KAISER PERMANENTE®

Kaiser Foundation Health Plan, Inc.
Southern California Region

A nonprofit corporation and a Medicare Advantage Organization

EOC #52 - Kaiser Permanente Senior Advantage (HMO) with Part D
Evidence of Coverage for
REEP/REDLANDS UNIFIED SCHOOL DISTRICT

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Member Services
Seven days a week, 8 a.m.–8 p.m.
1-800-443-0815 (TTY users call **711**)
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This document is available for free in Spanish. Please contact our Member Services number at **1-800-443-0815** for additional information. (TTY users should call **711**.) Hours are 8 a.m. to 8 p.m., 7 days a week.

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

- Your cost sharing
- Your medical and prescription drug benefits
- How to file a complaint if you are not satisfied with a service or treatment
- How to contact us if you need further assistance
- Other protections required by Medicare law

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Benefit Highlights

Accumulation Period

The Accumulation Period for this plan is 1/1/26 through 12/31/26 (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.....$1,000 per calendar year

Plan Deductible	None

Plan Provider Office Visits	**You Pay**
Most Primary Care Visits and most Non-Physician Specialist Visits	$20 per visit
Most Physician Specialist Visits	$20 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	$20 per visit
Urgent care consultations, evaluations, and treatment	$20 per visit
Physical, occupational, and speech therapy	$20 per visit

Telehealth Visits	**You Pay**
Primary Care Visits and Non-Physician Specialist Visits by interactive video	No charge
Physician Specialist Visits by interactive video	No charge
Primary Care Visits and Non-Physician Specialist Visits by telephone	No charge
Physician Specialist Visits by telephone	No charge

Outpatient Services	**You Pay**
Outpatient surgery and certain other outpatient procedures	$20 per procedure
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	$20 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**
This plan covers Medicare Part D prescription drugs in accord with our Part D formulary.	
Initial Coverage Stage—until you have spent $2,100 in 2026. (If you spend $2,100, you move on to the Catastrophic Coverage Stage)	$10 for up to a 100-day supply
Catastrophic Coverage Stage	No charge

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	$20 per visit
Group outpatient mental health treatment	$10 per visit

Substance Use Disorder Treatment	You Pay
Inpatient detoxification	No charge
Individual outpatient substance use disorder evaluation and treatment	$20 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*	No charge
Ostomy, urological, and specialized wound care supplies	No charge
Fitness benefit – One Pass® (includes access to in-network gyms and one home fitness kit per calendar year)	No charge

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 Kaiser Foundation Health Plan, Inc. ("Health Plan") 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 Services, 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
- Covered Services received outside of your Home Region Service Area as described under "Receiving Care Outside of Your Home Region Service Area" 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 July 1, 2026, through June 30, 2027, 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 1/1/26 through 12/31/26.

Allowance: A specified credit amount that you can use toward the cost of an item. If the cost of the item(s) or Service(s) you select exceeds the Allowance, you will pay the amount in excess of the Allowance.

Catastrophic Coverage Stage: The stage in the Part D Drug Benefit that begins when you (or other qualified parties on your behalf) have spent $2,100 for Part D covered drugs during the covered year. During this payment stage, you pay nothing for your covered Part D drugs.

Centers for Medicare & Medicaid Services (CMS): The federal agency that administers 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 only for certain types of problems. This includes problems about quality of care, waiting times, and the customer service you get. It also includes complaints if our plan doesn't follow the time periods in the appeal process.

Comprehensive Formulary (Formulary or Drug List): A list of Medicare Part D prescription drugs covered by our plan.

Comprehensive Outpatient Rehabilitation Facility (CORF): A facility that mainly provides rehabilitation Services after an illness or injury, 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. Cost Share also means any Charges you are required to pay for covered Medicare Part D drugs. 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 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 our plan, providers, or pharmacies, including a complaint concerning the quality of your care. This doesn't 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).

Income Related Monthly Adjustment Amount (IRMAA): If your modified adjusted gross income as reported on your IRS tax return from two years ago is above a certain amount, you'll pay the standard premium amount and an Income Related Monthly Adjustment Amount, also known as IRMAA. IRMAA is an extra charge added to your premium. Less than 5% of people with Medicare are affected, so most people won't pay a higher premium.

Initial Coverage Stage: This is the stage before your out-of-pocket costs for Part D in 2026 have reached $2,100.

Initial Enrollment Period: When you're first eligible for Medicare, the period of time when you can sign up for Medicare Part B. If you're eligible for Medicare when you turn 65, your Initial Enrollment Period is the 7-month period that begins 3 months before the month you turn 65, includes the month you turn 65, and ends 3 months after the month you turn 65.

