to, braces, prosthetic shoes, artificial limbs, and therapeutic footwear for severe diabetes-related foot disease in accord with Medicare guidelines
- Prosthetic devices and installation accessories to restore a method of speaking following the removal of all or part of the larynx (this coverage does not include electronic voice-producing machines, which are not prosthetic devices)
- After Medically Necessary removal of all or part of a breast, prosthesis including custom-made prostheses when Medically Necessary
- Podiatric devices (including footwear) to prevent or treat diabetes-related complications when prescribed by a Plan Physician or by a Plan Provider who is a podiatrist
- Compression burn garments and lymphedema wraps and garments
- Enteral formula for Members who require tube feeding in accord with Medicare guidelines
- Enteral pump and supplies
- Tracheostomy tube and supplies
- Prostheses to replace all or part of an external facial body part that has been removed or impaired as a result of disease, injury, or congenital defect

Other covered prosthetic and orthotic devices

- If all of the requirements described under "Prosthetic and orthotic coverage rules" in this "Prosthetics and Orthotic Devices" section are met, we cover the following items described in this "Other covered prosthetic and orthotic devices" section:
- Prosthetic devices required to replace all or part of an organ or extremity, in accord with Medicare guidelines
- Vacuum erection device for sexual dysfunction
- Certain surgical boots following surgery when provided during an outpatient visit

- Orthotic devices required to support or correct a defective body part, in accord with Medicare guidelines
- Covered special footwear when custom made for foot disfigurement due to disease, injury, or developmental disability

Your Cost Share. You pay the following for other covered prosthetic and orthotic devices: **no charge**.

For the following Services, refer to these sections

- Eyeglasses and contact lenses, including contact lenses to treat aniridia or aphakia (refer to "Vision Services")
- Eyewear following cataract surgery (refer to "Vision Services")
- Hearing aids other than internally implanted devices described in this section (refer to "Hearing Services")
- Injectable implants (refer to "Administered drugs and products" under "Outpatient Care")

Prosthetic and orthotic devices exclusion(s)

- Dental appliances
- Nonrigid supplies not covered by Medicare, such as elastic stockings and wigs, except as otherwise described above in this "Prosthetic and Orthotic Devices" section and the "Ostomy, Urological, and Wound Care Supplies" section
- Comfort, convenience, or luxury equipment or features
- Repair or replacement of device due to misuse
- Shoes, shoe inserts, arch supports, or any other footwear, even if custom-made, except footwear described above in this "Prosthetic and Orthotic Devices" section for diabetes-related complications and foot disfigurement
- Prosthetic and orthotic devices not intended for maintaining normal activities of daily living (including devices intended to provide additional support for recreational or sports activities)
- Nonconventional intraocular lenses (IOLs) following cataract surgery (for example, presbyopia-correcting IOLs). You may request and we may provide insertion of presbyopia-correcting IOLs or astigmatism-correcting IOLs following cataract surgery in lieu of conventional IOLs. However, you must pay the difference between Charges for nonconventional IOLs and associated services and Charges for insertion of conventional IOLs following cataract surgery

Reconstructive Surgery

We cover the following reconstructive surgery Services:

- Reconstructive surgery to correct or repair abnormal structures of the body caused by congenital defects, developmental abnormalities, trauma, infection, tumors, or disease, if a Plan Physician determines that it is necessary to improve function, or create a normal appearance, to the extent possible
- Following Medically Necessary removal of all or part of a breast, we cover reconstruction of the breast, surgery and reconstruction of the other breast to produce a symmetrical appearance, and treatment of physical complications, including lymphedemas

Your Cost Share. You pay the following for covered reconstructive surgery Services:

- Outpatient surgery and outpatient procedures when provided in an outpatient 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: **no charge**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **no charge**
- Any other outpatient procedures that do not require a licensed staff member to monitor your vital signs as described above: **the Cost Share that would otherwise apply for the procedure** in this "Benefits and Your Cost Share" section (for example, radiology procedures that do not require a licensed staff member to monitor your vital signs as described above are covered under "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Hospital inpatient care (including room and board, drugs, imaging, laboratory, other diagnostic and treatment Services, and Plan Physician Services): **no charge**

For the following Services, refer to these sections

- Office visits not described in this "Reconstructive Surgery" section (refer to "Outpatient Care")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")

- Outpatient administered drugs (refer to "Outpatient Care")
- Prosthetics and orthotics (refer to "Prosthetic and Orthotic Devices")
- Telehealth Visits (refer to "Telehealth Visits")

Reconstructive surgery exclusion(s)

- Surgery that, in the judgment of a Plan Physician specializing in reconstructive surgery, offers only a minimal improvement in appearance

Religious Nonmedical Health Care Institution Services

Care in a Medicare-certified Religious Nonmedical Health Care Institution (RNHCI) is covered by our Plan under certain conditions. Covered Services in an RNHCI are limited to nonreligious aspects of care. To be eligible for covered Services in a RNHCI, you must have a medical condition that would allow you to receive inpatient hospital or Skilled Nursing Facility care. You may get Services furnished in the home, but only items and Services ordinarily furnished by home health agencies that are not RNHCIs. In addition, you must sign a legal document that says you are conscientiously opposed to the acceptance of "nonexcepted" medical treatment. ("Excepted" medical treatment is a Service or treatment that you receive involuntarily or that is required under federal, state, or local law.
"Nonexcepted" medical treatment is any other Service or treatment.) Your stay in the RNHCI is not covered by us unless you obtain authorization (approval) in advance from us.

Note: Covered Services are subject to the same limitations and Cost Share required for Services provided by Plan Providers as described in this "Benefits and Your Cost Share" section.

Services Associated with Clinical Trials

We cover Services you receive in connection with a clinical trial if all of the following requirements are met:

- We would have covered the Services if they were not related to a clinical trial
- You are eligible to participate in the clinical trial according to the trial protocol with respect to treatment of cancer or other life-threatening condition (a condition from which the likelihood of death is probable unless the course of the condition is interrupted), as determined in one of the following ways:
  - a Plan Provider makes this determination
  - you provide us with medical and scientific information establishing this determination
- If any Plan Providers participate in the clinical trial and will accept you as a participant in the clinical trial, you must participate in the clinical trial through a Plan Provider unless the clinical trial is outside the state where you live
- The clinical trial is an Approved Clinical Trial

"Approved Clinical Trial" means a phase I, phase II, phase III, or phase IV clinical trial related to the prevention, detection, or treatment of cancer or other life-threatening condition, and that meets one of the following requirements:

- The study or investigation is conducted under an investigational new drug application reviewed by the U.S. Food and Drug Administration
- The study or investigation is a drug trial that is exempt from having an investigational new drug application
- The study or investigation is approved or funded by at least one of the following:
  - the National Institutes of Health
  - the Centers for Disease Control and Prevention
  - the Agency for Health Care Research and Quality
  - the Centers for Medicare & Medicaid Services
  - a cooperative group or center of any of the above entities or of the Department of Defense or the Department of Veterans Affairs
  - a qualified non-governmental research entity identified in the guidelines issued by the National Institutes of Health for center support grants
  - the Department of Veterans Affairs or the Department of Defense or the Department of Energy, but only if the study or investigation has been reviewed and approved though a system of peer review that the U.S. Secretary of Health and Human Services determines meets all of the following requirements: (1) It is comparable to the National Institutes of Health system of peer review of studies and investigations and (2) it assures unbiased review of the highest scientific standards by qualified people who have no interest in the outcome of the review

Your Cost Share. For covered Services related to a clinical trial, you will pay the **Cost Share you would pay if the Services were not related to a clinical trial**.

For example, see "Hospital Inpatient Care" in this "Benefits and Your Cost Share" section for the Cost Share that applies for hospital inpatient care.

Services covered by Medicare

If you do not meet the requirements above, you may be able to participate in a Medicare-approved clinical trial, Original Medicare (and not Senior Advantage) pays most of the routine costs for the covered Services you receive as part of the trial. When you are in a clinical trial, you may stay enrolled in Senior Advantage and continue to get the rest of your care (the care that is not related to the trial) through our plan.

If you want to participate in a Medicare-approved clinical trial, you don't need to get a referral from a Plan Provider, and the providers that deliver your care as part of the clinical trial don't need to be Plan Providers. Although you don't need to get a referral from a Plan Provider, you do need to tell us before you start participating in a clinical trial so we can keep track of your Services.

Once you join a Medicare-approved clinical trial, you are covered for routine Services you receive as part of the trial. Routine Services include room and board for a hospital stay that Medicare would pay for even if you weren't in a trial, an operation or other medical procedure if it is part of the trial, and treatment of side effects and complications arising from the new care.

Original Medicare pays most of the cost of the covered Services you receive as part of the trial. After Medicare has paid its share of the cost for these Services, we will pay the difference between the cost share of Original Medicare and your Cost Share as a Member of our plan. This means you will pay the same amount for the routine Services you receive as part of the trial as you would if you received these Services from our plan.

In order for us to pay for our share of the costs, you will need to submit a request for payment. With your request, you will need to send us a copy of your Medicare Summary Notices or other documentation that shows what services you received as part of the trial and how much you owe. Please see the "Requests for Payment" section for more information about submitting requests for payment.

To learn more about joining a clinical trial, refer to the "Medicare and Clinical Research Studies" brochure. To get a free copy, call Medicare directly toll free at **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week, or visit https://www.medicare.gov on the Web.

Services associated with clinical trials exclusion(s)

When you are part of a clinical research study, neither Medicare nor our plan will pay for any of the following:

- The investigational Service
- The new item or service that the study is testing, unless Medicare would cover the item or service even if you were not in a study
- Items or services provided only to collect data, and not used in your direct health care
- Services that are customarily provided by the research sponsors free of charge to enrollees in the clinical trial
- Items and services provided solely to determine trial eligibility

Skilled Nursing Facility Care

Inside our Service Area, we cover skilled inpatient Services in a Plan Skilled Nursing Facility and in accord with Medicare guidelines. The skilled inpatient Services must be customarily provided by a Skilled Nursing Facility, and above the level of custodial or intermediate care.

We cover the following Services:

- Physician and nursing Services
- Room and board
- Drugs prescribed by a Plan Physician as part of your plan of care in the Plan Skilled Nursing Facility in accord with our drug formulary guidelines if they are administered to you in the Plan Skilled Nursing Facility by medical personnel
- Durable medical equipment in accord with our durable medical equipment formulary and Medicare guidelines if Skilled Nursing Facilities ordinarily furnish the equipment
- Imaging and laboratory Services that Skilled Nursing Facilities ordinarily provide
- Medical social services
- Whole blood, red blood cells, plasma, platelets, and their administration
- Medical supplies
- Physical, occupational, and speech therapy in accord with Medicare guidelines
- Respiratory therapy

Your Cost Share. We cover these Skilled Nursing Facility Services at **no charge**.

For the following Services, refer to these sections

- Outpatient imaging, laboratory, and other diagnostic and treatment Services (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")

Non–Plan Skilled Nursing Facility care

Generally, you will get your Skilled Nursing Facility care from Plan Facilities. However, under certain conditions listed below, you may be able to receive covered care from a non–Plan facility, if the facility accepts our Plan's amounts for payment.

- A nursing home or continuing care retirement community where you were living right before you went to the hospital (as long as it provides Skilled Nursing Facility care)
- A Skilled Nursing Facility where your spouse is living at the time you leave the hospital

Substance Use Disorder Treatment

We cover Services specified in this "Substance Use Disorder Treatment" section only when the Services are for the diagnosis or treatment of Substance Use Disorders. A "Substance Use Disorder" is a condition identified as a "substance use disorder" in the most recently issued edition of the Diagnostic and Statistical Manual of Mental Disorders ("DSM").

Outpatient substance use disorder treatment

We cover the following Services for treatment of substance use disorders:

- Day-treatment programs
- Individual and group substance use disorder counseling
- Intensive outpatient programs
- Medical treatment for withdrawal symptoms

Your Cost Share. You pay the following for these covered Services:

- Individual substance use disorder evaluation and treatment: **no charge**
- Group substance use disorder treatment: **no charge**
- Intensive outpatient and day-treatment programs: **no charge**

Residential treatment

Inside our Service Area, we cover the following Services when the Services are provided in a licensed residential treatment facility that provides 24-hour individualized substance use disorder treatment, the Services are generally and customarily provided by a substance use disorder residential treatment program in a licensed residential treatment facility, and the Services are above the level of custodial care:

- Individual and group substance use disorder counseling
- Medical services
- Medication monitoring
- Room and board
- Drugs prescribed by a Plan 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 (for discharge drugs prescribed when you are released from the residential treatment facility, refer to "Outpatient Prescription Drugs, Supplies, and Supplements" in this "Benefits and Your Cost Share" section)
- Discharge planning

Your Cost Share. We cover residential substance use disorder treatment Services at **no charge**.

Inpatient detoxification

We cover hospitalization in a Plan Hospital only for medical management of withdrawal symptoms, including room and board, Plan Physician Services, drugs, dependency recovery Services, education, and counseling.

Your Cost Share. We cover inpatient detoxification Services at **no charge**.

For the following Services, refer to these sections

- Outpatient laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient self-administered drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Telehealth Visits (refer to "Telehealth Visits")

Telehealth Visits

Telehealth Visits between you and your provider are intended to make it more convenient for you to receive covered Services, when a Plan Provider determines it is medically appropriate for your medical condition. You have the option of receiving these services either through

an in-person visit or via telehealth. You may receive covered Services via Telehealth Visits, when available and if the Services would have been covered under this *EOC* if provided in person. If you choose to receive Services via telehealth, then you must use a Plan Provider that currently offers the service via telehealth. We offer the following telehealth Services:

- 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 for diagnosis, evaluation or treatment of symptoms of an acute stroke
- Virtual check-ins (for example, by phone or video chat) with your doctor for 5 to 10 minutes if all of the following are true:
  - you're not a new patient
  - the check-in isn't related to an office visit within the past 7 days
  - 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 (except weekends and holidays) if all of the following are true:
  - you're not a new patient
  - the check-in isn't related to an office visit within the past 7 days
  - the check-in 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—if you are an established patient

Your Cost Share. You pay the following types for Telehealth Visits with Primary Care Physicians, Non-Physician Specialists, and Physician Specialists:

- Interactive video visits: **no charge**
- Scheduled telephone visits: **no charge**

Transplant Services

We cover transplants of organs, tissue, or bone marrow in accord with Medicare guidelines and if the Medical Group provides a written referral for care to a transplant facility as described in "Medical Group authorization procedure for certain referrals" under "Getting a Referral" in the "How to Obtain Services" section.

After the referral to a transplant facility, the following applies:

- If either the Medical Group or the referral facility determines that you do not satisfy its respective criteria for a transplant, we will only cover Services you receive before that determination is made
- Health Plan, Plan Hospitals, the Medical Group, and Plan Physicians are not responsible for finding, furnishing, or ensuring the availability of an organ, tissue, or bone marrow donor
- In accord with our guidelines for Services for living transplant donors, we provide certain donation-related Services for a donor, or an individual identified by the Medical Group as a potential donor, whether or not the donor is a Member. These Services must be directly related to a covered transplant for you, which may include certain Services for harvesting the organ, tissue, or bone marrow and for treatment of complications. Please call our Member Service Contact Center for questions about donor Services

Your Cost Share. For covered transplant Services that you receive, you will pay the **Cost Share you would pay if the Services were not related to a transplant**. For example, see "Hospital Inpatient Care" in this "Benefits and Your Cost Share" section for the Cost Share that applies for hospital inpatient care.

We provide or pay for donation-related Services for actual or potential donors (whether or not they are Members) in accord with our guidelines for donor Services at **no charge**.

For the following Services, refer to these sections

- Dental Services that are Medically Necessary to prepare for a transplant (refer to "Dental Services")
- Outpatient imaging and laboratory (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")
- Outpatient prescription drugs (refer to "Outpatient Prescription Drugs, Supplies, and Supplements")
- Outpatient administered drugs (refer to "Outpatient Care")

Vision Services

We cover the following:

- Routine eye exams with a Plan Optometrist to determine the need for vision correction (including dilation Services when Medically Necessary) and to provide a prescription for eyeglass lenses: **no charge**

- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye: **no charge**
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye: **no charge**

Optical Services

We cover the Services described in this "Optical Services" section when received from Plan Medical Offices or Plan Optical Sales Offices.

The date we provide an Allowance toward (or otherwise cover) an item described in this "Optical Services" section is the date on which you order the item. For example, if we last provided an Allowance toward an item you ordered on May 1, 2020, and if we provide an Allowance not more than once every 24 months for that type of item, then we would not provide another Allowance toward that type of item until on or after May 1, 2022. You can use the Allowances under this "Optical Services" section only when you first order an item. If you use part but not all of an Allowance when you first order an item, you cannot use the rest of that Allowance later.

Eyeglasses and contact lenses following cataract surgery

We cover at **no charge** one pair of eyeglasses or contact lenses (including fitting or dispensing) following each cataract surgery that includes insertion of an intraocular lens at Plan Medical Offices or Plan Optical Sales Offices when prescribed by a physician or optometrist. When multiple cataract surgeries are needed, and you do not obtain eyeglasses or contact lenses between procedures, we will only cover one pair of eyeglasses or contact lenses after any surgery. If the eyewear you purchase costs more than what Medicare covers for someone who has Original Medicare (also known as "Fee-for-Service Medicare"), you pay the difference.

Special contact lenses

We cover the following:

- For aniridia (missing iris), we cover up to two Medically Necessary contact lenses per eye (including fitting and dispensing) in any 12-month period when prescribed by a Plan Physician or Plan Optometrist: **no charge**
- In accord with Medicare guidelines, we cover corrective lenses (including contact lens fitting and dispensing) and frames (and replacements) for Members who are aphakic (for example, who have had a cataract removed but do not have an implanted intraocular lens (IOL) or who have congenital absence of the lens): **no charge**
- For other specialty 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 (up to six months, including fitting and dispensing) in any 24 months at **no charge**

Eyeglasses and contact lenses

We provide a single **$350 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 Plan 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 Plan Provider puts two lenses (at least one of which must have refractive value) into the frame
- Contact lenses, fitting, and dispensing

We will not provide the Allowance if we have provided an Allowance toward (or otherwise covered) eyeglass lenses or frames within the previous 24 months.

Replacement lenses

If you have a change in prescription of at least .50 diopter in one or both eyes 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 will 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.

Low vision devices

If a low vision device will provide a significant improvement in your vision not obtainable with eyeglasses or contact lenses (or with a combination of eyeglasses and contact lenses), we cover low vision devices (including fitting and dispensing) at **no charge** up to a benefit limit of **$500** every 24 months (including low vision devices we provided an Allowance toward, or otherwise covered, under any other evidence of coverage offered by your Group) when prescribed by a Plan

Physician or Plan Optometrist. We will calculate accumulation toward the benefit limit by adding up the Charges for the low vision devices (including fitting and dispensing) we provided an Allowance toward (or otherwise covered) during the previous 24 months, less any amounts (other than deductible payments) that you paid for those devices.

For the following Services, refer to these sections

- Services related to the eye or vision other than Services covered under this "Vision Services" section, such as outpatient surgery and outpatient prescription drugs, supplies, and supplements (refer to the applicable heading in this "Benefits and Your Cost Share" section)

Vision Services exclusion(s)

- Eyeglass or contact lens adornment, such as engraving, faceting, or jeweling
- Items that do not require a prescription by law (other than eyeglass frames), such as eyeglass holders, eyeglass cases, and repair kits
- Lenses and sunglasses without refractive value, except as described in this "Vision Services" section
- Replacement of lost, broken, or damaged contact lenses, eyeglass lenses, and frames

Exclusions, Limitations, Coordination of Benefits, and Reductions

Exclusions

The items and services listed in this "Exclusions" section are excluded from coverage. These exclusions apply to all Services that would otherwise be covered under this *EOC* regardless of whether the services are within the scope of a provider's license or certificate. Additional exclusions that apply only to a particular benefit are listed in the description of that benefit in this *EOC*. These exclusions or limitations do not apply to Services that are Medically Necessary to treat Severe Mental Illness or Serious Emotional Disturbance of a Child Under Age 18.

Certain exams and Services

Routine physical exams and other Services that are not Medically Necessary, such as when required (1) for obtaining or maintaining employment or participation in employee programs, (2) for insurance, credentialing or licensing, (3) for travel, or (4) by court order or for parole or probation.

Chiropractic Services

Chiropractic Services and the Services of a chiropractor, except for manual manipulation of the spine as described under "Outpatient Care" in the "Benefits and Your Cost Share" section or if you have coverage for supplemental chiropractic Services as described in an amendment to this *EOC*.

Cosmetic Services

Services that are intended primarily to change or maintain your appearance (including Cosmetic Surgery, which is defined as surgery that is performed to alter or reshape normal structures of the body in order to improve appearance), except that this exclusion does not apply to any of the following:

- Services covered under "Reconstructive Surgery" in the "Benefits and Your Cost Share" section
- The following devices covered under "Prosthetic and Orthotic Devices" in the "Benefits and Your Cost Share" section: testicular implants implanted as part of a covered reconstructive surgery, breast prostheses needed after a removal of all or part of a breast or lumpectomy, and prostheses to replace all or part of an external facial body part

Custodial care

Assistance with activities of daily living (for example: walking, getting in and out of bed, bathing, dressing, feeding, toileting, and taking medicine).

This exclusion does not apply to assistance with activities of daily living that is provided as part of covered hospice for Members who do not have Part A, Skilled Nursing Facility, or hospital inpatient care.

Dental care

Dental care and dental X-rays, such as dental Services following accidental injury to teeth, dental appliances, dental implants, orthodontia, and dental Services resulting from medical treatment such as surgery on the jawbone and radiation treatment, except for Services covered in accord with Medicare guidelines or under "Dental Services" in the "Benefits and Your Cost Share" section.

Disposable supplies

Disposable supplies for home use, such as bandages, gauze, tape, antiseptics, dressings, Ace-type bandages, and diapers, underpads, and other incontinence supplies.

This exclusion does not apply to disposable supplies covered in accord with Medicare guidelines or under "Durable Medical Equipment ("DME") for Home Use," "Home Health Care," "Hospice Care," "Ostomy, Urological, and Wound Care Supplies," "Outpatient Prescription Drugs, Supplies, and Supplements," and "Prosthetic and Orthotic Devices" in the "Benefits and Your Cost Share" section.

Experimental or investigational Services

A Service is experimental or investigational if we, in consultation with the Medical Group, determine that one of the following is true:

- Generally accepted medical standards do not recognize it as safe and effective for treating the condition in question (even if it has been authorized by law for use in testing or other studies on human patients)
- It requires government approval that has not been obtained when the Service is to be provided

Hair loss or growth treatment

Items and services for the promotion, prevention, or other treatment of hair loss or hair growth.

Intermediate care

Care in a licensed intermediate care facility. This exclusion does not apply to Services covered under "Durable Medical Equipment ("DME") for Home Use," "Home Health Care," and "Hospice Care" in the "Benefits and Your Cost Share" section.

Items and services that are not health care items and services

For example, we do not cover:

- Teaching manners and etiquette
- Teaching and support services to develop planning skills such as daily activity planning and project or task planning
- Items and services for the purpose of increasing academic knowledge or skills
- Teaching and support services to increase intelligence
- Academic coaching or tutoring for skills such as grammar, math, and time management
- Teaching you how to read, whether or not you have dyslexia
- Educational testing
- Teaching art, dance, horse riding, music, play, or swimming
- Teaching skills for employment or vocational purposes
- Vocational training or teaching vocational skills
- Professional growth courses
- Training for a specific job or employment counseling
- Aquatic therapy and other water therapy, except when ordered as part of a physical therapy program in accord with Medicare guidelines

Items and services to correct refractive defects of the eye

Items and services (such as eye surgery or contact lenses to reshape the eye) for the purpose of correcting refractive defects of the eye such as myopia, hyperopia, or astigmatism.

Massage therapy

Massage therapy, except when ordered as part of a physical therapy program in accord with Medicare guidelines.

Oral nutrition

Outpatient oral nutrition, such as dietary supplements, herbal supplements, weight loss aids, formulas, and food.

This exclusion does not apply to any of the following:

- Amino acid–modified products and elemental dietary enteral formula covered under "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section
- Enteral formula covered under "Prosthetic and Orthotic Devices" in the "Benefits and Your Cost Share" section

Residential care

Care in a facility where you stay overnight, except that this exclusion does not apply when the overnight stay is part of covered care in a hospital, a Skilled Nursing Facility, inpatient respite care covered in the "Hospice Care" section for Members who do not have Part A, or residential treatment program Services covered in the "Substance Use Disorder Treatment" and "Mental Health Services" sections.

Routine foot care items and services

Routine foot care items and services, except for Medically Necessary Services covered in accord with Medicare guidelines.

Services not approved by the federal Food and Drug Administration

Drugs, supplements, tests, vaccines, devices, radioactive materials, and any other Services that by law require federal Food and Drug Administration (FDA) approval in order to be sold in the U.S., but are not approved by

the FDA. This exclusion applies to Services provided anywhere, even outside the U.S., unless the Services are covered under the "Emergency Services and Urgent Care" section.

Services and items not covered by Medicare

Services and items that are not covered by Medicare, including services and items that aren't reasonable and necessary, according to the standards of the Original Medicare plan, unless these Services are otherwise listed in this *EOC* as a covered Service.

Services performed by unlicensed people

Services that are performed safely and effectively by people who do not require licenses or certificates by the state to provide health care services and where the Member's condition does not require that the services be provided by a licensed health care provider.

Services related to a noncovered Service

When a Service is not covered, all Services related to the noncovered Service are excluded, except for Services we would otherwise cover to treat complications of the noncovered Service or if covered in accord with Medicare guidelines. For example, if you have a noncovered cosmetic surgery, we would not cover Services you receive in preparation for the surgery or for follow-up care. If you later suffer a life-threatening complication such as a serious infection, this exclusion would not apply and we would cover any Services that we would otherwise cover to treat that complication.

Surrogacy

Services for anyone in connection with a Surrogacy Arrangement, except for otherwise-covered Services provided to a Member who is a surrogate. Refer to "Surrogacy arrangements" under "Reductions" in this "Exclusions, Limitations, Coordination of Benefits, and Reductions" section for information about your obligations to us in connection with a Surrogacy Arrangement, including your obligations to reimburse us for any Services we cover and to provide information about anyone who may be financially responsible for Services the baby (or babies) receive.

Travel and lodging expenses

Travel and lodging expenses, except as described in our Travel and Lodging Program Description. The Travel and Lodging Program Description is available online at kp.org/specialty-care/travel-reimbursements or by calling our Member Service Contact Center.

Limitations

We will make a good faith effort to provide or arrange for covered Services within the remaining availability of facilities or personnel in the event of unusual circumstances that delay or render impractical the provision of Services under this *EOC*, such as a major disaster, epidemic, war, riot, civil insurrection, disability of a large share of personnel at a Plan Facility, complete or partial destruction of facilities, and labor dispute. Under these circumstances, if you have an Emergency Medical Condition, call 911 or go to the nearest hospital as described under "Emergency Services" in the "Emergency Services and Urgent Care" section, and we will provide coverage and reimbursement as described in that section.

Additional limitations that apply only to a particular benefit are listed in the description of that benefit in this *EOC*.

Coordination of Benefits

If you have other medical or dental coverage besides your Group's non-Medicare plan, it is important to use your other coverage in combination with your coverage as a Senior Advantage Member to pay for the care you receive. This is called "coordination of benefits" because it involves coordinating all of the health benefits that are available to you. Using all of the coverage you have helps keep the cost of health care more affordable for everyone.

You must tell us if you have other health care coverage, in addition to your Group's non-Medicare plan, and let us know whenever there are any changes in your additional coverage. The types of additional coverage that you might have include the following:

- Coverage that you have from another employer's group health care coverage for employees or retirees, either through yourself or your spouse
- Coverage that you have under workers' compensation because of a job-related illness or injury, or under the Federal Black Lung Program
- Coverage you have for an accident where no-fault insurance or liability insurance is involved
- Coverage you have through Medicaid
- Coverage you have through the "TRICARE for Life" program (veteran's benefits)
- Coverage you have for dental insurance or prescription drugs

- ☐ "Continuation coverage" you have through COBRA (COBRA is a law that requires employers with 20 or more employees to let employees and their dependents keep their group health coverage for a time after they leave their group health plan under certain conditions)

When you have additional health care coverage besides your Group's non-Medicare plan, how we coordinate your benefits as a Senior Advantage Member with your benefits from your other coverage depends on your situation. With coordination of benefits, you will often get your care as usual from Plan Providers, and the other coverage you have will simply help pay for the care you receive. In other situations, such as benefits that we don't cover, you may get your care outside of our plan directly through your other coverage.

In general, the coverage that pays its share of your bills first is called the "primary payer." Then the other company or companies that are involved (called the "secondary payers") each pay their share of what is left of your bills. Often your other coverage will settle its share of payment directly with us and you will not have to be involved. However, if payment owed to us is sent directly to you, you are required under Medicare law to give this payment to us. When you have additional coverage, whether we pay first or second, or at all, depends on what type or types of additional coverage you have and the rules that apply to your situation. Many of these rules are set by Medicare. Some of them take into account whether you have a disability or have end-stage renal disease, or how many employees are covered by an employer's group plan.

If you have additional health coverage besides your Group's non-Medicare plan, please call our Member Service Contact Center to find out which rules apply to your situation, and how payment will be handled.

Reductions

Employer responsibility

For any Services that the law requires an employer to provide, we will not pay the employer, and, when we cover any such Services, we may recover the value of the Services from the employer.

Government agency responsibility

For any Services that the law requires be provided only by or received only from a government agency, we will not pay the government agency, and, when we cover any such Services, we may recover the value of the Services from the government agency.

Injuries or illnesses alleged to be caused by third parties

Third parties who cause you injury or illness (and/or their insurance companies) usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue these primary payments. If you obtain a judgment or settlement from or on behalf of a third party who allegedly caused an injury or illness for which you received covered Services, you must ensure we receive reimbursement for those Services. Note: This "Injuries or illnesses alleged to be caused by third parties" section does not affect your obligation to pay your Cost Share for these Services.

To the extent permitted or required by law, we shall be subrogated to all claims, causes of action, and other rights you may have against a third party or an insurer, government program, or other source of coverage for monetary damages, compensation, or indemnification on account of the injury or illness allegedly caused by the third party. We will be so subrogated as of the time we mail or deliver a written notice of our exercise of this option to you or your attorney.

To secure our rights, we will have a lien and reimbursement rights to the proceeds of any judgment or settlement you or we obtain against a third party that results in any settlement proceeds or judgment, from other types of coverage that include but are not limited to: liability, uninsured motorist, underinsured motorist, personal umbrella, 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:

Equian
Kaiser Permanente - Northern California Region
Subrogation Mailbox
P.O. Box 36380
Louisville, KY 40233
Fax: 1-502-214-1137

In order for us to determine the existence of any rights we may have and to satisfy those rights, you must complete and send us all consents, releases, authorizations, assignments, and other documents, including lien forms directing your attorney, the third party, and the third party's liability insurer to pay us directly. You may not agree to waive, release, or reduce our rights under this provision without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against a third party based on your injury or illness, your estate, parent, guardian, or conservator and any settlement or judgment recovered by the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

Surrogacy arrangements

This "Surrogacy arrangements" section applies to all types of Surrogacy Arrangements, including traditional Surrogacy Arrangements and gestational Surrogacy Arrangements. If you enter into a Surrogacy Arrangement and you or any other payee are entitled to receive payments or other compensation under the Surrogacy Arrangement, you must reimburse us for covered Services you receive related to conception, pregnancy, delivery, or postpartum care in connection with that arrangement ("Surrogacy Health Services") to the maximum extent allowed under California Civil Code Section 3040. A "Surrogacy Arrangement" is one in which a woman agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children), whether or not the woman receives payment for being a surrogate. Note: This "Surrogacy arrangements" section does not affect your obligation to pay your Cost Share for these Services. After you surrender a baby to the legal parents, you are not obligated to reimburse us for any Services that the baby receives (the legal parents are financially responsible for any Services that the baby receives).

By accepting Surrogacy Health Services, you automatically assign to us your right to receive payments that are payable to you or any other payee under the Surrogacy Arrangement, regardless of whether those payments are characterized as being for medical expenses. To secure our rights, we will also have a lien on those payments and on any escrow account, trust, or any other account that holds those payments. Those payments (and amounts in any escrow account, trust, or other account that holds those payments) shall first be applied to satisfy our lien. The assignment and our lien will not exceed the total amount of your obligation to us under the preceding paragraph.

Within 30 days after entering into a Surrogacy Arrangement, you must send written notice of the arrangement, including all of the following information:

- Names, addresses, and telephone numbers of the other parties to the arrangement
- Names, addresses, and telephone numbers of any escrow agent or trustee
- Names, addresses, and telephone numbers of the intended parents and any other parties who are financially responsible for Services the baby (or babies) receive, including names, addresses, and telephone numbers for any health insurance that will cover Services that the baby (or babies) receive
- A signed copy of any contracts and other documents explaining the arrangement
- Any other information we request in order to satisfy our rights

You must send this information to:

Equian
Kaiser Permanente – Northern California Region
Surrogacy Mailbox
P.O. Box 36380
Louisville, KY 40233
Fax: 1-502-214-1137

You must complete and send us all consents, releases, authorizations, lien forms, and other documents that are reasonably necessary for us to determine the existence of any rights we may have under this "Surrogacy arrangements" section and to satisfy those rights. You may not agree to waive, release, or reduce our rights under this "Surrogacy arrangements" section without our prior, written consent.

If your estate, parent, guardian, or conservator asserts a claim against another party based on the surrogacy arrangement, your estate, parent, guardian, or conservator and any settlement or judgment recovered by

the estate, parent, guardian, or conservator shall be subject to our liens and other rights to the same extent as if you had asserted the claim against the other party. We may assign our rights to enforce our liens and other rights.

If you have questions about your obligations under this provision, please call our Member Service Contact Center.

U.S. Department of Veterans Affairs

For any Services for conditions arising from military service that the law requires the Department of Veterans Affairs to provide, we will not pay the Department of Veterans Affairs, and when we cover any such Services we may recover the value of the Services from the Department of Veterans Affairs.

Workers' compensation or employer's liability benefits

Workers' compensation usually must pay first before Medicare or our plan. Therefore, we are entitled to pursue primary payments under workers' compensation or employer's liability law. You may be eligible for payments or other benefits, including amounts received as a settlement (collectively referred to as "Financial Benefit"), under workers' compensation or employer's liability law. We will provide covered Services even if it is unclear whether you are entitled to a Financial Benefit, but we may recover the value of any covered Services from the following sources:

- From any source providing a Financial Benefit or from whom a Financial Benefit is due
- From you, to the extent that a Financial Benefit is provided or payable or would have been required to be provided or payable if you had diligently sought to establish your rights to the Financial Benefit under any workers' compensation or employer's liability law

Requests for Payment

Requests for Payment of Covered Services or Part D drugs

If you pay our share of the cost of your covered services or Part D drugs, or if you receive a bill, you can ask us for payment

Sometimes when you get medical care or a Part D drug, you may need to pay the full cost right away. Other times, you may find that you have paid more than you expected under the coverage rules of our plan. In either case, you can ask us to pay you back (paying you back is often called "reimbursing" you). It is your right to be paid back by our plan whenever you've paid more than your share of the cost for medical services or Part D drugs that are covered by our plan.

There may also be times when you get a bill from a provider for the full cost of medical care you have received. In many cases, you should send this bill to us instead of paying it. We will look at the bill and decide whether the services should be covered. If we decide they should be covered, we will pay the provider directly.

Here are examples of situations in which you may need to ask us to pay you back or to pay a bill you have received:

- **When you've received emergency, urgent, or dialysis care from a Non–Plan Provider.** You can receive emergency services from any provider, whether or not the provider is a Plan Provider. When you receive emergency, urgent, or dialysis care from a Non–Plan Provider, you are only responsible for paying your share of the cost, not for the entire cost. You should ask the provider to bill our plan for our share of the cost
  - if you pay the entire amount yourself at the time you receive the care, you need to ask us to pay you back for our share of the cost. Send us the bill, along with documentation of any payments you have made
  - at times you may get a bill from the provider asking for payment that you think you do not owe. Send us this bill, along with documentation of any payments you have already made
  - if the provider is owed anything, we will pay the provider directly
  - if you have already paid more than your share of the cost of the service, we will determine how much you owed and pay you back for our share of the cost
- **When a Plan Provider sends you a bill you think you should not pay.** Plan Providers should always bill us directly, and ask you only for your share of the cost. But sometimes they make mistakes, and ask you to pay more than your share
  - you only have to pay your Cost Share amount when you get Services covered by our plan. We do not allow providers to add additional separate charges, called "balance billing." This protection (that you never pay more than your Cost Share amount) applies even if we pay the provider less than the provider charges for a service, and even

if there is a dispute and we don't pay certain provider charges

- whenever you get a bill from a Plan Provider that you think is more than you should pay, send us the bill. We will contact the provider directly and resolve the billing problem
- if you have already paid a bill to a Plan Provider, but you feel that you paid too much, send us the bill along with documentation of any payment you have made and ask us to pay you back the difference between the amount you paid and the amount you owed under our plan

- **If you are retroactively enrolled in our plan.** Sometimes a person's enrollment in our plan is retroactive. ("Retroactive" means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.) If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered Services or Part D drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You will need to submit paperwork for us to handle the reimbursement. Please call our Member Service Contact Center for additional information about how to ask us to pay you back and deadlines for making your request
- **When you use a Non–Plan Pharmacy to get a prescription filled.** If you go to a Non–Plan Pharmacy and try to use your membership card to fill a prescription, the pharmacy may not be able to submit the claim directly to us. When that happens, you will have to pay the full cost of your prescription. We cover prescriptions filled at Non–Plan Pharmacies only in a few special situations. Please see "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section to learn more
  - save your receipt and send a copy to us when you ask us to pay you back for our share of the cost
- **When you pay the full cost for a prescription because you don't have your plan membership card with you.** If you do not have your plan membership card with you, you can ask the pharmacy to call us or to look up your plan enrollment information. However, if the pharmacy cannot get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself
  - save your receipt and send a copy to us when you ask us to pay you back for our share of the cost
- **When you pay the full cost for a prescription in other situations.** You may pay the full cost of the prescription because you find that the drug is not covered for some reason
  - for example, the drug may not be on our *2022 Comprehensive Formulary*; or it could have a requirement or restriction that you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it
  - save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor in order to pay you back for our share of the cost
- **When you pay copayments under a drug manufacturer patient assistance program.** If you get help from, and pay copayments under, a drug manufacturer patient assistance program outside our plan's benefit, you may submit a paper claim to have your out-of-pocket expense count toward qualifying you for catastrophic coverage
  - save your receipt and send a copy to us

All of the examples above are types of coverage decisions. This means that if we deny your request for payment, you can appeal our decision. The "Coverage Decisions, Appeals, and Complaints" section has information about how to make an appeal.

How to Ask Us to Pay You Back or to Pay a Bill You Have Received

How and where to send us your request for payment

To file a claim, this is what you need to do:

- As soon as possible, request our claim form by calling our Member Service Contact Center toll free at **1-800-443-0815** or **1-800-390-3510** (TTY users call **711**). One of our representatives will be happy to assist you if you need help completing our claim form
- If you have paid for services, you must send us your request for reimbursement. Please attach any bills and receipts from the Non–Plan Provider
- You must complete and return to us any information that we request to process your claim, such as claim forms, consents for the release of medical records, assignments, and claims for any other benefits to which you may be entitled. For example, we may require documents such as travel documents or original travel tickets to validate your claim
- The completed claim form must be mailed to the following address as soon as possible, but no later than 15 months after receiving the care (or up to 27

months according to Medicare rules, in some cases). Please do not send any bills or claims to Medicare. Any additional information we request should also be mailed to this address:
Kaiser Permanente
Claims Administration - NCAL
P.O. Box 12923
Oakland, CA 94604-2923

Note: If you are requesting payment of a Part D drug that was prescribed by a Plan Provider and obtained from a Plan Pharmacy, write to:
Kaiser Foundation Health Plan, Inc.
Part D Unit
P.O. Box 23170
Oakland, CA 94623-0170

Contact our Member Service Contact Center if you have any questions. If you don't know what you should have paid, or you receive bills and you don't know what to do about those bills, we can help. You can also call if you want to give us more information about a request for payment you have already sent to us.

We Will Consider Your Request for Payment and Say *Yes* or *No*

We check to see whether we should cover the service or Part D drug and how much we owe

When we receive your request for payment, we will let you know if we need any additional information from you. Otherwise, we will consider your request and make a coverage decision.

- If we decide that the medical care or Part D drug is covered and you followed all the rules for getting the care or Part D drug, we will pay for our share of the cost. If you have already paid for the service or Part D drug, we will mail your reimbursement of our share of the cost to you. If you have not paid for the service or Part D drug yet, we will mail the payment directly to the provider
- If we decide that the medical care or Part D drug is not covered, or you did not follow all the rules, we will not pay for our share of the cost. Instead, we will send you a letter that explains the reasons why we are not sending the payment you have requested and your rights to appeal that decision

If we tell you that we will not pay for all or part of the medical care or Part D drug, you can make an appeal

If you think we have made a mistake in turning down your request for payment or you don't agree with the amount we are paying, you can make an appeal. If you make an appeal, it means you are asking us to change the decision we made when we turned down your request for payment.

For the details about how to make this appeal, go to the "Coverage Decisions, Appeals, and Complaints" section. The appeals process is a formal process with detailed procedures and important deadlines. If making an appeal is new to you, you will find it helpful to start by reading "A Guide to the Basics of Coverage Decisions and Appeals" in the "Coverage Decisions, Appeals, and Complaints" section, which is an introductory section that explains the process for coverage decisions and appeals and gives you definitions of terms such as "appeal." Then, after you have read "A Guide to the Basics of Coverage Decisions and Appeals," you can go to the section in "Coverage Decisions, Appeals, and Complaints" that tells you what to do for your situation:

- If you want to make an appeal about getting paid back for a medical service, go to "Step-by-step: How to make a Level 2 appeal" under "Your Medical Care: How to Ask for a Coverage Decision or Make an Appeal" in the "Coverage Decisions, Appeals, and Complaints" section
- If you want to make an appeal about getting paid back for a Part D drug, go to "Step-by-step: How to make a Level 2 appeal" under "Your Part D Prescription Drugs: How to Ask for a Coverage Decision or Make an Appeal" in the "Coverage Decisions, Appeals, and Complaints" section

Other Situations in Which You Should Save Your Receipts and Send Copies to Us

In some cases, you should send copies of your receipts to us to help us track your out-of-pocket drug costs

There are some situations when you should let us know about payments you have made for your covered Part D prescription drugs. In these cases, you are not asking us for payment. Instead, you are telling us about your payments so that we can calculate your out-of-pocket costs correctly. This may help you to qualify for the Catastrophic Coverage Stage more quickly.