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

Manufacturer Discount Program – A program under which drug manufacturers pay a portion of our plan's full cost for covered Part D brand-name drugs and biologics. Discounts are based on agreements between the federal government and drug manufacturers.

Medical Group: The Southern California Permanente Medical Group, a for-profit professional partnership.

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).

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 and Part B benefits. A Medicare Advantage Plan can be (i) an HMO, (ii) a PPO, (iii) a Private Fee-for-Service (PFFS) plan, or (iv) a Medicare Medical Savings Account (MSA) plan. Besides choosing from these types of plans, a Medicare Advantage HMO or PPO plan can also be a Special Needs Plan (SNP). In most cases, Medicare Advantage Plans also offer Medicare Part D (prescription drug coverage). These plans are called **Medicare Advantage Plans with Prescription Drug Coverage**. A person enrolled in a Medicare Part D plan has Medicare Part D by virtue of their enrollment in the Part D plan. 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 our 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: A decision our plan makes about whether items or services are covered or how much you have to pay for covered items or Services. Organization determinations are called coverage decisions in this *EOC*.

Original Medicare (Traditional Medicare or Fee-for-Service Medicare): Original Medicare is offered by the government, and not a private health plan like Medicare Advantage Plans and prescription drug plans. Under Original Medicare, Medicare services are covered by paying doctors, hospitals, and other health care providers payment amounts established by Congress. You can see any doctor, hospital, or other health care provider that accepts Medicare. You must pay the deductible. Medicare pays its share of the Medicare-approved amount, and you pay your share. Original Medicare has 2 parts: Part A (Hospital Insurance) and Part B (Medical Insurance) and is available everywhere in the United States.

Out-of-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 Member Services.

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 Member Services.

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 Member Services.

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 Member Services.

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 Member Services.

Plan Physician: Any licensed physician who is a partner or 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 clinically stable. You're considered clinically stable when your treating physician believes, within a reasonable medical probability and in accordance with recognized medical standards that you're safe for discharge or transfer and that your condition is not expected to get materially worse during or as a result of the discharge or transfer.

Premiums: The periodic amounts 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 Member Services.

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 Member Services. The directory is updated periodically. The availability of Plan Physicians and Plan Facilities may change. If you have questions, please call Member Services.

Real-Time Benefit Tool: A portal or computer application in which enrollees can look up complete, accurate, timely, clinically appropriate, enrollee-specific formulary and benefit information. This includes cost-

sharing amounts, alternative formulary medications that may be used for the same health condition as a given drug, and coverage restrictions (Prior Authorization, Step Therapy, Quantity Limits) that apply to alternative medications.

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 Member Services.

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:

- Kern County: 93203, 93205-06, 93215-16, 93220, 93222, 93224-26, 93238, 93240-41, 93243, 93249-52, 93263, 93268, 93276, 93280, 93285, 93287, 93301-09, 93311-14, 93380, 93383-90, 93501-02, 93504-05, 93518-19, 93531, 93536, 93560-61, 93581
- Los Angeles County: 90001-84, 90086-89, 90091, 90093-96, 90099, 90134, 90140, 90189, 90201-02, 90205, 90209-13, 90220-24, 90230-32, 90239-42, 90245, 90247-51, 90254-55, 90260, 90262-67, 90270, 90272, 90274-75, 90277-78, 90280, 90290-96, 90301-12, 90401-11, 90501-10, 90601-10, 90623, 90630-31, 90637-40, 90650-52, 90660-62, 90670-71, 90701-03, 90706-07, 90710-17, 90723, 90731-34, 90744-49, 90755, 90801-10, 90813-15, 90822, 90831-33, 90840, 90842, 90844, 90846-48, 90853, 90895, 91001, 91003, 91006-12, 91016-17, 91020-21, 91023-25, 91030-31, 91040-43, 91046, 91066, 91077, 91101-10, 91114-18, 91121, 91123-26, 91129, 91182, 91184-85, 91188-89, 91199, 91201-10, 91214, 91221-22, 91224-26, 91301-11, 91313, 91316, 91321-22, 91324-28, 91330-31, 91333-35, 91337, 91340-46, 91350-57, 91361-62, 91364-65, 91367, 91371-72, 91376, 91380-87, 91390, 91392-96, 91401-13, 91416, 91423, 91426, 91436, 91470, 91482, 91499, 91501-08, 91510, 91521-23, 91601-10, 91614-18, 91702, 91706, 91711, 91714-16, 91722-24, 91731-35, 91740-41, 91744-50, 91754-56, 91759, 91765-73, 91775-76, 91778, 91780, 91788-93, 91801-04, 91896, 91899, 93243, 93510, 93532, 93534-36, 93539, 93543-44, 93550-53, 93560, 93563, 93584, 93586, 93590-91, 93599
- Orange County (whole county): 90620-24, 90630-33, 90638, 90680, 90720-21, 90740, 90742-43, 92602-07, 92609-10, 92612, 92614-20, 92623-30, 92637, 92646-63, 92672-79, 92683-85, 92688, 92690-94, 92697-98, 92701-08, 92711, 92728, 92735, 92780-82, 92799, 92801-09, 92811-12, 92814-17, 92821-23, 92825, 92831-38, 92840-46, 92856-57, 92859, 92861-71, 92885-87, 92899
- Riverside County: 91752, 92201-03, 92210-11, 92220, 92223, 92230, 92234-36, 92240-41, 92247-48, 92253, 92255, 92258, 92260-64, 92270, 92276, 92282, 92320, 92324, 92373, 92399, 92501-09, 92513-14, 92516-19, 92521-22, 92530-32, 92543-46, 92548, 92551-57, 92562-64, 92567, 92570-72, 92581-87, 92589-93, 92595-96, 92599, 92860, 92877-83
- San Bernardino County: 91701, 91708-10, 91729-30, 91737, 91739, 91743, 91758-59, 91761-64, 91766, 91784-86, 92305, 92307-08, 92313-18, 92321-22, 92324-25, 92329, 92331, 92333-37, 92339-41, 92344-46, 92350, 92352, 92354, 92357-59, 92369, 92371-78, 92382, 92385-86, 92391-95, 92397, 92399, 92401-08, 92410-11, 92413, 92415, 92418, 92423, 92427, 92880
- San Diego County: 91901-03, 91908-17, 91921, 91931-33, 91935, 91941-46, 91950-51, 91962-63, 91976-80, 91987, 92003, 92007-11, 92013-14, 92018-30, 92033, 92037-40, 92046, 92049, 92051-52, 92054-61, 92064-65, 92067-69, 92071-72, 92074-75, 92078-79, 92081-86, 92088, 92091-93, 92096,

92101-24, 92126-32, 92134-40, 92142-43, 92145, 92147, 92149-50, 92152-55, 92158-61, 92163, 92165-79, 92182, 92186-87, 92191-93, 92195-99

- Ventura County: 90265, 91304, 91307, 91311, 91319-20, 91358-62, 91377, 93001-07, 93009-12, 93015-16, 93020-22, 93030-36, 93040-44, 93060-66, 93094, 93099, 93252

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 Member Services. Also, the ZIP codes listed above may include ZIP codes for Post Office boxes and commercial rental mailboxes. A Post Office box or rental mailbox cannot be used to determine whether you meet the residence eligibility requirements for Senior Advantage. Your permanent residence address must be used to determine your Senior Advantage eligibility.

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 person who is having contractions, when there is inadequate time to safely transfer them to another hospital before delivery (or the transfer may pose a threat to the health or safety of the pregnant person 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).

Surrogacy Arrangement: An arrangement in which an individual agrees to become pregnant and to surrender the baby (or babies) to another person or persons who intend to raise the child (or children). The person may be impregnated in any manner including, but not limited to, artificial insemination, intrauterine insemination, in vitro fertilization, or through the surgical implantation of a fertilized egg of another person. For the purposes of this *EOC*, "Surrogacy Arrangements" includes all types of surrogacy arrangements, including traditional surrogacy arrangements and gestational surrogacy arrangements.

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

Please contact your Group for information about your plan Premiums. You must also continue to pay Medicare your monthly Medicare premium.

If you don't 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 Late Enrollment Penalty

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

The Part D late enrollment penalty is added to your plan premium. Your Group or Health Plan will inform you if the penalty applies to you.