Here is one situation when you should send us copies of receipts to let us know about payments you have made for your drugs:

- **When you get a drug through a patient assistance program offered by a drug manufacturer.** Some members are enrolled in a patient assistance program offered by a drug manufacturer that is outside our plan benefits. If you get any drugs through a program

offered by a drug manufacturer, you may pay a copayment to the patient assistance program

- save your receipt and send a copy to us so that we can have your out-of-pocket expenses count toward qualifying you for the Catastrophic Coverage Stage
- note: Because you are getting your drug through the patient assistance program and not through our plan's benefits, we will not pay for any share of these drug costs. But sending a copy of the receipt allows us to calculate your out-of-pocket costs correctly and may help you qualify for the Catastrophic Coverage Stage more quickly

Since you are not asking for payment in the case described above, this situation is not considered a coverage decision. Therefore, you cannot make an appeal if you disagree with our decision.

Your Rights and Responsibilities

We must honor your rights as a Member of our plan

We must provide information in a way that works for you (in languages other than English, Braille, large print, or CD)

Our plan has people and free interpreter services available to answer questions from disabled and non-English-speaking members. This booklet is available in Spanish by calling our Member Service Contact Center. We can also give you information in braille, large print, or CD at no cost if you need it. We are required to give you information about our plan's benefits in a format that is accessible and appropriate for you. To get information from us in a way that works for you, please call our Member Service Contact Center or contact our Civil Rights Coordinator.

If you have any trouble getting information from our plan in a format that is accessible and appropriate for you, please call to file a grievance with our Member Service Contact Center. You may also file a complaint with Medicare by calling **1-800-MEDICARE** (**1-800-633-4227**) or directly with the Office for Civil Rights. Contact information is included in this *EOC* or you may contact our Member Service Contact Center for additional information.

Debemos proporcionar la información de un modo adecuado para usted (en idiomas distintos al inglés, en braille, en letra grande o en CD)

Para obtener información de una forma que se adapte a sus necesidades, por favor llame a la Central de Llamadas de Servicio a los Miembros (los números de teléfono están impresos en la contraportada de este folleto).

Nuestro plan cuenta con personas y servicios de interpretación disponibles sin costo para responder las preguntas de los miembros discapacitados y que no hablan inglés. Este folleto está disponible en español; llame a la Central de Llamadas de Servicio a los Miembros. Si la necesita, también podemos darle, sin costo, información en braille, letra grande of CD. Tenemos la obligación de darle información acerca de los beneficios de nuestro plan en un formato que sea accesible y adecuado para usted. Para obtener nuestra información de una forma que se adapte a sus necesidades, por favor llame a la Central de Llamadas de Servicio a los Miembros o comuníquese con nuestro Coordinador de Derechos Civiles.
Si tiene algún problema para obtener información de nuestro plan en un formato que sea accesible y adecuado para usted, por favor llame para presentar una queja a la Central de Llamadas de Servicio a los Miembros (los números de teléfono están impresos en la contraportada de este folleto). También puede presentar una queja en Medicare llamando al ***1-800-MEDICARE (1-800-633-4227)*** *o directamente en la Oficina de Derechos Civiles****.*** *En esta Evidence of Coverage (****Evidencia de Cobertura)*** *o en esta carta se incluye la información de contacto, o bien puede comunicarse con nuestra Central de Llamadas de Servicio a los Miembros para obtener información adicional.*

We must ensure that you get timely access to your covered services and Part D drugs

As a Member of our plan, you have the right to choose a primary care provider (PCP) in our network to provide and arrange for your covered services (the "How to Obtain Services" section explains more about this). Call our Member Service Contact Center to learn which doctors are accepting new patients. You also have the right to go to a women's health specialist (such as a gynecologist), a mental health services provider, and an optometrist without a referral, as well as other providers described in the "How to Obtain Services" section.

As a plan Member, you have the right to get appointments and covered services from our network of providers within a reasonable amount of time. This includes the right to get timely services from specialists when you need that care. You also have the right to get your prescriptions filled or refilled at any of our network pharmacies without long delays.

If you think that you are not getting your medical care or Part D drugs within a reasonable amount of time, "How to make a complaint about quality of care, waiting times, customer service, or other concerns" in the "Coverage Decisions, Appeals, and Complaints" section tells you what you can do. (If we have denied coverage for your medical care or Part D drugs and you don't agree with our decision, "A guide to the basics of coverage decisions and appeals" in the "Coverage Decisions, Appeals, and Complaints" section tells you what you can do.)

We must protect the privacy of your personal health information

Federal and state laws protect the privacy of your medical records and personal health information. We protect your personal health information as required by these laws.

- Your "personal health information" includes the personal information you gave us when you enrolled in our plan as well as your medical records and other medical and health information
- The laws that protect your privacy give you rights related to getting information and controlling how your health information is used. We give you a written notice, called a "Notice of Privacy Practices," that tells you about these rights and explains how we protect the privacy of your health information

How do we protect the privacy of your health information?

- We make sure that unauthorized people don't see or change your records
- In most situations, if we give your health information to anyone who isn't providing your care or paying for your care, we are required to get written permission from you first. Written permission can be given by you or by someone you have given legal power to make decisions for you
- Your health information is shared with your Group only with your authorization or as otherwise permitted by law
- There are certain exceptions that do not require us to get your written permission first. These exceptions are allowed or required by law.
  - for example, we are required to release health information to government agencies that are checking on quality of care
  - because you are a Member of our plan through Medicare, we are required to give Medicare your health information, including information about your Part D prescription drugs. If Medicare releases your information for research or other uses, this will be done according to federal statutes and regulations

You can see the information in your records and know how it has been shared with others

You have the right to look at your medical records held by our plan, and to get a copy of your records. We are allowed to charge you a fee for making copies. You also have the right to ask us to make additions or corrections to your medical records. If you ask us to do this, we will work with your health care provider to decide whether the changes should be made.

You have the right to know how your health information has been shared with others for any purposes that are not routine.

If you have questions or concerns about the privacy of your personal health information, please call our Member Service Contact Center.

We must give you information about our plan, our Plan Providers, and your covered services

As a Member of our plan, you have the right to get several kinds of information from us. You have the right to get information from us in a way that works for you. This includes getting the information in Spanish, braille, large print, or CD.

If you want any of the following kinds of information, please call our Member Service Contact Center:

- **Information about our plan.** This includes, for example, information about our plan's financial condition. It also includes information about the number of appeals made by Members and our plan's performance ratings, including how it has been rated by Members and how it compares to other Medicare health plans
- **Information about our network providers, including our network pharmacies**
  - for example, you have the right to get information from us about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network
  - for a list of the providers in our network, see the *Provider Directory*
  - for a list of the pharmacies in our network, see the *Pharmacy Directory*
  - for more detailed information about our providers or pharmacies, you can call our Member Service Contact Center or visit our website at kp.org/directory

- **Information about your coverage and the rules you must follow when using your coverage**
  - in the "How to Obtain Services" and "Benefits and Your Cost Share" sections, we explain what medical services are covered for you, any restrictions to your coverage, and what rules you must follow to get your covered medical services
  - to get the details about your Part D prescription drug coverage, see "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section plus our plan's *Drug List.* That section, together with the *Drug List,* tell you what drugs are covered and explain the rules you must follow and the restrictions to your coverage for certain drugs
  - if you have questions about the rules or restrictions, please call our Member Service Contact Center
- **Information about why something is not covered and what you can do about it**
  - if a medical service or Part D drug is not covered for you, or if your coverage is restricted in some way, you can ask us for a written explanation. You have the right to this explanation even if you received the medical service or Part D drug from an out-of-network provider or pharmacy
  - if you are not happy or if you disagree with a decision we make about what medical care or Part D drug is covered for you, you have the right to ask us to change the decision. You can ask us to change the decision by making an appeal. For details on what to do if something is not covered for you in the way you think it should be covered, see the "Coverage Decisions, Appeals, and Complaints" section. It gives you the details about how to make an appeal if you want us to change our decision. (it also tells you about how to make a complaint about quality of care, waiting times, and other concerns)
  - if you want to ask us to pay our share of a bill you have received for medical care or a Part D drug, see the "Request for Payments" section

We must treat you with dignity and respect and support your right to make decisions about your care

You have the right to know your treatment options and participate in decisions about your health care

You have the right to get full information from your doctors and other health care providers when you go for medical care. Your providers must explain your medical condition and your treatment choices in a way that you can understand.

You also have the right to participate fully in decisions about your health care. To help you make decisions with your doctors about what treatment is best for you, your rights include the following:

- **To know about all of your choices.** This means that you have the right to be told about all of the treatment options that are recommended for your condition, no matter what they cost or whether they are covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. Of course, if you refuse treatment or stop taking a medication, you accept full responsibility for what happens to your body as a result
- **To receive an explanation if you are denied coverage for care.** You have the right to receive an explanation from us if a provider has denied care that you believe you should receive. To receive this explanation, you will need to ask us for a coverage decision. The "coverage Decisions, Appeals, and Complaints" section of this booklet tells you how to ask us for a coverage decision

You have the right to give instructions about what is to be done if you are not able to make medical decisions for yourself

Sometimes people become unable to make health care decisions for themselves due to accidents or serious illness. You have the right to say what you want to happen if you are in this situation. This means that, if you want to, you can:

- Fill out a written form to give someone the legal authority to make medical decisions for you if you ever become unable to make decisions for yourself
- Give your doctors written instructions about how you want them to handle your medical care if you become unable to make decisions for yourself

The legal documents that you can use to give your directions in advance in these situations are called "**advance directives**." There are different types of advance directives and different names for them.

Documents called "**living will**" and "**power of attorney for health care**" are examples of advance directives.

If you want to use an "advance directive" to give your instructions, here is what to do:

- **Get the form**. If you want to have an advance directive, you can get a form from your lawyer, from a social worker, or from some office supply stores. You can sometimes get advance directive forms from organizations that give people information about Medicare. You can also contact our Member Service Contact Center to ask for the forms
- **Fill it out and sign it**. Regardless of where you get this form, keep in mind that it is a legal document. You should consider having a lawyer help you prepare it
- **Give copies to appropriate people.** You should give a copy of the form to your doctor and to the person you name on the form as the one to make decisions for you if you can't. You may want to give copies to close friends or family members as well. Be sure to keep a copy at home

If you know ahead of time that you are going to be hospitalized, and you have signed an advance directive, take a copy with you to the hospital.

- If you are admitted to the hospital, they will ask you whether you have signed an advance directive form and whether you have it with you
- If you have not signed an advance directive form, the hospital has forms available and will ask if you want to sign one

Remember, it is your choice whether you want to fill out an advance directive (including whether you want to sign one if you are in the hospital). According to law, no one can deny you care or discriminate against you based on whether or not you have signed an advance directive.

What if your instructions are not followed?
If you have signed an advance directive, and you believe that a doctor or hospital did not follow the instructions in it, you may file a complaint with the Quality Improvement Organization listed in the "Important Phone Numbers and Resources" section.

You have the right to make complaints and to ask us to reconsider decisions we have made

If you have any problems or concerns about your covered services or care, the "Coverage Decisions, Appeals, and Complaints" section of this booklet tells you what you can do. It gives you the details about how to deal with all types of problems and complaints.

What you need to do to follow up on a problem or concern depends upon the situation. You might need to ask us to make a coverage decision for you, make an appeal to us to change a coverage decision, or make a complaint. Whatever you do—ask for a coverage decision, make an appeal, or make a complaint—we are required to treat you fairly.

You have the right to get a summary of information about the appeals and complaints that other members have filed against our plan in the past. To get this information, please call our Member Service Contact Center.

What can you do if you believe you are being treated unfairly or your rights are not being respected?

If it is about discrimination, call the Office for Civil Rights
If you believe you have been treated unfairly or your rights have not been respected due to your race, disability, religion, sex, health, ethnicity, creed (beliefs), age, or national origin, you should call the Department of Health and Human Services' Office for Civil Rights at **1-800-368-1019** (TTY users call **1-800-537-7697)** or call your local Office for Civil Rights.

Is it about something else?
If you believe you have been treated unfairly or your rights have not been respected, and it's not about discrimination, you can get help dealing with the problem you are having:

- You can call our Member Service Contact Center
- You can call the State Health Insurance Assistance Program. For details about this organization and how to contact it, go to the "Important Phone Numbers and Resources" section
- Or you can call Medicare at **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week

How to get more information about your rights

There are several places where you can get more information about your rights:

- **You can call our Member Service Contact Center**
- **You can call the State Health Insurance Assistance Program**. For details about this organization and how to contact it, go to the "Important Phone Numbers and Resources" section
- **You can contact Medicare:**
  - you can visit the Medicare website to read or download the publication "Medicare Rights & Protections." (The publication is available at

https://www.medicare.gov/Pubs/pdf/11534-Medicare-Rights-and-Protections.pdf)

- or you can call **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week

Information about new technology assessments

Rapidly changing technology affects health care and medicine as much as any other industry. To determine whether a new drug or other medical development has long-term benefits, our plan carefully monitors and evaluates new technologies for inclusion as covered benefits. These technologies include medical procedures, medical devices, and new drugs.

You can make suggestions about rights and responsibilities

As a Member of our plan, you have the right to make recommendations about the rights and responsibilities included in this section. Please call our Member Service Contact Center with any suggestions.

You have some responsibilities as a Member of our plan

What are your responsibilities?

Things you need to do as a Member of our plan are listed below. If you have any questions, please call our Member Service Contact Center. We're here to help

- **Get familiar with your covered services and the rules you must follow to get these covered services**. Use this *EOC* booklet to learn what is covered for you and the rules you need to follow to get your covered services
  - the "How to Obtain Services" and "Benefits and Your Cost Share" sections give details about your medical services, including what is covered, what is not covered, rules to follow, and what you pay
  - the "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section gives details about your coverage for Part D prescription drugs
- **If you have any other health insurance coverage or prescription drug coverage in addition to our plan, you are required to tell us**. Please call our Member Service Contact Center to let us know
  - we are required to follow rules set by Medicare to make sure that you are using all of your coverage in combination when you get your covered services from our plan. This is called "coordination of benefits" because it involves coordinating the health and drug benefits you get from us with any other health and drug benefits available to you. We'll help you coordinate your benefits. (For more information about coordination of benefits, go to the "Exclusion, Limitations, Coordination of Benefits, and Reductions" section)
- **Tell your doctor and other health care providers that you are enrolled in our plan.** Show your plan membership card whenever you get your medical care or Part D drugs
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care**
  - to help your doctors and other health care providers give you the best care, learn as much as you are able to about your health problems and give them the information they need about you and your health. Follow the treatment plans and instructions that you and your doctors agree upon
  - make sure you understand your health problems and participate in developing mutually agreed upon treatment goals with your providers whenever possible
  - make sure your doctors know all of the drugs you are taking, including over-the-counter drugs, vitamins, and supplements
  - if you have any questions, be sure to ask. Your doctors and other health care providers are supposed to explain things in a way you can understand. If you ask a question and you don't understand the answer you are given, ask again
- **Be considerate.** We expect all our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices
- **Pay what you owe.** As a plan member, you are responsible for these payments:
  - in order to be eligible for our plan, you must have Medicare Part B. Most plan Members must pay a premium for Medicare Part B to remain a Member of our plan
  - for most of your Services or Part D drugs covered by our plan, you must pay your share of the cost when you get the Service or Part D drug. This will be a Copayment (a fixed amount) or Coinsurance (a percentage of the total cost). The "Benefits and Your Cost Share" section tells you what you must pay for your Services and Part D drugs
  - if you get any medical services or Part D drugs that are not covered by our plan or by other insurance you may have, you must pay the full cost
  - if you disagree with our decision to deny coverage for a service or Part D drug, you can make an

appeal. Please see the "Coverage Decisions, Appeals, and Complaints" section for information about how to make an appeal
    - if you are required to pay a late enrollment penalty, you must pay the penalty to keep your prescription drug coverage
    - if you are required to pay the extra amount for Part D because of your yearly income, you must pay the extra amount directly to the government to remain a Member of our plan
- **Tell us if you move.** If you are going to move, it's important to tell us right away. Call our Member Service Contact Center
    - if you move outside of our Service Area, you cannot remain a Member of our plan. (The "Definitions" section tells you about our Service Area.) We can help you figure out whether you are moving outside our Service Area.
    - if you move within our Service Area, we still need to know so we can keep your membership record up-to-date and know how to contact you
    - if you move, it is also important to tell Social Security (or the Railroad Retirement Board). You can find phone numbers and contact information for these organizations in the "Important Phone Numbers and Resources" section
- **Call our Member Service Contact Center for help if you have questions or concerns.** We also welcome any suggestions you may have for improving our plan
    - phone numbers and calling hours for our Member Service Contact Center
    - for more information about how to reach us, including our mailing address, please see the "Important Phone Numbers and Resources" section

Coverage Decisions, Appeals, and Complaints

What to Do if You Have a Problem or Concern

This section explains two types of processes for handling problems and concerns:

- For some types of problems, you need to use the process for coverage decisions and appeals
- For other types of problems, you need to use the process for making complaints

Both of these processes have been approved by Medicare. To ensure fairness and prompt handling of your problems, each process has a set of rules, procedures, and deadlines that must be followed by you and us.

Which one do you use? That depends upon the type of problem you are having. The guide under "To Deal with Your Problem, Which Process Should You Use?" in this "Coverage Decisions, Appeals, and Complaints" section will help you identify the right process to use.

This section describes the procedures under this Senior Advantage *EOC* when Medicare is secondary. You must refer to your non-Medicare plan document which provides your primary Group coverage for the dispute resolution procedures applicable to your non-Medicare plan.

What about the legal terms?

There are technical legal terms for some of the rules, procedures, and types of deadlines explained in this "Coverage Decisions, Appeals, and Complaints" section. Many of these terms are unfamiliar to most people and can be hard to understand.

To keep things simple, this section explains the legal rules and procedures using simpler words in place of certain legal terms. For example, this section generally says "making a complaint" rather than "filing a grievance," "coverage decision" rather than "organization determination" or "coverage determination," or "at-risk determination," and "Independent Review Organization" instead of "Independent Review Entity." It also uses abbreviations as little as possible.

However, it can be helpful, and sometimes quite important, for you to know the correct legal terms for the situation you are in. Knowing which terms to use will help you communicate more clearly and accurately when you are dealing with your problem and get the right help or information for your situation.

You Can Get Help from Government Organizations That Are Not Connected with Us

Where to get more information and personalized assistance

Sometimes it can be confusing to start or follow through the process for dealing with a problem. This can be especially true if you do not feel well or have limited

energy. Other times, you may not have the knowledge you need to take the next step.

Get help from an independent government organization

We are always available to help you. But in some situations you may also want help or guidance from someone who is not connected with us. You can always contact your State Health Insurance Assistance Program. This government program has trained counselors in every state. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you are having. They can also answer your questions, give you more information, and offer guidance on what to do.

The services of the State Health Insurance Assistance Program counselors are free. You will find phone numbers in the "Important Phone Numbers and Resources" section.

You can also get help and information from Medicare

For more information and help in handling a problem, you can also contact Medicare. Here are two ways to get information directly from Medicare:

- ☐ You can call **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week
- ☐ You can visit the Medicare website (https://www.medicare.gov)

To Deal with Your Problem, Which Process Should You Use?

Should you use the process for coverage decisions and appeals? Or should you use the process for making complaints?

If you have a problem or concern, you only need to read the parts of this section that apply to your situation. The guide that follows will help.

To figure out which part of this section will help you with your specific problem or concern, START HERE:

- ☐ **Is your problem or concern about your benefits or coverage?** (This includes problems about whether particular medical care or Part D drugs are covered or not, the way in which they are covered, and problems related to payment for medical care or Part D drugs)
  - ☐ **yes, my problem is about benefits or coverage:** Go on to "A Guide to the Basics of Coverage Decisions and Appeals"
  - ☐ **no, my problem is not about benefits or coverage:** Skip ahead to "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns"

A Guide to the Basics of Coverage Decisions and Appeals

Asking for coverage decisions and making appeals—*The big picture*

The process for coverage decisions and appeals deals with problems related to your benefits and coverage for medical care and Part D drugs, including problems related to payment. This is the process you use for issues such as whether something is covered or not, and the way in which something is covered.

Asking for coverage decisions

A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services or Part D drugs. For example, your Plan Physician makes a (favorable) coverage decision for you whenever you receive medical care from him or her or if your Plan Physician refers you to a medical specialist. You or your doctor can also contact us and ask for a coverage decision, if your doctor is unsure whether we will cover a particular medical service or refuses to provide medical care you think that you need. In other words, if you want to know if we will cover a medical service before you receive it, you can ask us to make a coverage decision for you.

We are making a coverage decision for you whenever we decide what is covered for you and how much we pay. In some cases, we might decide a service or Part D drug is not covered or is no longer covered by Medicare for you. If you disagree with this coverage decision, you can make an appeal.

Making an appeal

If we make a coverage decision and you are not satisfied with this decision, you can "appeal" the decision. An appeal is a formal way of asking us to review and change a coverage decision we have made.

When you appeal a decision for the first time, this is called a Level 1 Appeal. In this appeal, we review the coverage decision we have made to check to see if we were following all of the rules properly. Your appeal is handled by different reviewers than those who made the original unfavorable decision. When we have completed the review we give you our decision. Under certain circumstances, which we discuss later, you can request an expedited or "fast coverage decision" or fast appeal of a coverage decision.

If we say ***no*** to all or part of your Level 1 Appeal, you can go on to a Level 2 Appeal. The Level 2 Appeal is conducted by an Independent Review Organization that is not connected to us. (In some situations, your case will be automatically sent to the Independent Review Organization for a Level 2 Appeal. In other situations, you will need to ask for a Level 2 Appeal.) If you are not satisfied with the decision at the Level 2 Appeal, you may be able to continue through additional levels of appeal.

How to get help when you are asking for a coverage decision or making an appeal

Would you like some help? Here are resources you may wish to use if you decide to ask for any kind of coverage decision or appeal a decision:

- You can call our Member Service Contact Center (phone numbers are on the cover of this *EOC*)
- To can get free help from your State Health Insurance Assistance Program (see the "Important Phone Numbers and Resources" section)
- Your doctor can make a request for you
  - for medical care or Medicare Part B prescription drugs, your doctor can request a coverage decision or a Level 1 Appeal on your behalf. If your appeal is denied at Level 1, it will be automatically forwarded to Level 2. To request any appeal after Level 2, your doctor must be appointed as your representative
  - for Part D prescription drugs, your doctor or other prescriber can request a coverage decision or a Level 1 or Level 2 Appeal on your behalf. To request any appeal after Level 2, your doctor or other prescriber must be appointed as your representative
- You can ask someone to act on your behalf. If you want to, you can name another person to act for you as your "representative" to ask for a coverage decision or make an appeal
  - there may be someone who is already legally authorized to act as your representative under state law
  - if you want a friend, relative, your doctor or other provider, or other person to be your representative, call our Member Service Contact Center and ask for the "Appointment of Representative" form. (The form is also available on Medicare's website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at kp.org.) The form gives that person permission to act on your behalf. It must be signed by you and by the person whom you would like to act on your behalf. You must give us a copy of the signed form
- You also have the right to hire a lawyer to act for you. You may contact your own lawyer, or get the name of a lawyer from your local bar association or other referral service. There are also groups that will give you free legal services if you qualify. However, you are not required to hire a lawyer to ask for any kind of coverage decision or appeal a decision

Which section gives the details for your situation?

There are four different types of situations that involve coverage decisions and appeals. Since each situation has different rules and deadlines, we give the details for each one in a separate section:

- "Your Medical Care: How to Ask for a Coverage Decision or Make an Appeal"
- "Your Part D Prescription Drugs: How to Ask for a Coverage Decision or Make an Appeal"
- "How to Ask Us to Cover a Longer Inpatient Hospital Stay if You Think the Doctor Is Discharging You Too Soon"
- "How to Ask Us to Keep Covering Certain Medical Services if You Think Your Coverage is Ending Too Soon" (applies to these services only: home health care, Skilled Nursing Facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which section you should be using, please call our Member Service Contact Center (phone numbers are on the cover of this *EOC*). You can also get help or information from government organizations such as your State Health Insurance Assistance Program (the "Important Phone Numbers and Resources" section has the phone numbers for this program).

Your Medical Care: How to Ask for a Coverage Decision or Make an Appeal

This section tells what to do if you have problems getting coverage for medical care or if you want us to pay you back for our share of the cost of your care

This section is about your benefits for medical care and services. These benefits are described in the "Benefits and Your Cost Share" section. To keep things simple, we generally refer to "medical care coverage" or "medical care" in the rest of this section, instead of repeating "medical care or treatment or services" every time. The term "medical care" includes medical items and services as well as Medicare Part B prescription drugs. In some

cases, different rules apply to a request for a Medicare Part B prescription drug. In those cases, we will explain how the rules for Medicare Part B prescription drugs are different from the rules for medical items and services.

This section tells you what you can do if you are in any of the following situations:

- You are not getting certain medical care you want, and you believe that this care is covered by our plan
- We will not approve the medical care your doctor or other medical provider wants to give you, and you believe that this care is covered by our plan
- You have received medical care that you believe should be covered by our plan, but we have said we will not pay for this care
- You have received and paid for medical care that you believe should be covered by our plan, and you want to ask us to reimburse you for this care
- You are being told that coverage for certain medical care you have been getting that we previously approved will be reduced or stopped, and you believe that reducing or stopping this care could harm your health
- Note: If the coverage that will be stopped is for hospital care, home health care, Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, you need to read a separate section because special rules apply to these types of care. Here's what to read in those situations:
  - go to "How to Ask Us to Cover a Longer Inpatient Hospital Stay if You Think the Doctor Is Discharging You Too Soon"
  - go to "How to Ask Us to Keep Covering Certain Medical Services if You Think Your Coverage Is Ending Too Soon." This section is about three services only: home health care, Skilled Nursing Facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services
  - For all other situations that involve being told that medical care you have been getting will be stopped, use this "Your Medical Care: How to Ask for a Coverage Decision or Make an Appeal" section as your guide for what to do.

Which of these situations are you in?

- To find out whether we will cover the medical care you want
  - you can ask us to make a coverage decision for you. **Go to "Step-by-step: How to ask for a coverage decision"**
- If we already told you that we will not cover or pay for a medical service in the way that you want it to be covered or paid for
  - you can make an appeal. (This means you are asking us to reconsider.) **Skip ahead to "Step-by-step: How to make a Level 1 Appeal"**
- If you want to ask us to pay you back for medical care you have already received and paid for
  - you can send us the bill. **Skip ahead to "What if you are asking us to pay you for our share of a bill you have received for medical care?"**

Step-by-step: How to ask for a coverage decision (how to ask us to authorize or provide the services you want)

Step 1: You ask us to make a coverage decision on the medical care you are requesting. If your health requires a quick response, you should ask us to make a "fast coverage decision." A "fast coverage decision" is called an "expedited determination."

How to request coverage for the medical care you want

- Start by calling, writing, or faxing us to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this
- For the details about how to contact us, go to "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care" in the "Important Phone Numbers and Resources" section

Generally we use the standard deadlines for giving you our decision

When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 14 calendar days after we receive your request for a medical item or service. If your request is for a Medicare Part B prescription drug, we will give you an answer within 72 hours after we receive your request.

- However, for a request for a medical item or service, we can take up to 14 more calendar days if you ask for more time, or if we need information (such as medical records from Non–Plan Providers) that may benefit you. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug

- If you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, including fast complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section)

If your health requires it, ask us to give you a "fast coverage decision"

- A fast coverage decision means we will answer within 72 hours if your request is for a medical item or service. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours
  - however, for a request for a medical item or service, we can take up to 14 more calendar days if we find that some information that may benefit you is missing (such as medical records from Non–Plan Providers), or if you need time to get information to us for the review. If we decide to take extra days, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug
  - if you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. (For more information about the process for making complaints, including fast complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section.) We will call you as soon as we make the decision
- To get a fast coverage decision, you must meet two requirements:
  - you can get a fast coverage decision only if you are asking for coverage for medical care you have not yet received. (You cannot ask for a fast coverage decision if your request is about payment for medical care you have already received)
  - you can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function
- If your doctor tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision
- If you ask for a fast coverage decision on your own, without your doctor's support, we will decide whether your health requires that we give you a fast coverage decision
  - if we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead)
  - this letter will tell you that if your doctor asks for the fast coverage decision, we will automatically give a fast coverage decision
  - the letter will also tell how you can file a "fast complaint" about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. (For more information about the process for making complaints, including fast complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section)

Step 2: We consider your request for medical care coverage and give you our answer

Deadlines for a "fast coverage decision"

- Generally, for a fast coverage decision on a request for a medical item or service, we will give you our answer within 72 hours. If your request is for a Medicare Part B prescription drug, we will answer within 24 hours
  - as explained above, we can take up to 14 more calendar days under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug
  - if you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section)
  - if we do not give you our answer within 72 hours (or if there is an extended time period, by the end of that period), or within 24 hours if your request is for a Medicare Part B prescription drug, you have the right to appeal. "Step-by-step: How to make a Level 1 Appeal" below tells you how to make an appeal
- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the medical

care coverage we have agreed to provide within 72 hours after we received your request. If we extended the time needed to make our coverage decision on your request for a medical item or service, we will authorize or provide the coverage by the end of that extended period

- If our answer is ***no*** to part or all of what you requested, we will send you a detailed written explanation as to why we said ***no***

Deadlines for a "standard coverage decision"

- Generally, for a standard coverage decision on your request for a medical item or service, we will give you our answer within 14 calendar days of receiving your request. If your request is for a Medicare Part B prescription drug, we will give you an answer within 72 hours of receiving your request
  - for a request for a medical item or service, we can take up to 14 more calendar days ("an extended time period") under certain circumstances. If we decide to take extra days to make the coverage decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug
  - if you believe we should not take extra days, you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section)
  - if we do not give you our answer within 14 calendar days (or if there is an extended time period, by the end of that period), or within 72 hours if your request is for a Medicare Part B prescription drug, you have the right to appeal. "Step-by-step: How to make a Level 1 Appeal" below tells you how to make an appeal
- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the medical care coverage we have agreed to provide within 14 calendar days, or 72 hours if your request is for a Part B prescription drug, after we received your request. If we extended the time needed to make our coverage decision on your request for a medical item or service, we will authorize or provide the coverage by the end of that extended period
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said ***no***

Step 3: If we say ***no*** to your request for coverage for medical care, you decide if you want to make an appeal

- If we say ***no***, you have the right to ask us to reconsider, and perhaps change this decision by making an appeal. Making an appeal means making another try to get the medical care coverage you want
- If you decide to make an appeal, it means you are going on to Level 1 of the appeals process (see "Step-by-step: How to make a Level 1 Appeal" below)

Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a medical care coverage decision made by our plan)

Step 1: You contact us and make your appeal. If your health requires a quick response, you must ask for a "fast appeal"

An appeal to our plan about a medical care coverage decision is called a plan "reconsideration."

What to do:

- To start an appeal, you, your doctor, or your representative must contact us. For details about how to reach us for any purpose related to your appeal, go to "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care" in the "Important Phone Numbers and Resources" section
- If you are asking for a standard appeal, make your standard appeal in writing by submitting a request
  - if you have someone appealing our decision for you other than your doctor, your appeal must include an "Appointment of Representative" form authorizing this person to represent you. To get the form, call our Member Service Contact Center and ask for the "Appointment of Representative" form. It is also available on Medicare's website at https://www.cms.gov/Medicare/CMS-Forms/CMS-Forms/downloads/cms1696.pdf or on our website at kp.org. While we can accept an appeal request without the form, we cannot begin or complete our review until we receive it. If we do not receive the form within 44 calendar days after receiving your appeal request (our deadline for making a decision on your appeal), your appeal request will be dismissed. If this happens, we will send you a written notice explaining your right to ask the Independent Review Organization to review our decision to dismiss your appeal

- If you are asking for a fast appeal, make your appeal in writing or call us (see "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care" in the "Important Phone Numbers and Resources" section)
- You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for requesting an appeal
- You can ask for a copy of the information regarding your medical decision and add more information to support your appeal
  - you have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you
  - if you wish, you and your doctor may give us additional information to support your appeal

If your health requires it, ask for a "fast appeal" (you can make a request by calling us)

- A "fast appeal" is also called an "expedited reconsideration."
- If you are appealing a decision we made about coverage for care that you have not yet received, you and/or your doctor will need to decide if you need a "fast appeal"
- The requirements and procedures for getting a "fast appeal" are the same as those for getting a "fast coverage decision." To ask for a fast appeal, follow the instructions for asking for a fast coverage decision. (These instructions are given earlier in this section)
- If your doctor tells us that your health requires a "fast appeal," we will give you a fast appeal

Step 2: We consider your appeal and we give you our answer

- When we are reviewing your appeal, we take another careful look at all of the information about your request for coverage of medical care. We check to see if we were following all the rules when we said ***no*** to your request
- We will gather more information if we need it. We may contact you or your doctor to get more information

Deadlines for a "fast appeal"

- When we are using the fast deadlines, we must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires us to do so
  - however, if you ask for more time, or if we need to gather more information that may benefit you, we can take up to 14 more calendar days on your request for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to make a decision if your request is for a Medicare Part B prescription drug
  - if we do not give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we are required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we tell you about this organization and explain what happens at Level 2 of the appeals process
- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 72 hours after we receive your appeal
- If our answer is ***no*** to part or all of what you requested, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer on a request for a medical item or service within 30 calendar days after we receive your appeal if your appeal is about coverage for services you have not yet received. If your request is for a Medicare Part B prescription drug you have not yet received, we will give you our answer within 7 calendar days after we receive your appeal. We will give you our decision sooner if your health condition requires us to
  - however, if you ask for more time, or if we need to gather more information that may benefit you, we can take up to 14 more calendar days if your request is for a medical item or service. If we decide to take extra days to make the decision, we will tell you in writing. We can't take extra time to

make a decision if your request is for a Medicare Part B prescription drug

- if you believe we should not take extra days , you can file a "fast complaint" about our decision to take extra days. When you file a fast complaint, we will give you an answer to your complaint within 24 hours. (For more information about the process for making complaints, including fast complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section)
- if we do not give you an answer by the applicable deadline above (or by the end of the extended time period if we took extra days on your request for a medical item or service), we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process

- If our answer is ***yes*** to part or all of what you requested, we must authorize or provide the coverage we have agreed to provide within 30 calendar days if your request is for a medical item or service, or within 7 calendar days if your request is for a Medicare Part B prescription drug
- If our answer is ***no*** to part or all of what you requested, we will automatically send your appeal to the Independent Review Organization for a Level 2 Appeal

Step 3: If our plan says ***no*** to part or all of your appeal, your case will automatically be sent on to the next level of the appeals process

- To make sure we were following all the rules when we said ***no*** to your appeal, we are required to send your appeal to the Independent Review Organization. When we do this, it means that your appeal is going on to the next level of the appeals process, which is Level 2

Step-by-step: How a Level 2 Appeal is done

If we say ***no*** to your Level 1 Appeal, your case will automatically be sent on to the next level of the appeals process. During the Level 2 Appeal, the Independent Review Organization reviews our decision for your first appeal. This organization decides whether the decision we made should be changed. The formal name for the Independent Review Organization is the "Independent Review Entity." It is sometimes called the "IRE."

Step 1: The Independent Review Organization reviews your appeal

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work
- We will send the information about your appeal to this organization. This information is called your "case file." You have the right to ask us for a copy of your case file. We are allowed to charge you a fee for copying and sending this information to you
- You have a right to give the Independent Review Organization additional information to support your appeal
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal

If you had a "fast appeal" at Level 1, you will also have a "fast appeal" at Level 2

- If you had a fast appeal to our plan at Level 1, you will automatically receive a fast appeal at Level 2. The review organization must give you an answer to your Level 2 Appeal within 72 hours of when it receives your appeal
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days. The Independent Review Organization can't take extra time to make a decision if your request is for a Medicare Part B prescription drug

If you had a "standard appeal" at Level 1, you will also have a "standard appeal" at Level 2

- If you had a standard appeal to our plan at Level 1, you will automatically receive a standard appeal at Level 2. If your request is for a medical item or service, the review organization must give you an answer to your Level 2 Appeal within 30 calendar days of when it receives your appeal. If your request is for a Medicare Part B prescription drug, the review organization must give you an answer to your Level 2 Appeal within 7 calendar days of when it receives your appeal
- However, if your request is for a medical item or service and the Independent Review Organization needs to gather more information that may benefit you, it can take up to 14 more calendar days. The Independent Review Organization can't take extra

time to make a decision if your request is for a Medicare Part B prescription drug

Step 2: The Independent Review Organization gives you their answer

The Independent Review Organization will tell you its decision in writing and explain the reasons for it.

- If the review organization says ***yes*** to part or all of a request for a medical item or service, we must authorize the medical care coverage within 72 hours or provide the service within 14 calendar days after we receive the decision from the review organization for standard requests or within 72 hours from the date we receive the decision from the review organization for expedited requests
- If the review organization says ***yes*** to part or all of a request for a Medicare Part B prescription drug, we must authorize or provide the Medicare Part B prescription drug under dispute within 72 hours after we receive the decision from the review organization for standard requests or within 24 hours from the date we receive the decision from the review organization for expedited requests.
- If this organization says ***no*** to part or all of your appeal, it means they agree with us that your request (or part of your request) for coverage for medical care should not be approved. (This is called "upholding the decision." It is also called "turning down your appeal")
  - if the Independent Review Organization "upholds the decision," you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the medical care coverage you are requesting must meet a certain minimum. If the dollar value of the coverage you are requesting is too low, you cannot make another appeal, which means that the decision at Level 2 is final. The written notice you get from the Independent Review Organization will tell you how to find out the dollar amount to continue the appeals process

Step 3: If your case meets the requirements, you choose whether you want to take your appeal further

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal)
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. The details about how to do this are in the written notice you get after your Level 2 Appeal
- The Level 3 Appeal is handled by an administrative law judge or attorney adjudicator. "Taking Your Appeal to Level 3 and Beyond" in this "Coverage Decisions, Appeals, and Complaints" section tells you more about Levels 3, 4, and 5 of the appeals process

What if you are asking us to pay you for our share of a bill you have received for medical care?

If you want to ask us for payment for medical care, start by reading the "Requests for Payment" section, which describes the situations in which you may need to ask for reimbursement or to pay a bill you have received from a provider. It also tells you how to send us the paperwork that asks us for payment.

Asking for reimbursement is asking for a coverage decision from us

If you send us the paperwork that asks for reimbursement, you are asking us to make a coverage decision (for more information about coverage decisions, see "Asking for coverage decisions and making appeals—*The big picture*" in this "Coverage Decisions, Appeals, and Complaints" section). To make this coverage decision, we will check to see if the medical care you paid for is a covered service (see the "Benefits and Your Cost Share" section). We will also check to see if you followed all the rules for using your coverage for medical care (these rules are given in the "How to Obtain Services" section).

We will say *yes* or *no* to your request

- If the medical care you paid for is covered and you followed all the rules, we will send you the payment for our share of the cost of your medical care within 60 calendar days after we receive your request. Or if you haven't paid for the services, we will send the payment directly to the provider. (When we send the payment, it's the same as saying ***yes*** to your request for a coverage decision)
- If the medical care is not covered, or you did not follow all the rules, we will not send payment. Instead, we will send you a letter that says we will not pay for the medical care and the reasons why in detail. (When we turn down your request for payment, it's the same as saying ***no*** to your request for a coverage decision)

What if you ask for payment and we say that we will not pay?

If you do not agree with our decision to turn you down, you can make an appeal. If you make an appeal, it means

you are asking us to change the coverage decision we made when we turned down your request for payment.

To make this appeal, follow the process for appeals that we describe under "Step-by-step: How to make a Level 1 Appeal." Go to this section for step-by-step instructions. When you are following these instructions, please note:

- If you make an appeal for reimbursement, we must give you our answer within 60 calendar days after we receive your appeal. (If you are asking us to pay you back for medical care you have already received and paid for yourself, you are not allowed to ask for a fast appeal)
- If the Independent Review Organization reverses our decision to deny payment, we must send the payment you have requested to you or to the provider within 30 calendar days. If the answer to your appeal is ***yes*** at any stage of the appeals process after Level 2, we must send the payment you requested to you or to the provider within 60 calendar days

Your Part D Prescription Drugs: How to Ask for a Coverage Decision or Make an Appeal

What to do if you have problems getting a Part D drug or you want us to pay you back for a Part D drug

Your benefits as a Member of our plan include coverage for many prescription drugs. Refer to our *2022 Comprehensive Formulary*. To be covered, the Part D drug must be used for a medically accepted indication. (A "medically accepted indication" is a use of the drug that is either approved by the federal Food and Drug Administration or supported by certain reference books.)

- **This section is about your Part D drugs only.** To keep things simple, we generally say "drug" in the rest of this section, instead of repeating "covered outpatient prescription drug" or "Part D drug" every time
- For details about what we mean by Part D drugs, the *2022 Comprehensive Formulary*, rules and restrictions on coverage, and cost information, see "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section

Part D coverage decisions and appeals

As discussed under "A Guide to the Basics of Coverage Decisions and Appeals" in this "Coverage Decisions, Appeals, and Complaints" section, a coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your drugs. An initial coverage decision about your Part D drugs is called a "coverage determination."

Here are examples of coverage decisions you ask us to make about your Part D drugs:

- You ask us to make an exception, including:
  - asking us to cover a Part D drug that is not on our *2022 Comprehensive Formulary*
  - asking us to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get)
  - asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier
- You ask us whether a drug is covered for you and whether you satisfy any applicable coverage rules. For example, when your drug is on our *2022 Comprehensive Formulary*, but we require you to get approval from us before we will cover it for you
  - note: if your pharmacy tells you that your prescription cannot be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision
- You ask us to pay for a prescription drug you already bought. This is a request for a coverage decision about payment

If you disagree with a coverage decision we have made, you can appeal our decision.