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

- You get Extra Help from Medicare to help pay your drug costs
- You went less than 63 days in a row without creditable coverage
- You had creditable drug coverage through another source (like a former employer, union, TRICARE, or Veterans Health Administration (VA)). Your insurer or human resources department will tell you each year if your drug coverage is creditable coverage. You may get this information in a letter or in a newsletter from that plan. Keep this information because you may need it if you join a Medicare drug plan later
  - ♦ Note: any letter or notice must state that you had creditable prescription drug coverage that's expected to pay as much as Medicare's standard drug plan pays
  - ♦ **Note:** prescription drug discount cards, free clinics, and drug discount websites aren't creditable prescription drug coverage

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

- If you went 63 days or more without Part D or other creditable prescription drug coverage after you were first eligible to enroll in Part D, our plan will count the number of full months you didn't have coverage. The penalty is 1% for every month you didn't have creditable coverage. For example, if you go 14 months without coverage, the penalty percentage will be 14%
- Then Medicare determines the amount of the average monthly plan premium for Medicare drug plans in the nation from the previous year (national base beneficiary premium). For 2026, this average premium amount is $38.99
- To calculate your monthly penalty, multiply the penalty percentage by the national base beneficiary premium and round it to the nearest 10 cents. In the example here, it would be 14% times $38.99, which equals $5.45. This rounds to $5.50. This amount would be added **to the monthly plan premium for someone with a Part D late enrollment penalty**

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

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

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

Income Related Monthly Adjustment Amount

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

If you have to pay an extra IRMAA, Social Security, not your Medicare plan, will send you a letter telling you

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

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

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

Moving outside your Home Region Service Area. If you permanently move outside your Home Region Service Area, or you're temporarily absent from your Home Region Service Area for a period of more than six months in a row, you must notify us and you cannot continue your Senior Advantage membership under this *EOC*.

Send your notice to:

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

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
- Covered Services received outside of your Home Region Service Area as described under "Receiving Care Outside of Your Home Region Service Area" 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, 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 Member Services.

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:
  - biological children
  - stepchildren
  - adopted children
  - children placed with you for adoption
  - foster children if you or your Spouse have the legal authority to direct their 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 child under your family coverage (including adopted children and children placed with your Dependent child for adoption or 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

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 or 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
- If requested, you give us proof of their incapacity and dependency within 60 days after receiving our request (see "Overage Dependent certification" below in this "Eligibility as a Dependent" section)

Overage Dependent certification

Proof may be required for a Dependent to be eligible to continue coverage as an overage Dependent. If we request it, 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 an overage 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 an overage 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 an overage 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 an overage 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're eligible to enroll and what your effective date of coverage is. If you're 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're a Subscriber under this *EOC* and you have dependents who don't have Medicare Part B coverage or for some other reason aren't 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. Contact your Group for details, including eligibility and benefit information, and to request a copy of the non-Medicare plan document.

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

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 (or through an alternate, approved electronic process) 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, placement for adoption, or placement for foster care 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 of newly acquired Dependent children are effective as follows:

- Enrollments due to birth are effective on the date of birth
- Enrollments due to adoption are effective on the date of adoption
- Enrollments due to placement for adoption or foster care are effective on the date you or your Spouse have newly assumed a legal right to control health care

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
- Covered Services received outside of your Home Region Service Area as described under "Receiving Care Outside of Your Home Region Service Area" 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 Services, 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 Member Services. 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 Member Services.

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 Member Services.

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 Member Services. 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 Member Services. 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 Member Services 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.

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 Services

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 your Home Region Service Area for certain specialty Services such as a transplant or transgender surgery
- If you are outside of California and you need an abortion on an emergency or urgent basis, and the abortion can't be obtained in a timely manner due to a near total or total ban on health care providers' ability to provide such Services

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 Member Services.

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.

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 Services for Members, please visit our website at **kp.org** or call Member Services.

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 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 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.

Completion of Services. If you're undergoing treatment for specific conditions from a Plan Physician (or certain other providers) when the contract with them 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.

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, call Member Services.

Receiving Care Outside of Your Home Region Service Area

For information about your coverage when you are away from home, visit our website at **kp.org/travel**. You can also call the Away from Home Travel Line at **1-951-268-3900**, 24 hours a day, seven days a week (closed holidays).

Receiving care in another Kaiser Permanente service area

If you are visiting in another Kaiser Permanente service area, you may receive certain covered Services from designated providers in that other Kaiser Permanente service area, subject to exclusions, limitations, prior authorization or approval requirements, and reductions. For more information about receiving covered Services in another Kaiser Permanente service area, including provider and facility locations, please visit **kp.org/travel** or call our Away from Home Travel Line at **1-951-268-3900**, 24 hours a day, seven days a week (closed holidays).

Receiving care outside of any Kaiser Permanente service area

If you are traveling outside of any Kaiser Permanente service area, we cover Services 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.