Which of these situations are you in?

This section tells you both how to ask for coverage decisions and how to request an appeal. Use this guide to help you determine which part has information for your situation:

- If you need a drug that isn't on our *Drug List* or need us to waive a rule or restriction on a drug we cover. You can ask us to make an exception. (This is a type of coverage decision.) **Start with "What is a Part D exception?"**
- If you want us to cover a drug on our *Drug List* and you believe you meet any plan rules or restrictions (such as getting approval in advance) for the drug you need. You can us for a coverage decision. **Skip ahead to "Step-by-step: How to ask for a coverage decision, including a Part D exception"**
- If you want to ask us to pay you back for a drug you have already received and paid for. You can ask us to pay you back. (This is a type of coverage decision.) **Skip ahead to "Step-by-step: How to ask for a coverage decision, including a Part D exception"**
- If we already told you that we will not cover or pay for a drug in the way that you want it to be covered or

paid for. You can make an appeal. (This means you are asking us to reconsider.) **Skip ahead to "Step-by-step: How to make a Level 1 Appeal"**

What is a Part D exception?

If a Part D drug is not covered in the way you would like it to be covered, you can ask us to make an "exception." An exception is a type of coverage decision. Similar to other types of coverage decisions, if we turn down your request for an exception, you can appeal our decision.

When you ask for an exception, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. We will then consider your request. Here are two examples of exceptions that you or your doctor or other prescriber can ask us to make:

- **Covering a Part D drug for you that is not on our *2022 Comprehensive Formulary.*** (We call it the "*Drug List"* for short.) Asking for coverage of a drug that is not on the *Drug List* is sometimes called asking for a "formulary exception"
  - if we agree to make an exception and cover a drug that is not on the *Drug List*, you will need to pay the Cost Share amount that applies to drugs in the brand-name drug tier. You cannot ask for an exception to the Copayment or Coinsurance amount we require you to pay for the drug
  - you cannot ask for coverage of any "excluded drugs" or other non–Part D drugs that Medicare does not cover. (For more information about excluded drugs, see "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section)
- **Removing a restriction on our coverage for a covered Part D drug**. There are extra rules or restrictions that apply to certain drugs on our *2022 Comprehensive Formulary* (for more information, go to "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section). Asking for a removal of a restriction on coverage for a drug is sometimes called asking for a "formulary exception"
  - the extra rules and restrictions on coverage for certain drugs include 1) being required to use the generic version of a drug instead of the brand-name drug, and 2) getting **plan approval in advance** before we will agree to cover the drug for you. (This is sometimes called "prior authorization")
  - if we agree to make an exception and waive a restriction for you, you can ask for an exception to the Copayment or Coinsurance amount we require you to pay for the Part D drug

Important things to know about asking for a Part D exception

Your doctor must tell us the medical reasons

Your doctor or other prescriber must give us a statement that explains the medical reasons for requesting a Part D exception. For a faster decision, include this medical information from your doctor or other prescriber when you ask for the exception.

Typically, our Drug List includes more than one drug for treating a particular condition. These different possibilities are called "alternative" drugs. If an alternative drug would be just as effective as the drug you are requesting and would not cause more side effects or other health problems, we will generally not approve your request for an exception. If you ask us for a tiering exception, we will generally not approve your request for an exception unless all the alternative drugs in the lower cost-sharing tier(s) won't work as well for you or are likely to cause an adverse reaction or other harm.

We can say ***yes*** or ***no*** to your request

- If we approve your request for a Part D exception, our approval usually is valid until the end of the plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition
- If we say ***no*** to your request for a Part D exception, you can ask for a review of our decision by making an appeal. The "Step-by-step: How to make a Level 1 Appeal" section tells how to make an appeal if we say no

The next section tells you how to ask for a coverage decision, including a Part D exception.

Step-by-step: How to ask for a coverage decision, including a Part D exception

Step 1: You ask us to make a coverage decision about the drug(s) or payment you need.

If your health requires a quick response, you must ask us to make a "fast coverage decision." You **cannot** ask for a fast coverage decision if you are asking us to pay you back for a drug you already bought.

What to do:

- Request the type of coverage decision you want. Start by calling, writing, or faxing OptumRx Prior Authorization Member Services Desk to make your request. You, your representative, or your doctor (or other prescriber) can do this. You can also access the coverage decision process through our website. For the details, go to "How to contact us when you are

asking for a coverage decision about your Part D prescription drugs" in the "Important Phone Numbers and Resources" section. Or if you are asking us to pay you back for a drug, go to "Where to send a request asking us to pay for our share of the cost for medical care or a Part D drug you have received" in the "Important Phone Numbers and Resources" section

- You or your doctor or someone else who is acting on your behalf can ask for a coverage decision. The "A Guide to the Basics of Coverage Decisions and Appeals" section tells you how you can give written permission to someone else to act as your representative. You can also have a lawyer act on your behalf
- If you want to ask us to pay you back for a drug, start by reading the "Requests for Payment" section, which describes the situations in which you may need to ask for reimbursement. It also tells you how to send us the paperwork that asks us to pay you back for our share of the cost of a drug you have paid for
- If you are requesting a Part D exception, provide the "supporting statement." Your doctor or other prescriber must give us the medical reasons for the drug exception you are requesting. (We call this the "supporting statement.") Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary. See "What is a Part D exception?" and "Important things to know about asking for a Part D exception" for more information about exception requests
- We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website

If your health requires it, ask us to give you a "fast coverage decision"

A "fast coverage decision" is called an "expedited coverage determination."

- When we give you our decision, we will use the "standard" deadlines unless we have agreed to use the "fast" deadlines. A standard coverage decision means we will give you an answer within 72 hours after we receive your doctor's statement. A fast coverage decision means we will answer within 24 hours after we receive your doctor's statement
- To get a fast coverage decision, you must meet two requirements:
  - you can get a fast coverage decision only if you are asking for a drug you have not yet received. (You cannot ask for a fast coverage decision if you are asking us to pay you back for a drug you have already bought)
  - you can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to function
- If your doctor or other prescriber tells us that your health requires a "fast coverage decision," we will automatically agree to give you a fast coverage decision
- If you ask for a fast coverage decision on your own (without your doctor's or other prescriber's support), we will decide whether your health requires that we give you a fast coverage decision
  - if we decide that your medical condition does not meet the requirements for a fast coverage decision, we will send you a letter that says so (and we will use the standard deadlines instead)
  - this letter will tell you that if your doctor or other prescriber asks for the fast coverage decision, we will automatically give a fast coverage decision
  - the letter will also tell you how you can file a complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you requested. It tells you how to file a "fast complaint," which means you would get our answer to your complaint within 24 hours of receiving the complaint. (The process for making a complaint is different from the process for coverage decisions and appeals. For more information about the process for making complaints, see "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section

Step 2: We consider your request and we give you our answer

Deadlines for a "fast coverage decision"

- If we are using the fast deadlines, we must give you our answer within 24 hours
  - generally, this means within 24 hours after we receive your request. If you are requesting a Part D exception, we will give you our answer within 24 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to
  - if we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2

- If our answer is ***yes*** to part or all of what you requested, we must provide the coverage we have agreed to provide within 24 hours after we receive your request or doctor's statement supporting your request
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal

Deadlines for a "standard coverage decision" about a Part D drug you have not yet received

- If we are using the standard deadlines, we must give you our answer within 72 hours
  - generally, this means within 72 hours after we receive your request. If you are requesting a Part D exception, we will give you our answer within 72 hours after we receive your doctor's statement supporting your request. We will give you our answer sooner if your health requires us to
  - if we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2
- If our answer is ***yes*** to part or all of what you requested:
  - if we approve your request for coverage, we must provide the coverage we have agreed to provide within 72 hours after we receive your request or doctor's statement supporting your request
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal

Deadlines for a "standard coverage decision" about payment for a drug you have already bought

- We must give you our answer within 14 calendar days after we receive your request
  - if we do not meet this deadline, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2
- If our answer is ***yes*** to part or all of what you requested, we are also required to make payment to you within 14 calendar days after we receive your request
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal

Step 3: If we say ***no*** to your coverage request, you decide if you want to make an appeal

- If we say ***no***, you have the right to request an appeal. Requesting an appeal means asking us to reconsider—and possibly change—the decision we made

Step-by-step: How to make a Level 1 Appeal (how to ask for a review of a coverage decision made by our plan)

An appeal to our plan about a Part D drug coverage decision is called a plan "redetermination."

Step 1: You contact us and make your Level 1 Appeal. If your health requires a quick response, you must ask for a "fast appeal."

What to do:

- To start your appeal, you (or your representative or your doctor or other prescriber) must contact us
  - for details about how to reach us by phone, fax, or mail, or on our website for any purpose related to your appeal, go to "How to contact us when you are making an appeal about your Part D prescription drugs" in the "Important Phone Numbers and Resources" section
- If you are asking for a standard appeal, make your appeal by submitting a written request
- If you are asking for a fast appeal, you may make your appeal in writing or you may call us at the phone number shown under "How to contact us when you are making an appeal about your Part D prescription drugs" in the "Important Phone Numbers and Resources" section
- We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website
- You must make your appeal request within 60 calendar days from the date on the written notice we sent to tell you our answer to your request for a coverage decision. If you miss this deadline and have a good reason for missing it, we may give you more time to make your appeal. Examples of good cause for missing the deadline may include if you had a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete

information about the deadline for requesting an appeal

- You can ask for a copy of the information in your appeal and add more information
  - you have the right to ask us for a copy of the information regarding your appeal. We are allowed to charge a fee for copying and sending this information to you
  - if you wish, you and your doctor or other prescriber may give us additional information to support your appeal

If your health requires it, ask for a "fast appeal"

A "fast appeal" is also called an "expedited redetermination."

- If you are appealing a decision we made about a drug you have not yet received, you and your doctor or other prescriber will need to decide if you need a "fast appeal"
- The requirements for getting a "fast appeal" are the same as those for getting a "fast coverage decision" in "Step-by-step: How to ask for a coverage decision, including a Part D exception"

Step 2: We consider your appeal and we give you our answer

- When we are reviewing your appeal, we take another careful look at all of the information about your coverage request. We check to see if we were following all the rules when we said ***no*** to your request. We may contact you or your doctor or other prescriber to get more information

Deadlines for a "fast appeal"

- If we are using the fast deadlines, we must give you our answer within 72 hours after we receive your appeal. We will give you our answer sooner if your health requires it
  - if we do not give you an answer within 72 hours, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process
- If our answer is ***yes*** to part or all of what you requested, we must provide the coverage we have agreed to provide within 72 hours after we receive your appeal
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said ***no*** and how you can appeal our decision

Deadlines for a "standard appeal"

- If we are using the standard deadlines, we must give you our answer within 7 calendar days after we receive your appeal for a drug you have not received yet. We will give you our decision sooner if you have not received the drug yet and your health condition requires us to do so. If you believe your health requires it, you should ask for a "fast appeal"
  - if we do not give you a decision within 7 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Level 2 of the appeals process
- If our answer is ***yes*** to part or all of what you requested:
  - if we approve a request for coverage, we must provide the coverage we have agreed to provide as quickly as your health requires, but no later than 7 calendar days after we receive your appeal
  - if we approve a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive your appeal request
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said ***no*** and how you can appeal our decision
- If you are requesting that we pay you back for a drug you have already bought, we must give you our answer within 14 calendar days after we receive your request
  - If we do not give you a decision within 14 calendar days, we are required to send your request on to Level 2 of the appeals process, where it will be reviewed by an Independent Review Organization. Later in this section, we talk about this review organization and explain what happens at Appeal Level 2.
- If our answer is yes to part or all of what you requested, we are also required to make payment to you within 30 calendar days after we receive your request
- If our answer is ***no*** to part or all of what you requested, we will send you a written statement that explains why we said no. We will also tell you how you can appeal our decision

Step 3: If we say ***no*** to your appeal, you decide if you want to continue with the appeals process and make another appeal

- If we say ***no*** to your appeal, you then choose whether to accept this decision or continue by making another appeal
- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process (see below)

Step-by-step: How to make a Level 2 Appeal

If we say ***no*** to your appeal, you then choose whether to accept this decision or continue by making another appeal. If you decide to go on to a Level 2 Appeal, the Independent Review Organization reviews the decision we made when we said ***no*** to your first appeal. This organization decides whether the decision we made should be changed.

The formal name for the Independent Review Organization is the "Independent Review Entity." It is sometimes called the "IRE."

Step 1: To make a Level 2 Appeal, you (or your representative or your doctor or other prescriber) must contact the Independent Review Organization and ask for a review of your case

- If we say ***no*** to your Level 1 Appeal, the written notice we send you will include instructions about how to make a Level 2 Appeal with the Independent Review Organization. These instructions will tell you who can make this Level 2 Appeal, what deadlines you must follow, and how to reach the review organization
- When you make an appeal to the Independent Review Organization, we will send the information we have about your appeal to this organization. This information is called your "case file." You have the right to ask us for a copy of your case file. We are allowed to charge you a fee for copying and sending this information to you
- You have a right to give the Independent Review Organization additional information to support your appeal

Step 2: The Independent Review Organization does a review of your appeal and gives you an answer

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with us and it is not a government agency. This organization is a company chosen by Medicare to review our decisions about your Part D benefits with us
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal. The organization will tell you its decision in writing and explain the reasons for it

Deadlines for "fast appeal" at Level 2

- If your health requires it, ask the Independent Review Organization for a fast appeal
- If the review organization agrees to give you a fast appeal, the review organization must give you an answer to your Level 2 Appeal within 72 hours after it receives your appeal request
- If the Independent Review Organization says ***yes*** to part or all of what you requested, we must provide the drug coverage that was approved by the review organization within 24 hours after we receive the decision from the review organization

Deadlines for "standard appeal" at Level 2

- If you have a standard appeal at Level 2, the review organization must give you an answer to your Level 2 Appeal within 7 calendar days after it receives your appeal if it is for a drug you have not received yet. If you are requesting that we pay you back for a drug you have already bought, the review organization must give you an answer to your Level 2 appeal within 14 calendar days after it receives your request
- If the Independent Review Organization says ***yes*** to part or all of what you requested:
  - if the Independent Review Organization approves a request for coverage, we must provide the drug coverage that was approved by the review organization within 72 hours after we receive the decision from the review organization
  - if the Independent Review Organization approves a request to pay you back for a drug you already bought, we are required to send payment to you within 30 calendar days after we receive the decision from the review organization

What if the review organization says no to your appeal?

If this organization says ***no*** to your appeal, it means the organization agrees with our decision not to approve your request. (This is called "upholding the decision." It is also called "turning down your appeal.")

If the Independent Review Organization "upholds the decision," you have the right to a Level 3 Appeal. However, to make another appeal at Level 3, the dollar value of the drug coverage you are requesting must meet a minimum amount. If the dollar value of the drug coverage you are requesting is too low, you cannot make

another appeal and the decision at Level 2 is final. The notice you get from the Independent Review Organization will tell you the dollar value that must be in dispute to continue with the appeals process.

Step 3: If the dollar value of the coverage you are requesting meets the requirement, you choose whether you want to take your appeal further

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal)
- If your Level 2 Appeal is turned down and you meet the requirements to continue with the appeals process, you must decide whether you want to go on to Level 3 and make a third appeal. If you decide to make a third appeal, the details about how to do this are in the written notice you got after your second appeal
- The Level 3 Appeal is handled by an administrative law judge or attorney adjudicator. "Taking your Appeal to Level 3 and Beyond" tells you more about Levels 3, 4, and 5 of the appeals process

How to Ask Us to Cover a Longer Inpatient Hospital Stay if You Think the Doctor Is Discharging You Too Soon

When you are admitted to a hospital, you have the right to get all of your covered hospital Services that are necessary to diagnose and treat your illness or injury. For more information about our coverage for your hospital care, including any limitations on this coverage, see the "Benefits and Your Cost Share" section.

During your covered hospital stay, your doctor and the hospital staff will be working with you to prepare for the day when you will leave the hospital. They will also help arrange for care you may need after you leave.

- The day you leave the hospital is called your "discharge date"
- When your discharge date has been decided, your doctor or the hospital staff will let you know
- If you think you are being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered. This section tells you how to ask

During your inpatient hospital stay, you will get a written notice from Medicare that tells about your rights

During your covered hospital stay, you will be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice whenever they are admitted to a hospital. Someone at the hospital (for example, a caseworker or nurse) must give it to you within two days after you are admitted. If you do not get the notice, ask any hospital employee for it. If you need help, please call our Member Service Contact Center. You can also call **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week.

- **Read this notice carefully and ask questions if you don't understand it. It tells you about your rights as a hospital patient, including:**
  - your right to receive Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them
  - your right to be involved in any decisions about your hospital stay, and your right to know who will pay for it
  - where to report any concerns you have about quality of your hospital care
  - your right to appeal your discharge decision if you think you are being discharged from the hospital too soon
  - the written notice from Medicare tells you how you can "request an immediate review." Requesting an immediate review is a formal, legal way to ask for a delay in your discharge date so that we will cover your hospital care for a longer time. "Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date" tells you how you can request an immediate review
- **You will be asked to sign the written notice to show that you received it and understand your rights**
  - you or someone who is acting on your behalf will be asked to sign the notice. ("A Guide to the Basics of Coverage Decisions and Appeals" in this "Coverage Decisions, Appeals, and Complaints" section tells you how you can give written permission to someone else to act as your representative)
  - signing the notice shows only that you have received the information about your rights. The notice does not give your discharge date (your doctor or hospital staff will tell you your discharge date). Signing the notice does not mean you are agreeing on a discharge date

- **Keep your copy of the notice so you will have the information about making an appeal (or reporting a concern about quality of care) handy if you need it**
  - if you sign the notice more than two days before the day you leave the hospital, you will get another copy before you are scheduled to be discharged
  - to look at a copy of this notice in advance, you can call our Member Service Contact Center or **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week. You can also see the notice online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices .html

Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date

If you want to ask for your inpatient hospital services to be covered by us for a longer time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do
- **Ask for help if you need it.** If you have questions or need help at any time, please call our Member Service Contact Center (phone numbers are on the cover of this *EOC*). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see the "Important Phone Numbers and Resources" section)

During a Level 1 Appeal, the Quality Improvement Organization reviews your appeal. It checks to see if your planned discharge date is medically appropriate for you.

Step 1: Contact the Quality Improvement Organization for your state and ask for a "fast review" of your hospital discharge. You must act quickly

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care professionals who are paid by the federal government. These experts are not part of our plan. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare

How can you contact this organization?

- The written notice you received (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in the "Important Phone Numbers and Resources" section)

Act quickly

- To make your appeal, you must contact the Quality Improvement Organization before you leave the hospital and no later than midnight the day of your discharge date. (Your "planned discharge date" is the date that has been set for you to leave the hospital)
  - if you meet this deadline, you are allowed to stay in the hospital after your discharge date without paying for it while you wait to get the decision on your appeal from the Quality Improvement Organization
  - if you do not meet this deadline, and you decide to stay in the hospital after your planned discharge date, you may have to pay all of the costs for hospital care you receive after your planned discharge date
- If you miss the deadline for contacting the Quality Improvement Organization and you still wish to appeal, you must make an appeal directly to our plan instead. For details about this other way to make your appeal, see "What if you miss the deadline for making your Level 1 Appeal?"

Ask for a "fast review" (a "fast review" is also called an "immediate review" or an "expedited review")

- You must ask the Quality Improvement Organization for a "fast review" of your discharge. Asking for a "fast review" means you are asking for the organization to use the "fast" deadlines for an appeal instead of using the standard deadlines

Step 2: The Quality Improvement Organization conducts an independent review of your case

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish

- The reviewers will also look at your medical information, talk with your doctor, and review information that the hospital and we have given to them
- By noon of the day after the reviewers informed our plan of your appeal, you will also get a written notice that gives you your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date. This written explanation is called the *Detailed Notice of Discharge*. You can get a sample of this notice by calling our Member Service Contact Center or **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**), 24 hours a day, seven days a week. Or you can see a sample notice online at https://www.cms.gov/Medicare/Medicare-General-Information/BNI/HospitalDischargeAppealNotices.html

Step 3: Within one full day after it has all the needed information, the Quality Improvement Organization will give you its answer to your appeal

What happens if the answer is yes?

- If the review organization says ***yes*** to your appeal, we must keep providing your covered inpatient hospital services for as long as these services are medically necessary
- You will have to keep paying your share of the costs (such as Cost Share, if applicable). In addition, there may be limitations on your covered hospital services. (See the "Benefits and Your Cost Share" section)

What happens if the answer is no?

- If the review organization says ***no*** to your appeal, they are saying that your planned discharge date is medically appropriate. If this happens, our coverage for your inpatient hospital services will end at noon on the day after the Quality Improvement Organization gives you its answer to your appeal
- If the review organization says ***no*** to your appeal and you decide to stay in the hospital, then you may have to pay the full cost of hospital care you receive after noon on the day after the Quality Improvement Organization gives you its answer to your appeal

Step 4: If the answer to your Level 1 Appeal is ***no***, you decide if you want to make another appeal

- If the Quality Improvement Organization has turned down your appeal, and you stay in the hospital after your planned discharge date, then you can make another appeal. Making another appeal means you are going on to "Level 2" of the appeals process

Step-by-step: How to make a Level 2 Appeal to change your hospital discharge date

If the Quality Improvement Organization has turned down your appeal and you stay in the hospital after your planned discharge date, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your stay after your planned discharge date.

Here are the steps for Level 2 of the appeals process:

Step 1: You contact the Quality Improvement Organization again and ask for another review

- You must ask for this review within 60 calendar days after the day the Quality Improvement Organization said ***no*** to your Level 1 Appeal. You can ask for this review only if you stay in the hospital after the date that your coverage for the care ended

Step 2: The Quality Improvement Organization does a second review of your situation

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal

Step 3: Within 14 calendar days of receipt of your request for a second review, the Quality Improvement Organization reviewers will decide on your appeal and tell you their decision

If the review organization says yes

- We must reimburse you for our share of the costs of hospital care you have received since noon on the day after the date your first appeal was turned down by the Quality Improvement Organization. We must continue providing coverage for your inpatient hospital care for as long as it is medically necessary
- You must continue to pay your share of the costs, and coverage limitations may apply

If the review organization says no

- It means they agree with the decision they made on your Level 1 Appeal and will not change it. This is called "upholding the decision"
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an administrative law judge or attorney adjudicator

Step 4: If the answer is ***no***, you will need to decide whether you want to take your appeal further by going on to Level 3

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If the review organization turns down your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an administrative law judge or attorney adjudicator
- The "Taking Your Appeal to Level 3 and Beyond" section tells you more about Levels 3, 4, and 5 of the appeals process

What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained under "Step-by-step: How to make a Level 1 Appeal to change your hospital discharge date" in this "Coverage Decisions, Appeals, and Complaints" section, you must act quickly to contact the Quality Improvement Organization to start your first appeal of your hospital discharge. ("Quickly" means before you leave the hospital and no later than your planned discharge date whichever comes first.) If you miss the deadline for contacting this organization, there is another way to make your appeal.

If you use this other way of making your appeal, the first two levels of appeal are different.

Step-by-step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines. A "fast review" (or "fast appeal") is also called an "expedited appeal."

Step 1: Contact us and ask for a "fast review"

- For details about how to contact us, go to "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care" in the "Important Phone Numbers and Resources" section
- Be sure to ask for a "fast review." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines

Step 2: We do a "fast review" of your planned discharge date, checking to see if it was medically appropriate

- During this review, we take a look at all of the information about your hospital stay. We check to see if your planned discharge date was medically appropriate. We will check to see if the decision about when you should leave the hospital was fair and followed all the rules
- In this situation, we will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal")

- If we say ***yes*** to your fast appeal, it means we have agreed with you that you still need to be in the hospital after the discharge date, and will keep providing your covered inpatient hospital services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs, and there may be coverage limitations that apply)
- If we say ***no*** to your fast appeal, we are saying that your planned discharge date was medically appropriate. Our coverage for your inpatient hospital services ends as of the day we said coverage would end
- If you stayed in the hospital after your planned discharge date, then you may have to pay the full cost of hospital care you received after the planned discharge date

Step 4: If we say ***no*** to your fast appeal, your case will automatically be sent on to the next level of the appeals process

- To make sure we were following all the rules when we said ***no*** to your fast appeal, we are required to send your appeal to the Independent Review Organization. When we do this, it means that you are automatically going on to Level 2 of the appeals process

Step-by-step: Level 2 *Alternate* Appeal Process

During the Level 2 Appeal, an Independent Review Organization reviews the decision we made when we said ***no*** to your "fast appeal." This organization decides whether the decision we made should be changed. The formal name for the Independent Review Organization is the "Independent Review Entity." It is sometimes called the "IRE."

Step 1: We will automatically forward your case to the Independent Review Organization

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying ***no*** to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeals process. "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section tells you how to make a complaint)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal of your hospital discharge
- If this organization says ***yes*** to your appeal, then we must reimburse you (pay you back) for our share of the costs of hospital care you have received since the date of your planned discharge. We must also continue our plan's coverage of your inpatient hospital services for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services
- If this organization says ***no*** to your appeal, it means they agree with us that your planned hospital discharge date was medically appropriate
    - the notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal, which is handled by an administrative law judge or attorney adjudicator

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further

- There are three additional levels in the appeals process after Level 2 (for a total of five levels of appeal). If reviewers say ***no*** to your Level 2 Appeal, you decide whether to accept their decision or go on to Level 3 and make a third appeal
- "Taking Your Appeal to Level 3 and Beyond" in this "Coverage Decisions, Appeals, and Complaints" section tells you more about Levels 3, 4, and 5 of the appeals process

How to Ask Us to Keep Covering Certain Medical Services if You Think Your Coverage Is Ending Too Soon

Home health care, Skilled Nursing Facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services

This section is only about the following types of care:

- **Home health care services** you are getting
- **Skilled nursing care** you are getting as a patient in a Skilled Nursing Facility. (To learn about requirements for being considered a "Skilled Nursing Facility," see the "Definitions" section)
- **Rehabilitation care** you are getting as an outpatient at a Medicare-approved Comprehensive Outpatient Rehabilitation Facility (CORF). Usually this means you are getting treatment for an illness or accident, or you are recovering from a major operation. (For more information about this type of facility, see the "Definitions" section)

When you are getting any of these types of care, you have the right to keep getting your covered services for that type of care for as long as the care is needed to diagnose and treat your illness or injury. For more information about your covered services, including your share of the cost and any limitations to coverage that may apply, see the "Benefits and Your Cost Share" section.

When we decide it is time to stop covering any of the three types of care for you, we are required to tell you in advance. When your coverage for that care ends, we will stop paying our share of the cost for your care.

If you think we are ending the coverage of your care too soon, you can appeal our decision. This section tells you how to ask for an appeal.

We will tell you in advance when your coverage will be ending

- **You receive a notice in writing.** At least two days before our plan is going to stop covering your care, you will receive a notice

- the written notice tells you the date when we will stop covering the care for you
- the written notice also tells you what you can do if you want to ask us to change this decision about when to end your care, and keep covering it for a longer period of time
- in telling you what you can do, the written notice is telling how you can request a "fast-track appeal." Requesting a fast-track appeal is a formal, legal way to request a change to our coverage decision about when to stop your care. "Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time" tells you how you can request a fast-track appeal
- the written notice is called the *Notice of Medicare Non-Coverage*

- **You will be asked to sign the written notice to show that you received it**
  - you or someone who is acting on your behalf will be asked to sign the notice. ("A Guide to the Basics of Coverage Decisions and Appeals" in this "Coverage Decisions, Appeals, and Complaints" section tells you how you can give written permission to someone else to act as your representative.)
  - signing the notice shows only that you have received the information about when your coverage will stop. Signing it does not mean you agree with us that it's time to stop getting the care

Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time

If you want to ask us to cover your care for a longer period of time, you will need to use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process.** Each step in the first two levels of the appeals process is explained below
- **Meet the deadlines.** The deadlines are important. Be sure that you understand and follow the deadlines that apply to things you must do. There are also deadlines our plan must follow. (If you think we are not meeting our deadlines, you can file a complaint. "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section tells you how to file a complaint)
- **Ask for help if you need it**. If you have questions or need help at any time, please call our Member Service Contact Center (phone numbers are on the front cover of this booklet). Or call your State Health Insurance Assistance Program, a government organization that provides personalized assistance (see the "Important Phone Numbers and Resources" section)

If you ask for a Level 1 Appeal on time, the Quality Improvement Organization reviews your appeal and decides whether to change the decision made by our plan.

Step 1: Make your Level 1 Appeal: Contact the Quality Improvement Organization for your state and ask for a review. You must act quickly

What is the Quality Improvement Organization?

- This organization is a group of doctors and other health care experts who are paid by the federal government. These experts are not part of our plan. They check on the quality of care received by people with Medicare and review plan decisions about when it's time to stop covering certain kinds of medical care

How can you contact this organization?

- The written notice you received tells you how to reach this organization. (Or find the name, address, and phone number of the Quality Improvement Organization for your state in the "Important Phone Numbers and Resources" section)

What should you ask for?

- Ask this organization for a "fast-track appeal" (to do an independent review) of whether it is medically appropriate for us to end coverage for your medical services

Your deadline for contacting this organization

- You must contact the Quality Improvement Organization to start your appeal by noon of the day before the effective date of the *Notice of Medicare Non-Coverage*
- If you miss the deadline for contacting the Quality Improvement Organization, and you still wish to file an appeal, you must make an appeal directly to us instead. For details about this other way to make your appeal, see "Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time"

Step 2: The Quality Improvement Organization conducts an independent review of your case

What happens during this review?

- Health professionals at the Quality Improvement Organization (we will call them "the reviewers" for short) will ask you (or your representative) why you

believe coverage for the services should continue. You don't have to prepare anything in writing, but you may do so if you wish

- The review organization will also look at your medical information, talk with your doctor, and review information that our plan has given to them
- By the end of the day the reviewers inform us of your appeal, you will also get a written notice from us that explains in detail our reasons for ending our coverage for your services. This notice of explanation is called the *Detailed Explanation of Non-Coverage*

Step 3: Within one full day after they have all the information they need, the reviewers will tell you their decision

What happens if the reviewers say yes to your appeal?

- If the reviewers say ***yes*** to your appeal, then we must keep providing your covered services for as long as it is medically necessary
- You will have to keep paying your share of the costs (such as Cost Share, if applicable). In addition, there may be limitations on your covered services (see the "Benefits and Your Cost Share" section)

What happens if the reviewers say no to your appeal?

- If the reviewers say ***no*** to your appeal, then your coverage will end on the date we have told you. We will stop paying our share of the costs of this care on the date listed on the notice
- If you decide to keep getting the home health care, or Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after this date when your coverage ends, then you will have to pay the full cost of this care yourself

Step 4: If the answer to your Level 1 Appeal is no, you decide if you want to make another appeal

- This first appeal you make is "Level 1" of the appeals process. If reviewers say ***no*** to your Level 1 Appeal, and you choose to continue getting care after your coverage for the care has ended, then you can make another appeal
- Making another appeal means you are going on to "Level 2" of the appeals process

Step-by-step: How to make a Level 2 Appeal to have our plan cover your care for a longer time

If the Quality Improvement Organization has turned down your appeal and you choose to continue getting care after your coverage for the care has ended, then you can make a Level 2 Appeal. During a Level 2 Appeal, you ask the Quality Improvement Organization to take another look at the decision they made on your first appeal. If the Quality Improvement Organization turns down your Level 2 Appeal, you may have to pay the full cost for your home health care, or Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services *after* the date when we said your coverage would end.

Here are the steps for Level 2 of the appeals process:

Step 1: You contact the Quality Improvement Organization again and ask for another review

- You must ask for this review within 60 days after the day when the Quality Improvement Organization said ***no*** to your Level 1 Appeal. You can ask for this review only if you continued getting care after the date that your coverage for the care ended

Step 2: The Quality Improvement Organization does a second review of your situation

- Reviewers at the Quality Improvement Organization will take another careful look at all of the information related to your appeal

Step 3: Within 14 days of receipt of your appeal request, reviewers will decide on your appeal and tell you their decision

What happens if the review organization says yes to your appeal?

- We must reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. We must continue providing coverage for the care for as long as it is medically necessary
- You must continue to pay your share of the costs and there may be coverage limitations that apply

What happens if the review organization says no?

- It means they agree with the decision we made to your Level 1 Appeal and will not change it
- The notice you get will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to the next level of appeal, which is handled by an administrative law judge or attorney adjudicator

Step 4: If the answer is no, you will need to decide whether you want to take your appeal further

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers turn down your Level 2 Appeal, you can choose whether to accept that decision or to go on to Level 3 and

make another appeal. At Level 3, your appeal is reviewed by a judge

- "Taking Your Appeal to Level 3 and Beyond" in this "Coverage Decisions, Appeals, and Complaints" section tells you more about Levels 3, 4, and 5 of the appeals process

What if you miss the deadline for making your Level 1 Appeal?

You can appeal to us instead

As explained under "Step-by-step: How to make a Level 1 Appeal to have our plan cover your care for a longer time," you must act quickly to contact the Quality Improvement Organization to start your first appeal (within a day or two, at the most). If you miss the deadline for contacting this organization, there is another way to make your appeal. If you use this other way of making your appeal, the first two levels of appeal are different.

Step-by-step: How to make a Level 1 *Alternate* Appeal

If you miss the deadline for contacting the Quality Improvement Organization, you can make an appeal to us, asking for a "fast review." A fast review is an appeal that uses the fast deadlines instead of the standard deadlines. A "fast review" (or "fast appeal") is also called an "expedited appeal."

Here are the steps for a Level 1 Alternate Appeal:

Step 1: Contact us and ask for a "fast review"

- For details about how to contact us, go to "How to contact us when you are asking for a coverage decision or making an appeal or complaint about your medical care" in the "Important Phone Numbers and Resources" section
- Be sure to ask for a "fast review." This means you are asking us to give you an answer using the "fast" deadlines rather than the "standard" deadlines

Step 2: We do a "fast review" of the decision we made about when to end coverage for your services

- During this review, we take another look at all of the information about your case. We check to see if we were following all the rules when we set the date for ending our plan's coverage for services you were receiving
- We will use the "fast" deadlines rather than the standard deadlines for giving you the answer to this review

Step 3: We give you our decision within 72 hours after you ask for a "fast review" ("fast appeal")

- If we say ***yes*** to your fast appeal, it means we have agreed with you that you need services longer, and will keep providing your covered services for as long as it is medically necessary. It also means that we have agreed to reimburse you for our share of the costs of care you have received since the date when we said your coverage would end. (You must pay your share of the costs and there may be coverage limitations that apply)
- If we say ***no*** to your fast appeal, then your coverage will end on the date we told you and we will not pay any share of the costs after this date
- If you continued to get home health care, or Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after the date when we said your coverage would end, then you will have to pay the full cost of this care yourself

Step 4: If we say *no* to your fast appeal, your case will automatically go on to the next level of the appeals process

- To make sure we were following all the rules when we said ***no*** to your fast appeal, we are required to send your appeal to the Independent Review Organization. When we do this, it means that you are automatically going on to Level 2 of the appeals process

Step-by-step: Level 2 *Alternate* Appeal Process

During the Level 2 Appeal, the Independent Review Organization reviews the decision we made when we said ***no*** to your "fast appeal." This organization decides whether the decision we made should be changed. The formal name for the Independent Review Organization is the "Independent Review Entity." It is sometimes called the "IRE."

Step 1: We will automatically forward your case to the Independent Review Organization

- We are required to send the information for your Level 2 Appeal to the Independent Review Organization within 24 hours of when we tell you that we are saying ***no*** to your first appeal. (If you think we are not meeting this deadline or other deadlines, you can make a complaint. The complaint process is different from the appeals process. "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this "Coverage Decisions, Appeals, and Complaints" section tells how to make a complaint)

Step 2: The Independent Review Organization does a "fast review" of your appeal. The reviewers give you an answer within 72 hours

- The Independent Review Organization is an independent organization that is hired by Medicare. This organization is not connected with our plan and it is not a government agency. This organization is a company chosen by Medicare to handle the job of being the Independent Review Organization. Medicare oversees its work
- Reviewers at the Independent Review Organization will take a careful look at all of the information related to your appeal
- If this organization says ***yes*** to your appeal, then we must reimburse you (pay you back) for our share of the costs of care you have received since the date when we said your coverage would end. We must also continue to cover the care for as long as it is medically necessary. You must continue to pay your share of the costs. If there are coverage limitations, these could limit how much we would reimburse or how long we would continue to cover your services
- If this organization says ***no*** to your appeal, it means they agree with the decision our plan made to your first appeal and will not change it
  - the notice you get from the Independent Review Organization will tell you in writing what you can do if you wish to continue with the review process. It will give you the details about how to go on to a Level 3 Appeal

Step 3: If the Independent Review Organization turns down your appeal, you choose whether you want to take your appeal further

- There are three additional levels of appeal after Level 2, for a total of five levels of appeal. If reviewers say ***no*** to your Level 2 Appeal, you can choose whether to accept that decision or whether to go on to Level 3 and make another appeal. At Level 3, your appeal is reviewed by an administrative law judge or attorney adjudicator
- "Taking Your Appeal to Level 3 and Beyond" in this "Coverage Decisions, Appeals, and Complaints" section tells you more about Levels 3, 4, and 5 of the appeals process

Taking Your Appeal to Level 3 and Beyond

Levels of Appeal 3, 4, and 5 for Medical Service Requests

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the dollar value of the item or medical service you have appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you cannot appeal any further. If the dollar value is high enough, the written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: A judge (called an administrative law judge) or an attorney adjudicator who works for the federal government will review your appeal and give you an answer

- If the administrative law judge or attorney adjudicator says ***yes*** to your appeal, the appeals process may or may not be over. We will decide whether to appeal this decision to Level 4. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 3 decision that is favorable to you
  - if we decide not to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the administrative law judge's or attorney adjudicator's decision
  - if we decide to appeal the decision, we will send you a copy of the Level 4 Appeal request with any accompanying documents. We may wait for the Level 4 Appeal decision before authorizing or providing the service in dispute
- If the administrative law judge or attorney adjudicator says ***no*** to your appeal, the appeals process may or may not be over
  - if you decide to accept this decision that turns down your appeal, the appeals process is over
  - if you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge or attorney adjudicator says ***no*** to your appeal, the notice you

get will tell you what to do next if you choose to continue with your appeal

Level 4 Appeal: The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the federal government

- If the answer is yes, or if the Council denies our request to review a favorable Level 3 Appeal decision, the appeals process may or may not be over. We will decide whether to appeal this decision to Level 5. Unlike a decision at Level 2 (Independent Review Organization), we have the right to appeal a Level 4 decision that is favorable to you if the value of the item or medical service meets the required dollar value
  - if we decide not to appeal the decision, we must authorize or provide you with the service within 60 calendar days after receiving the Council's decision
  - if we decide to appeal the decision, we will let you know in writing
- If the answer is ***no*** or if the Council denies the review request, the appeals process may or may not be over
  - if you decide to accept this decision that turns down your appeal, the appeals process is over
  - if you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says ***no*** to your appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what to do next if you choose to continue with your appeal

Level 5 Appeal: A judge at the Federal District Court will review your appeal

. This is the last step of the appeals process

Levels of Appeal 3, 4, and 5 for Part D Drug Requests

This section may be appropriate for you if you have made a Level 1 Appeal and a Level 2 Appeal, and both of your appeals have been turned down.

If the value of the Part D drug you have appealed meets a certain dollar amount, you may be able to go on to additional levels of appeal. If the dollar amount is less, you cannot appeal any further. The written response you receive to your Level 2 Appeal will explain whom to contact and what to do to ask for a Level 3 Appeal.

For most situations that involve appeals, the last three levels of appeal work in much the same way. Here is who handles the review of your appeal at each of these levels.

Level 3 Appeal: A judge (called an "administrative law judge") or an attorney adjudicator who works for the federal government will review your appeal and give you an answer

- If the answer is ***yes***, the appeals process is over. What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the administrative law judge or attorney adjudicator within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision
- If the answer is ***no***, the appeals process may or may not be over
  - If you decide to accept this decision that turns down your appeal, the appeals process is over
  - If you do not want to accept the decision, you can continue to the next level of the review process. If the administrative law judge or attorney adjudicator says ***no*** to your appeal, the notice you get will tell you what to do next if you choose to continue with your appeal

Level 4 Appeal: The Medicare Appeals Council (Council) will review your appeal and give you an answer. The Council is part of the federal government

- If the answer is ***yes***, the appeals process is over. What you asked for in the appeal has been approved. We must authorize or provide the drug coverage that was approved by the Council within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days after we receive the decision
- If the answer is ***no***, the appeals process may or may not be over
  - if you decide to accept this decision that turns down your appeal, the appeals process is over
  - if you do not want to accept the decision, you might be able to continue to the next level of the review process. If the Council says ***no*** to your appeal or denies your request to review the appeal, the notice you get will tell you whether the rules allow you to go on to a Level 5 Appeal. If the rules allow you to go on, the written notice will also tell you whom to contact and what to do next if you choose to continue with your appeal

Level 5 Appeal: A judge at the Federal District Court will review your appeal

- This is the last step of the appeals process

How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns

If your problem is about decisions related to benefits, coverage, or payment, then this section is not for you. Instead, you need to use the process for coverage decisions and appeals. Go to "A Guide to the Basics of Coverage Decisions and Appeals" in this "Coverage Decisions, Appeals, and Complaints" section.

What kinds of problems are handled by the complaint process?

This section explains how to use the process for making complaints. The complaint process is only used for certain types of problems. This includes problems related to quality of care, waiting times, and the customer service you receive.

Here are examples of the kinds of problems handled by the complaint process:

If you have any of these kinds of problems, you can "make a complaint"

- **Quality of your medical care**
  - ♦ are you unhappy with the quality of care you have received (including care in the hospital)?
- **Respecting your privacy**
  - ♦ do you believe that someone did not respect your right to privacy or shared information about you that you feel should be confidential?
- **Disrespect, poor customer service, or other negative behaviors**
  - ♦ has someone been rude or disrespectful to you?
  - ♦ are you unhappy with how our Member Services has treated you?
  - ♦ do you feel you are being encouraged to leave our plan?
- **Waiting times**
  - ♦ are you having trouble getting an appointment, or waiting too long to get it?
  - ♦ have you been kept waiting too long by doctors, pharmacists, or other health professionals? Or by Member Services or other staff at our plan? Examples include waiting too long on the phone, in the waiting room, when getting a prescription, or in the exam room
- **Cleanliness**
  - ♦ are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
- **Information you get from our plan**
  - ♦ do you believe we have not given you a notice that we are required to give?
  - ♦ do you think written information we have given you is hard to understand?

Timeliness (these types of complaints are all related to the timeliness of our actions related to coverage decisions and appeals)

The process of asking for a coverage decision and making appeals is explained in this "Coverage Decisions, Appeals, and Complaints" section. If you are asking for a coverage decision or making an appeal, you use that process, not the complaint process.

However, if you have already asked for a coverage decision or made an appeal, and you think that we are not responding quickly enough, you can also make a complaint about our slowness. Here are examples:

- If you have asked us to give you a "fast coverage decision" or a "fast appeal," and we have said we will not, you can make a complaint
- If you believe our plan is not meeting the deadlines for giving you a coverage decision or an answer to an appeal you have made, you can make a complaint
- When a coverage decision we made is reviewed and our plan is told that we must cover or reimburse you for certain medical services or Part D drugs, there are deadlines that apply. If you think we are not meeting these deadlines, you can make a complaint
- When we do not give you a decision on time, we are required to forward your case to the Independent Review Organization. If we do not do that within the required deadline, you can make a complaint

Step-by-step: Making a complaint

- What this section calls a "complaint" is also called a "grievance"
- Another term for "making a complaint" is "filing a grievance"
- Another way to say "using the process for complaints" is "using the process for filing a grievance"

Step 1: Contact us promptly – either by phone or in writing

- Usually calling our Member Service Contact Center is the first step. If there is anything else you need to do,

our Member Service Contact Center will let you know. Please call us at **1-800-443-0815** (TTY users call **711**), 8 a.m. to 8 p.m., seven days a week

- If you do not wish to call (or you called and were not satisfied), you can put your complaint in writing and send it to us. If you put your complaint in writing, we will respond to you in writing. We will also respond in writing when you make a complaint by phone if you request a written response or your complaint is related to quality of care
- If you have a complaint, we will try to resolve your complaint over the phone. If we cannot resolve your complaint over the phone, we have a formal procedure to review your complaints. Your grievance must explain your concern, such as why you are dissatisfied with the services you received. Please see the "Important Phone Numbers and Resources" section for whom you should contact if you have a complaint
  - you must submit your grievance to us (orally or in writing) within 60 calendar days of the event or incident. We must address your grievance as quickly as your health requires, but no later than 30 calendar days after receiving your complaint. We may extend the time frame to make our decision by up to 14 calendar days if you ask for an extension, or if we justify a need for additional information and the delay is in your best interest
  - you can file a fast grievance about our decision not to expedite a coverage decision or appeal, or if we extend the time we need to make a decision about a coverage decision or appeal. We must respond to your fast grievance within 24 hours
- Whether you call or write, you should contact our Member Service Contact Center right away. The complaint must be made within 60 calendar days after you had the problem you want to complain about
- If you are making a complaint because we denied your request for a "fast coverage decision" or a "fast appeal," we will automatically give you a "fast complaint." If you have a "fast complaint," it means we will give you an answer within 24 hours. What this section calls a "fast complaint" is also called an "expedited grievance"

Step 2: We look into your complaint and give you our answer

- If possible, we will answer you right away. If you call us with a complaint, we may be able to give you an answer on the same phone call. If your health condition requires us to answer quickly, we will do that
- Most complaints are answered within 30 calendar days. If we need more information and the delay is in your best interest or if you ask for more time, we can take up to 14 more calendar days (44 calendar days total) to answer your complaint. If we decide to take extra days, we will tell you in writing
- If we do not agree with some or all of your complaint or don't take responsibility for the problem you are complaining about, we will let you know. Our response will include our reasons for this answer. We must respond whether we agree with the complaint or not

You can also make complaints about quality of care to the Quality Improvement Organization

You can make your complaint about the quality of care you received to us by using the step-by-step process outlined above.

When your complaint is about quality of care, you also have two extra options:

- **You can make your complaint to the Quality Improvement Organization**. If you prefer, you can make your complaint about the quality of care you received directly to this organization (without making the complaint to us)
  - the Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients
  - to find the name, address, and phone number of the Quality Improvement Organization for your state, look in the "Important Phone Numbers and Resources" section. If you make a complaint to this organization, we will work with them to resolve your complaint
- **Or you can make your complaint to both at the same time**. If you wish, you can make your complaint about quality of care to us and also to the Quality Improvement Organization

You can also tell Medicare about your complaint

- You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.
- If you have any other feedback or concerns, or if you feel our plan is not addressing your issue, please call

1-800-MEDICARE (1-800-633-4227). TTY/TDD users should call **1-877-486-2048**.

Additional Review

You may have certain additional rights if you remain dissatisfied after you have exhausted our internal claims and appeals procedure, and if applicable, external review:

- If your Group's benefit plan is subject to the Employee Retirement Income Security Act (ERISA), you may file a civil action under section 502(a) of ERISA. To understand these rights, you should check with your Group or contact the Employee Benefits Security Administration (part of the U.S. Department of Labor) at 1-866-444-EBSA (1-866-444-3272)
- If your Group's benefit plan is not subject to ERISA (for example, most state or local government plans and church plans), you may have a right to request review in state court

Binding Arbitration

For all claims subject to this "Binding Arbitration" provision, 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" provision applies to claims asserted by Kaiser Permanente Parties, it shall apply retroactively to all unresolved claims that accrued before the effective date of this *EOC*. Such retroactive application shall be binding only on the Kaiser Permanente Parties.

Scope of arbitration

Any dispute shall be submitted to binding arbitration if all of the following requirements are met:

- The claim arises from or is related to an alleged violation of any duty incident to or arising out of or relating to this *EOC* or a Member Party's relationship to Kaiser Foundation Health Plan, Inc. ("Health Plan"), including any claim for medical or hospital malpractice (a claim that medical services or items were unnecessary or unauthorized or were improperly, negligently, or incompetently rendered), for premises liability, or relating to the coverage for, or delivery of, services or items, irrespective of the legal theories upon which the claim is asserted
- The claim is asserted by one or more Member Parties against one or more Kaiser Permanente Parties or by one or more Kaiser Permanente Parties against one or more Member Parties
- Governing law does not prevent the use of binding arbitration to resolve the claim

Members enrolled under this *EOC* thus give up their right to a court or jury trial, and instead accept the use of binding arbitration except that the following types of claims are not subject to binding arbitration:

- Claims within the jurisdiction of the Small Claims Court
- Claims subject to a Medicare appeal procedure as applicable to Kaiser Permanente Senior Advantage Members
- Claims that cannot be subject to binding arbitration under governing law

As referred to in this "Binding Arbitration" provision, "Member Parties" include:

- A Member
- A Member's heir, relative, or personal representative
- Any person claiming that a duty to them arises from a Member's relationship to one or more Kaiser Permanente Parties

"Kaiser Permanente Parties" include:

- Kaiser Foundation Health Plan, Inc.
- Kaiser Foundation Hospitals
- The Permanente Medical Group, Inc.
- Southern California Permanente Medical Group
- The Permanente Federation, LLC
- The Permanente Company, LLC
- Any Southern California Permanente Medical Group or The Permanente Medical Group physician
- Any individual or organization whose contract with any of the organizations identified above requires arbitration of claims brought by one or more Member Parties
- Any employee or agent of any of the foregoing

"Claimant" refers to a Member Party or a Kaiser Permanente Party who asserts a claim as described above. "Respondent" refers to a Member Party or a Kaiser Permanente Party against whom a claim is asserted.

Rules of procedure

Arbitrations shall be conducted according to the *Rules for Kaiser Permanente Member Arbitrations Overseen by the Office of the Independent Administrator* ("Rules of Procedure") developed by the Office of the Independent Administrator in consultation with Kaiser Permanente and the Arbitration Oversight Board. Copies of the Rules of Procedure may be obtained from our Member Service Contact Center.

Initiating arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and phone numbers of the Claimants and their attorney, if any; and the names of all Respondents. Claimants shall include in the Demand for Arbitration all claims against Respondents that are based on the same incident, transaction, or related circumstances.

Serving demand for arbitration

Health Plan, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., Southern California Permanente Medical Group, The Permanente Federation, LLC, and The Permanente Company, LLC, shall be served with a Demand for Arbitration by mailing the Demand for Arbitration addressed to that Respondent in care of:

Kaiser Foundation Health Plan, Inc.
Legal Department
1950 Franklin St., 17th Floor
Oakland, CA 94612

Service on that Respondent shall be deemed completed when received. All other Respondents, including individuals, must be served as required by the California Code of Civil Procedure for a civil action.

Filing fee

The Claimants shall pay a single, nonrefundable filing fee of $150 per arbitration payable to "Arbitration Account" regardless of the number of claims asserted in the Demand for Arbitration or the number of Claimants or Respondents named in the Demand for Arbitration.

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee Waiver Form sets forth the criteria for waiving fees and is available by calling our Member Service Contact Center.

Number of arbitrators

The number of Arbitrators may affect the Claimant's responsibility for paying the neutral arbitrator's fees and expenses (see the Rules of Procedure).

If the Demand for Arbitration seeks total damages of $200,000 or less, the dispute shall be heard and determined by one neutral arbitrator, unless the parties otherwise agree in writing 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" provision, 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" provision, 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 section. In accord with the rule that applies under Sections 3 and 4 of the Federal Arbitration Act, the right to arbitration under this 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 another party that arises out of the same or related transactions and presents a possibility of conflicting rulings or findings.

Termination of Membership

Your Group is required to inform the Subscriber of the date your membership terminates. Your membership termination date is the first day you are not covered (for example, if your termination date is January 1, 2023, your last minute of coverage was at 11:59 p.m. on December 31, 2022). When a Subscriber's membership ends, the memberships of any Dependents end at the same time. You will be billed as a non-Member for any Services you receive after your membership terminates. Health Plan and Plan Providers have no further liability or responsibility under this *EOC* after your membership terminates, except:

- As provided under "Payments after Termination" in this "Termination of Membership" section
- If you are receiving covered Services as an acute care hospital inpatient on the termination date, we will continue to cover those hospital Services (but not physician Services or any other Services) until you are discharged

Until your membership terminates, you remain a Senior Advantage Member and must continue to receive your medical care from us, except as described in the "Emergency Services and Urgent Care" section about Emergency Services, Post-Stabilization Care, and Out-of-Area Urgent Care and the "Benefits and Your Cost Share" section about out-of-area dialysis care.

Note: If you enroll in another Medicare Health Plan or a prescription drug plan, your Senior Advantage membership will terminate as described under "Disenrolling from Senior Advantage" in this "Termination of Membership" section. Such a termination will not affect your enrollment in your Group's non-Medicare plan.

Termination Due to Loss of Eligibility

If you meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section on the first day of a month, but later in that month you no longer meet those eligibility requirements, your membership will end at 11:59 p.m. on the last day of that month. For example, if you become ineligible on December 5, 2022, your termination date is January 1, 2023, and your last minute of coverage is at 11:59 p.m. on December 31, 2022.

Also, we will terminate your Senior Advantage membership under this *EOC* on the last day of the month if you:

- Are temporarily absent from our Service Area for more than six months in a row
- Permanently move from our Service Area
- No longer have Medicare Part B
- Medicare becomes primary, for example, when you retire
- Enroll in another Medicare Health Plan (for example, a Medicare Advantage Plan or a Medicare prescription drug plan). The Centers for Medicare & Medicaid Services will automatically terminate your Senior Advantage membership when your enrollment in the other plan becomes effective
- Are not a U.S. citizen or lawfully present in the United States. The Centers for Medicare & Medicaid Services will notify us if you are not eligible to remain a Member on this basis. We must disenroll you if you do not meet this requirement
- In addition, if you are required to pay the extra Part D amount because of your income and you do not pay it, Medicare will disenroll you from our Senior

Advantage Plan and you will lose prescription drug coverage.

Note: If you lose eligibility for Senior Advantage due to any of these circumstances, you will be able to continue membership under your Group's non-Medicare plan, or if you retire, you may be able to enroll in a different Senior Advantage plan either through your Group (if available) or as discussed under "Conversion to an Individual Plan" below. Please contact your Group for information.

Termination of *Agreement*

If your Group's *Agreement* with us terminates for any reason, your membership ends on the same date. Your Group is required to notify Subscribers in writing if its *Agreement* with us terminates.

Disenrolling from Senior Advantage

You may terminate (disenroll from) your Senior Advantage membership and remain a Member through your Group's non-Medicare plan at any time. Your disenrollment effective date will be the first day of the month following our receipt of your disenrollment request.

You may request disenrollment by calling toll free 1-800-MEDICARE/1-800-633-4227 (TTY users call 1-877-486-2048), 24 hours a day, seven days a week, or sending written notice to the following address:

Kaiser Foundation Health Plan, Inc.
California Service Center
P.O. Box 232400
San Diego, CA 92193-2400

Other Medicare Health Plans. If you want to enroll in another Medicare Health Plan or a Medicare prescription drug plan, you should first confirm with the other plan and your Group that you are able to enroll. Your new plan or your Group will tell you the date when your membership in the new plan begins and your Senior Advantage membership will end on that same day (your disenrollment date).

The Centers for Medicare & Medicaid Services will let us know if you enroll in another Medicare Health Plan, so you will not need to send us a disenrollment request.

Original Medicare. If you request disenrollment from Senior Advantage and you do not enroll in another Medicare Health Plan, you will automatically be enrolled in Original Medicare when your Senior Advantage membership terminates (your disenrollment date). On your disenrollment date, you can start using your red, white, and blue Medicare card to get services under Original Medicare. You will not get anything in writing that tells you that you have Original Medicare after you disenroll. If you choose Original Medicare and you want to continue to get Medicare Part D prescription drug coverage, you will need to enroll in a prescription drug plan.

If you receive Extra Help from Medicare to pay for your prescription drugs, and you switch to Original Medicare and do not enroll in a separate Medicare Part D prescription drug plan, Medicare may enroll you in a drug plan, unless you have opted out of automatic enrollment.

Note: If you disenroll from Medicare prescription drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may need to pay a Part D late enrollment penalty if you join a Medicare drug plan later. ("Creditable" coverage means the coverage is expected to pay, on average, as least as much as Medicare's standard prescription drug coverage.) See "Medicare Premiums" in the "Premiums, Eligibility, and Enrollment" section for more information about the late enrollment penalty.

Termination of Contract with the Centers for Medicare & Medicaid Services

If our contract with the Centers for Medicare & Medicaid Services to offer Senior Advantage terminates, your Senior Advantage membership will terminate on the same date. We will send you advance written notice and advise you of your health care options. However, you will still be enrolled under your Group's non-Medicare plan.

Termination for Cause

We may terminate your membership by sending you advance written notice if you commit one of the following acts:

- If you continuously behave in a way that is disruptive, to the extent that your continued enrollment seriously impairs our ability to arrange or provide medical care for you or for our other members. We cannot make you leave our Senior Advantage Plan for this reason unless we get permission from Medicare first
- If you let someone else use your Plan membership card to get medical care. We cannot make you leave our Senior Advantage Plan for this reason unless we

get permission from Medicare first. If you are disenrolled for this reason, the Centers for Medicare & Medicaid Services may refer your case to the Inspector General for additional investigation

- You commit theft from Health Plan, from a Plan Provider, or at a Plan Facility
- You intentionally misrepresent membership status or commit fraud in connection with your obtaining membership. We cannot make you leave our Senior Advantage Plan for this reason unless we get permission from Medicare first
- If you become incarcerated (go to prison)
- You knowingly falsify or withhold information about other parties that provide reimbursement for your prescription drug coverage

If we terminate your membership for cause, you will not be allowed to enroll in Health Plan in the future until you have completed a Member Orientation and have signed a statement promising future compliance. We may report fraud and other illegal acts to the authorities for prosecution.

Termination for Nonpayment of Premiums

If your Group fails to pay us Premiums for your Family, we may terminate the memberships of everyone in your Family.

Termination of a Product or all Products

We may terminate a particular product or all products offered in the group market as permitted or required by law. If we discontinue offering a particular product in the group market, we will terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's *Agreement* by sending you written notice at least 180 days before the *Agreement* terminates.

Payments after Termination

If we terminate your membership for cause or for nonpayment, we will:

- Refund any amounts we owe your Group for Premiums paid after the termination date
- Pay you any amounts we have determined that we owe you for claims during your membership in accord with the "Requests for Payment" section. We will deduct any amounts you owe Health Plan or Plan Providers from any payment we make to you

Review of Membership Termination

If you believe that we terminated your Senior Advantage membership because of your ill health or your need for care, you may file a complaint as described in the "Coverage Decisions, Appeals, and Complaints" section.

Continuation of Membership

If your membership under your Group's non-Medicare plan ends, you may be eligible to maintain Health Plan membership without a break in coverage (group coverage) or you may be eligible to convert to an individual (nongroup) plan.

Continuation of Group Coverage

COBRA

You may be able to continue your coverage under this Senior Advantage *EOC* for a limited time after you would otherwise lose eligibility, if required by the federal Consolidated Omnibus Budget Reconciliation Act ("COBRA"). COBRA applies to most employees (and most of their covered family Dependents) of most employers with 20 or more employees.

If your Group is subject to COBRA and you are eligible for COBRA coverage, in order to enroll, you must submit a COBRA election form to your Group within the COBRA election period. Please ask your Group for details about COBRA coverage, such as how to elect coverage, how much you must pay for coverage, when coverage and Premiums may change, and where to send your Premium payments.

As described in "Conversion from Group Membership to an Individual Plan" in this "Continuation of Membership" section, you may be able to convert to an individual (nongroup) plan if you don't apply for COBRA coverage, or if you enroll in COBRA and your COBRA coverage ends.

Coverage for a disabling condition

If you became Totally Disabled while you were a Member under your Group's *Agreement* with us and while the Subscriber was employed by your Group, and your Group's *Agreement* with us terminates and is not renewed, we will cover Services for your totally disabling condition until the earliest of the following events occurs:

- 12 months have elapsed since your Group's *Agreement* with us terminated
- You are no longer Totally Disabled
- Your Group's *Agreement* with us is replaced by another group health plan without limitation as to the disabling condition

Your coverage will be subject to the terms of this *EOC*, including Cost Share, but we will not cover Services for any condition other than your totally disabling condition.

For Subscribers and adult Dependents, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months, and makes the person unable to engage in any employment or occupation, even with training, education, and experience.

For Dependent children, "Totally Disabled" means that, in the judgment of a Medical Group physician, an illness or injury is expected to result in death or has lasted or is expected to last for a continuous period of at least 12 months and the illness or injury makes the child unable to substantially engage in any of the normal activities of children in good health of like age.

To request continuation of coverage for your disabling condition, you must call our Member Service Contact Center within 30 days after your Group's *Agreement* with us terminates.

Conversion from Group Membership to an Individual Plan

After your Group notifies us to terminate your Group membership, we will send a termination letter to the Subscriber's address of record. The letter will include information about options that may be available to you to remain a Health Plan Member.

Kaiser Permanente Conversion Plan

If you want to remain a Health Plan Member, one option that may be available is our Senior Advantage Individual Plan. You may be eligible to enroll in our individual plan if you no longer meet the eligibility requirements described under "Who Is Eligible" in the "Premiums, Eligibility, and Enrollment" section. Individual plan coverage begins when your Group coverage ends. The premiums and coverage under our individual plan are different from those under this *EOC* and will include Medicare Part D prescription drug coverage.

However, if you are no longer eligible for Senior Advantage and Group coverage, you may be eligible to convert to our non-Medicare individual plan, called "Kaiser Permanente Individual‑Conversion Plan." You may be eligible to enroll in our Individual‑Conversion Plan if we receive your enrollment application within 63 days of the date of our termination letter or of your membership termination date (whichever date is later).

You may not be eligible to convert if your membership ends for the reasons stated under "Termination for Cause" or "Termination of *Agreement"* in the "Termination of Membership" section.

Miscellaneous Provisions

Administration of Agreement

We may adopt reasonable policies, procedures, and interpretations to promote orderly and efficient administration of your Group's *Agreement*, including this *EOC.*

Amendment of *Agreement*

Your Group's *Agreement* with us will change periodically. If these changes affect this *EOC*, your Group is required to inform you in accord with applicable law and your Group's *Agreement.*

Applications and Statements

You must complete any applications, forms, or statements that we request in our normal course of business or as specified in this *EOC*.

Assignment

You may not assign this *EOC* or any of the rights, interests, claims for money due, benefits, or obligations hereunder without our prior written consent.

Attorney and Advocate Fees and Expenses

In any dispute between a Member and Health Plan, Medical Group, or Kaiser Foundation Hospitals, each party will bear its own fees and expenses, including attorneys' fees, advocates' fees, and other expenses, except as otherwise required by law.

Claims Review Authority

We are responsible for determining whether you are entitled to benefits under this *EOC* and we have the discretionary authority to review and evaluate claims that arise under this *EOC*. We conduct this evaluation independently by interpreting the provisions of this *EOC*. We may use medical experts to help us review claims. If coverage under this *EOC* is subject to the Employee Retirement Income Security Act (ERISA) claims procedure regulation (29 CFR 2560.503-1), then we are a "named claims fiduciary" to review claims under this *EOC*.

EOC Binding on Members

By electing coverage or accepting benefits under this *EOC*, all Members legally capable of contracting, and the legal representatives of all Members incapable of contracting, agree to all provisions of this *EOC*.

ERISA Notices

This "ERISA Notices" section applies only if your Group's health benefit plan is subject to the Employee Retirement Income Security Act (ERISA). We provide these notices to assist ERISA-covered groups in complying with ERISA. Coverage for Services described in these notices is subject to all provisions of this *EOC*.

Newborns' and Mothers' Health Protection Act
Group health plans and health insurance issuers generally may not, under Federal law, restrict benefits for any hospital length of stay in connection with childbirth for the mother or newborn child to less than 48 hours following a vaginal delivery, or less than 96 hours following a cesarean section. However, Federal law generally does not prohibit the mother's or newborn's attending provider, after consulting with the mother, from discharging the mother or her newborn earlier than 48 hours (or 96 hours as applicable). In any case, plans and issuers may not, under Federal law, require that a provider obtain authorization from the plan or the insurance issuer for prescribing a length of stay not in excess of 48 hours (or 96 hours).

Women's Health and Cancer Rights Act If you have had or are going to have a mastectomy, you may be entitled to certain benefits under the Women's Health and Cancer Rights Act. For individuals receiving mastectomy-related benefits, coverage will be provided in a manner determined in consultation with the attending physician and the patient, for all stages of reconstruction of the breast on which the mastectomy was performed, surgery and reconstruction of the other breast to produce a symmetrical appearance, prostheses, and treatment of physical complications of the mastectomy, including lymphedemas. These benefits will be provided subject to the same Cost Share applicable to other medical and surgical benefits provided under this plan.

Governing Law

Except as preempted by federal law, this *EOC* will be governed in accord with California law and any provision that is required to be in this *EOC* by state or federal law shall bind Members and Health Plan whether or not set forth in this *EOC*.

Group and Members not our Agents

Neither your Group nor any Member is the agent or representative of Health Plan.

No Waiver

Our failure to enforce any provision of this *EOC* will not constitute a waiver of that or any other provision, or impair our right thereafter to require your strict performance of any provision.

Notices Regarding Your Coverage

Our notices to you will be sent to the most recent address we have for the Subscriber. The Subscriber is responsible for notifying us of any change in address. Subscribers who move should call our Member Service Contact Center and Social Security toll free at **1-800-772-1213** (TTY users call **1-800-325-0778**) as soon as possible to give us their new address. If a Member does not reside with the Subscriber, or needs to have confidential information sent to an address other than the Subscriber's address, they should call our Member Service Contact Center to discuss alternate delivery options.

Note: When we tell your Group about changes to this *EOC* or provide your Group other information that affects you, your Group is required to notify the Subscriber within 30 days after receiving the information from us.

Notice about Medicare Secondary Payer Subrogation Rights

We have the right and responsibility to collect for covered Medicare services for which Medicare is not the primary payer. According to CMS regulations at 42 CFR sections 422.108 and 423.462, Kaiser Permanente Senior Advantage, as a Medicare Advantage Organization, will exercise the same rights of recovery that the Secretary exercises under CMS regulations in subparts B through D of part 411 of 42 CFR and the rules established in this section supersede any state laws.

Overpayment Recovery

We may recover any overpayment we make for Services from anyone who receives such an overpayment or from any person or organization obligated to pay for the Services.

Public Policy Participation

The Kaiser Foundation Health Plan, Inc., Board of Directors establishes public policy for Health Plan. A list of the Board of Directors is available on our website at kp.org or from our Member Service Contact Center. If you would like to provide input about Health Plan public policy for consideration by the Board, please send written comments to:

Kaiser Foundation Health Plan, Inc.
Office of Board and Corporate Governance Services
One Kaiser Plaza, 19th Floor
Oakland, CA 94612

Telephone Access (TTY)

If you use a text telephone device (TTY, also known as TDD) to communicate by phone, you can use the California Relay Service by calling 711.

Important Phone Numbers and Resources

Kaiser Permanente Senior Advantage

How to contact our plan's Member Services

For assistance, please call or write to our plan's Member Services. We will be happy to help you.

Member Services – contact information

Call **1-800-443-0815**

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

Member Services also has free language interpreter services available for non-English speakers.

TTY 711

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

Write Your local Member Services office (see the *Provider Directory* for locations).

Website kp.org

How to contact us when you are asking for a coverage decision or making an appeal or complaint about your Services

- A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your medical services
- An appeal is a formal way of asking us to review and change a coverage decision we have made
- You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes

For more information about asking for coverage decisions or making appeals or complaints about your medical care, see the "Coverage Decisions, Appeals, and Complaints" section.

Coverage decisions, appeals, or complaints for Services – contact information

Call **1-800-443-0815**

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

If your coverage decision, appeal, or complaint **qualifies for a fast decision** as described in the "Coverage Decisions, Appeals, and Complaints" section, call the Expedited Review Unit at **1-888-987-7247**, 8:30 a.m. to 5 p.m., Monday through Saturday.

TTY 711

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

Fax If your coverage decision, appeal, or complaint **qualifies for a fast decision**, fax your request to our Expedited Review Unit at **1-888-987-2252**.

Write For a **standard coverage decision or complaint**, write to your local Member Services office (see the *Provider Directory* for locations).

For a **standard appeal**, write to the address shown on the denial notice we send you.

- If your coverage decision, appeal, or complaint **qualifies for a fast decision**, write to:
  Kaiser 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 https://www.medicare.gov/MedicareComplaintForm/home.aspx.

How to contact us when you are asking for a coverage decision about your Part D prescription drugs

- A coverage decision is a decision we make about your benefits and coverage or about the amount we will pay for your prescription drugs covered under the Part D benefit included in your plan

For more information about asking for coverage decisions about your Part D prescription drugs, see the "Coverage Decisions, Appeals, and Complaints" section.

Coverage decisions for Part D prescription drugs – contact information

Call **1-877-645-1282**

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

TTY 711

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

Fax **1-844-403-1028**

- **Write** OptumRx
  c/o Prior Authorization
  P.O. Box 25183
  Santa Ana, CA 92799

Website kp.org

How to contact us when you are making an appeal about your Part D prescription drugs

- An appeal is a formal way of asking us to review and change a coverage decision we have made

For more information about making appeals about your Part D prescription drugs, see the "Coverage Decisions, Appeals, and Complaints" section. You may call us if you have questions about our appeals process.

Appeals for Part D prescription drugs – contact information

Call **1-866-206-2973**

Calls to this number are free.

Seven days a week, 8:30 a.m. to 5 p.m.

TTY 711

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

Fax **1-866-206-2974**

- **Write** Kaiser Permanente
  CA Medicare PDU/MSU Operations
  P.O. Box 1809
  Pleasanton, CA 94566

Website kp.org

How to contact us when you are making a complaint about your Part D prescription drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint does not involve coverage or payment disputes. (If your problem is about our plan's coverage or payment, you should look at the section above about requesting coverage decisions or making appeals.) For more information about making a complaint about your Part D prescription drugs, see the "Coverage Decisions, Appeals, and Complaints" section.

Complaints for Part D prescription drugs – contact information

Call **1-800-443-0815**

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

If your complaint **qualifies for a fast decision**, call the Part D Unit at **1-866-206-2973**, 8:30 a.m. to 5 p.m., Monday through Friday. See the "Coverage Decisions, Appeals, and Complaints" section to find out if your issue qualifies for a fast decision.

TTY 711

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

Fax If your complaint qualifies for a fast review, fax your request to our Part D Unit at **1-866-206-2974**.

Write For a **standard complaint**, write to your local Member Services office (see the *Provider Directory* for locations).

If your complaint **qualifies for a fast decision**, write to:

Kaiser Permanente
CA Medicare PDU/MSU Operations
P.O. Box 1809
Pleasanton, CA 94566

Medicare Website. You can submit a complaint about our plan directly to Medicare. To submit an online complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx.

Where to send a request asking us to pay for our share of the cost for Services or a Part D drug you have received

For more information about situations in which you may need to ask us for reimbursement or to pay a bill you have received from a provider, see the "Requests for Payment" section.

Note: If you send us a payment request and we deny any part of your request, you can appeal our decision. See the "Coverage Decisions, Appeals, and Complaints" section for more information.

Payment Requests – contact information

Call **1-800-443-0815**

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

Note: If you are requesting payment of a Part D drug that was prescribed by a Plan Provider and obtained from a Plan Pharmacy, call our Part D unit at **1-866-206-2973**, 8:30 a.m. to 5 p.m., Monday through Friday.

TTY 711

Calls to this number are free.

Seven days a week, 8 a.m. to 8 p.m.

Write For medical care:

Kaiser Permanente
Claims Department
P.O. Box 12923
Oakland, CA 94604-2923

For Part D drugs:

If you are requesting payment of a Part D drug that was prescribed and provided by a Plan Provider, you can fax your request to 1-866-206-2974 or mail it to:

Kaiser Permanente
CA Medicare PDU/MSU Operations
P.O. Box 1809
Pleasanton, CA 94566

Website kp.org

Medicare

How to get help and information directly from the federal Medicare program

Medicare is the federal health insurance program for people 65 years of age or older, some people under age 65 with disabilities, and people with end-stage renal disease (permanent kidney failure requiring dialysis or a kidney transplant). The federal agency in charge of Medicare is the Centers for Medicare & Medicaid Services (sometimes called "CMS"). This agency contracts with Medicare Advantage organizations, including our plan.

Medicare – contact information

Call **1-800-MEDICARE** or **1-800-633-4227**

Calls to this number are free. 24 hours a day, seven days a week.

TTY 1-877-486-2048

Calls to this number are free.

Website https://www.medicare.gov

This is the official government website for Medicare. It gives you up-to-date information about Medicare and current Medicare issues. It also has information about hospitals, nursing homes, physicians, home health agencies, and dialysis facilities. It includes booklets you can print directly from your computer. You can also find Medicare contacts in your state.

The Medicare website also has detailed information about your Medicare eligibility and enrollment options with the following tools:

Medicare Eligibility Tool: Provides Medicare eligibility status information.

Medicare Plan Finder: Provides personalized information about available Medicare prescription drug plans, Medicare Health Plans, and Medigap (Medicare Supplement Insurance) policies in your area. These tools provide an *estimate* of what your out-of-pocket costs might be in different Medicare plans.

You can also use the website to tell Medicare about any complaints you have about our plan.

Tell Medicare about your complaint: You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to https://www.medicare.gov/MedicareComplaintForm/home.aspx. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

If you don't have a computer, your local library or senior center may be able to help you visit this website using its computer. Or, you can call Medicare and tell them what information you are looking for. They will find the information on the website, print it out, and send it to you. You can call Medicare at **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**), 24 hours a day, 7 days a week.

State Health Insurance Assistance Program

Free help, information, and answers to your questions about Medicare

The State Health Insurance Assistance Program (SHIP) is a government program with trained counselors in every state. In California, the State Health Insurance Assistance Program is called the Health Insurance Counseling and Advocacy Program (HICAP).

The Health Insurance Counseling and Advocacy Program is independent (not connected with any insurance company or health plan). It is a state program that gets money from the federal government to give free local health insurance counseling to people with Medicare.

The Health Insurance Counseling and Advocacy Program counselors can help you with your Medicare questions or problems. They can help you understand your Medicare rights, help you make complaints about your Services or treatment, and help you straighten out problems with your Medicare bills. The Health Insurance Counseling and Advocacy Program counselors can also help you understand your Medicare plan choices and answer questions about switching plans.

Method to access SHIP and other resources:

. Visit www.medicare.gov.

- Click on "**Forms, Help, and Resources**" on far right of menu on top.
- In the drop down, click on "**Phone Numbers & Websites.**"
- You now have several options:
    - Option 1: You can have a live chat.
    - Option 2: You can click on any of the "Topics" in the menu on bottom.
    - Option 3: You can select your state from the dropdown menu and click "Go." This will take you to a page with phone numbers and resources specific to your state.

Health Insurance Counseling and Advocacy Program (California's State Health Insurance Assistance Program) – contact information

Call **1-800-434-0222**

Calls to this number are free.

TTY 711

Write Your HICAP office for your county.

Website www.aging.ca.gov/HICAP/

Quality Improvement Organization

Paid by Medicare to check on the quality of care for people with Medicare

There is a designated Quality Improvement Organization for serving Medicare beneficiaries in each state. For California, the Quality Improvement Organization is called Livanta.

Livanta has a group of doctors and other health care professionals who are paid by the federal government. This organization is paid by Medicare to check on and help improve the quality of care for people with Medicare. Livanta is an independent organization. It is not connected with our plan.

You should contact Livanta in any of these situations:

- You have a complaint about the quality of care you have received
- You think coverage for your hospital stay is ending too soon

- You think coverage for your home health care, Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services are ending too soon

Livanta (California's Quality Improvement Organization) – contact information

- **Call 1-877-588-1123**

  Calls to this number are free. Monday through Friday, 9 a.m. to 5 p.m Weekends and holidays 11 a.m. to 3 p.m.

- **TTY 1-855-887-6668**

Write Livanta
BFCC – QIO Program
10820 Guilford Road, Suite 202
Annapolis Junction, MD 20701–1105

- **Website** www.livantaqio.com/en

Social Security

Social Security is responsible for determining eligibility and handling enrollment for Medicare. U.S. citizens and lawful permanent residents who are 65 or older, or who have a disability or end stage renal disease and meet certain conditions, are eligible for Medicare. If you are already getting Social Security checks, enrollment into Medicare is automatic. If you are not getting Social Security checks, you have to enroll in Medicare. To apply for Medicare, you can call Social Security or visit your local Social Security office.

Social Security is also responsible for determining who has to pay an extra amount for their Part D drug coverage because they have a higher income. If you got a letter from Social Security telling you that you have to pay the extra amount and have questions about the amount or if your income went down because of a life-changing event, you can call Social Security to ask for reconsideration.

If you move or change your mailing address, it is important that you contact Social Security to let them know.

Social Security – contact information

Call **1-800-772-1213**

Calls to this number are free. Available 7 a.m. to 7 p.m., Monday through Friday.

You can use Social Security's automated telephone services and get recorded information 24 hours a day.

TTY 1-800-325-0778

Calls to this number are free. Available 7 a.m. to 7 p.m., Monday through Friday.

Website https://www.ssa.gov

Medicaid

A joint federal and state program that helps with medical costs for some people with limited income and resources

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid.

In addition, there are programs offered through Medicaid that help people with Medicare pay their Medicare costs, such as their Medicare premiums. These "Medicare Savings Programs" help people with limited income and resources save money each year:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other Cost Share. Some people with QMB are also eligible for full Medicaid benefits (QMB+)
- **Specified Low-Income Medicare Beneficiary (SLMB):** Helps pay Part B premiums. Some people with SLMB are also eligible for full Medicaid benefits (SLMB+)
- **Qualifying Individual (QI):** Helps pay Part B premiums
- **Qualified Disabled & Working Individuals (QDWI):** Helps pay Part A premiums

To find out more about Medicaid and its programs, contact Medi-Cal.

Medi-Cal (California's Medicaid program) – contact information

Call **1-800-541-5555**

Calls to this number are free. You can use Medi-Cal's automated telephone services and get recorded information 24 hours a day.

TTY 711

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking.

Write California Department of Health Care Services
P.O. Box 997417, MS 4607
Sacramento, CA 95899-7417

Website http://www.cdss.ca.gov

Railroad Retirement Board

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you have questions regarding your benefits from the Railroad Retirement Board, contact the agency.

If you receive your Medicare through the Railroad Retirement Board, it is important that you let them know if you move or change your mailing address.

Railroad Retirement Board – contact information

Call **1-877-772-5772**

Calls to this number are free. If you press "0," you may speak with an RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9 a.m. to 12 p.m. on Wednesday.

If you press "1," you may access the automated RRB HelpLine and recorded information 24 hours a day, including weekends and holidays.

TTY 1-312-751-4701

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are *not* free.

Website rrb.gov/

Group Insurance or Other Health Insurance from an Employer

If you have any questions about your employer-sponsored Group plan, please contact your Group's benefits administrator. You can ask about your employer or retiree health benefits, any contributions toward the Group's premium, eligibility, and enrollment periods.

If you have other prescription drug coverage through your (or your spouse's) employer or retiree group, please contact that group's benefits administrator. The benefits administrator can help you determine how your current prescription drug coverage will work with our plan.

Notice of nondiscrimination

Kaiser Permanente complies with applicable federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Kaiser Permanente does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex. We also:

- Provide no cost aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters.
  - Written information in other formats, such as large print, audio, and accessible electronic formats.
- Provide no cost language services to people whose primary language is not English, such as:
  - Qualified interpreters.
  - Information written in other languages.

If you need these services, call Member Services at **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., seven days a week.

If you believe that Kaiser Permanente has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance with our Civil Rights Coordinator by writing to One Kaiser Plaza, 12th Floor, Suite 1223, Oakland, CA 94612 or calling Member Services at the number listed above. You can file a grievance by mail or phone. If you need help filing a grievance, our Civil Rights Coordinator is available to help you. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at: U.S. Department of Health and Human Services, 200 Independence Avenue SW., Room 509F, HHH Building, Washington, DC 20201, **1-800-368-1019, 800-537-7697 (TDD)**. Complaint forms are available at **http://www.hhs.gov/ocr/office/file/index.html**.

KAISER PERMANENTE®

Multi-language Interpreter Services

English
ATTENTION: If you speak a language other than English, language assistance services, free of charge, are available to you. Call **1-800-443-0815** (TTY: **711**).

Spanish
ATENCIÓN: si habla español, tiene a su disposición servicios gratuitos de asistencia lingüistica. Llame al **1-800-443-0815** (TTY: **711**).

Chinese
注意：如果您使用繁體中文，您可以免費獲得語言援助服務。請致電 **1-800-443-0815**（TTY：**711**）。

Vietnamese
CHÚ Ý: Nếu bạn nói Tiếng Việt, có các dịch vụ hỗ trợ ngôn ngữ miễn phi dành cho bạn. Gọi số **1-800-443-0815** (TTY: **711**).

Tagalog
PAUNAWA: Kung nagsasalita ka ng Tagalog, maaari kang gumamit ng mga serbisyo ng tulong sa wika nang walang bayad. Tumawag sa **1-800-443-0815** (TTY: **711**).

Korean
주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다.
1-800-443-0815 (TTY: **711**)번으로 전화해 주십시오.

Armenian
ՈՒՇԱԴՐՈՒԹՅՈՒՆ՝ Եթե խոսում եք հայերեն, ապա ձեզ անվճար կարող են տրամադրվել լեզվական աջակցության ծառայություններ: Զանգահարեք **1-800-443-0815** (TTY (հեռատիպ)՝ **711**):

Russian
ВНИМАНИЕ: Если вы говорите на русском языке, то вам доступны бесплатные услуги перевода. Звоните **1-800-443-0815** (телетайп: **711**).

Japanese
注意事項：日本語を話される場合、無料の言語支援をご利用いただけます。**1-800-443-0815**（TTY:**711**）まで、お電話にてご連絡ください。

Punjabi
ਧਿਆਨ ਦਿਓ: ਜੇ ਤੁਸੀਂ ਪੰਜਾਬੀ ਬੋਲਦੇ ਹੋ, ਤਾਂ ਭਾਸ਼ਾ ਵਿੱਚ ਸਹਾਇਤਾ ਸੇਵਾ ਤੁਹਾਡੇ ਲਈ ਮੁਫਤ ਉਪਲਬਧ ਹੈ।
1-800-443-0815 (TTY: **711**) 'ਤੇ ਕਾਲ ਕਰੋ।

KAISER PERMANENTE®

Cambodian
ប្រយ័ត្ន៖ បើសិនជាអ្នកនិយាយ ភាសាខ្មែរ, សេវាជំនួយផ្នែកភាសា ដោយមិនគិតឈ្នួល
គឺអាចមានសំរាប់បំរើអ្នក។ ចូរ ទូរស័ព្ទ **1-800-443-0815** (TTY: **711**)។

Hmong
LUS CEEV: Yog tias koj hais lus Hmoob, cov kev pab txog lus, muaj kev pab dawb rau koj.
Hu rau **1-800-443-0815** (TTY: **711**).

Hindi
ध्यान दें: यदि आप हिंदी बोलते हैं तो आपके लिए मुफ्त में भाषा सहायता सेवाएं उपलब्ध हैं।
1-800-443-0815 (TTY: **711**) पर कॉल करें।

Thai
เรียน: ณพูดภาษาไทยคุณสามารถใช้บริการช่วยเหลือทางภาษาได้ฟรี โทร **1-800-443-**
(TTY: **711**).

Farsi
توجه: اگر به زبان فارسی گفتگو می کنید، تسهیلات زبانی بصورت رایگان برای شما فراهم می
باشد. با **1-800-443-0815** (TTY: **711**) تماس بگیرید.

Arabic
ملحوظة: إذا كنت تتحدث اذكر اللغة، فإن خدمات المساعدة اللغوية تتوافر لك بالمجان. اتصل برقم -
1-800-344-008-5180 (رقم هاتف الصم والبكم: -**117**).