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 Member Services 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

DON'T use your red, white, and blue Medicare card for covered medical Services while you're a Member of this plan. If you use your Medicare card instead of your Senior Advantage membership card, you may have to pay the full cost of medical services yourself. Keep your Medicare card in a safe place. You may be asked to show it if you need 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, Member Services 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 Member Services. The directory is updated periodically. The availability of Plan Facilities may change. If you have questions, please call Member Services.

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 Member Services)
- Same-day Urgent Care appointments are available at many locations (for Urgent Care locations, refer to our Provider Directory or call Member Services)
- Many Plan Medical Offices have evening and weekend appointments
- Many Plan Facilities have a Member Services office (for locations, refer to our Provider Directory or call Member Services)
- Plan Pharmacies are located at most Plan Medical Offices (for pharmacy locations, refer to our Pharmacy Directory or call Member Services)

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 Member Services or by visiting our website at **kp.org/directory**.

Pharmacy Directory

The 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 Pharmacy Directory, you can get a copy by calling Member Services 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 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 your Home Region 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 Member Services.

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 Member Services.

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:
  - covered Services received outside of your Home Region Service Area, as described under "Receiving Care Outside of Your Home Region Service Area" 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
  - covered Services received outside of your Home Region Service Area, as described under "Receiving Care Outside of Your Home Region Service Area" 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 hospital inpatient 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).

Provider fees

Some Plan Providers may charge you a fee for missed appointments without 24-hour advance notice, except in the case of an emergency.

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** to use our cost estimate tool or call Member Services.

- 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.
- For all other Cost Share estimates, please call Member Services

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 or Coinsurance 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 certain 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 **$1,000** 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 they each reach the **$1,000** maximum.

Payments that count toward the Plan Out-of-Pocket Maximum. Any amounts you pay for the following Services apply toward the Plan Out-of-Pocket Maximum:

- Covered in-network Medicare Part A and Part B Services
- Medicare Part B drugs (all other drugs do not apply)
- 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 Plan Out-of-Pocket Maximum. For those Services, you must continue to pay Copayments or Coinsurance even if you have already reached the Plan Out-of-Pocket Maximum. In

addition, the following **do not** apply toward the Plan Out-of-Pocket Maximum, if included in your plan:

- Chiropractic or acupuncture Services described in an amendment to this *EOC*
- Any amounts you pay that exceed the Allowance for specific Services (such as eyeglasses, contact lenses, or hearing aids)

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 $20 Copayment per visit**
- Physician Specialist Visits that are not described elsewhere in this *EOC*: **a $20 Copayment per visit**
- Outpatient visits that are available as group appointments that are not described elsewhere in this *EOC*: **a $10 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 $20 Copayment per visit**
  - Physician Specialist Visits: **a $20 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 $20 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 and related Services: **no charge**
- Physical, occupational, and speech therapy in accord with Medicare guidelines: **a $20 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 $20 Copayment per day**
- Manual manipulation of the spine to correct subluxation, in accord with Medicare guidelines, is covered by a participating chiropractor of the American Specialty Health Plans of California, Inc. (ASH Plans): **a $20 Copayment per visit**. (A referral by a Plan Physician is not required. For the list of participating ASH Plans providers, refer to the Provider Directory)

Acupuncture Services

- Acupuncture for chronic low back pain up to 12 visits in 90 days, in accord with Medicare guidelines: **a $20 Copayment per visit**. Chronic low back pain is defined as:
  - lasting 12 weeks or longer
  - non-specific, in that it has no identifiable systemic cause (i.e. not associated with metastatic, inflammatory, infectious, disease, etc)
  - not associated with surgery or pregnancy
- An additional 8 sessions covered for patients demonstrating an improvement. No more than 20 acupuncture treatments may be administered annually. Treatment must be discontinued if the patient is not improving or is regressing
- 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 $20 Copayment per visit**

Emergency Services and Urgent Care

- Urgent Care consultations, evaluations, and treatment: **a $20 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 Services" 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 $20 Copayment per procedure**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a $20 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 $20 Copayment per visit**
  - Physician Specialist Visits: **a $20 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): **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" in this "Benefits and Your Cost Share" section 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
- Mental Health Services
- Ostomy, Urological, and Specialized 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 Services

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")
- Religious Nonmedical Health Care Institution Services (refer to "Religious Nonmedical Health Care Institution")
- 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 Services 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 Services" in this "Benefits and Your Cost Share" section for the Cost Share that applies for hospital inpatient Services.

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

In general, preventive dental services (such as cleaning, routine dental exams, and dental x-rays) aren't covered by Original Medicare. However, Medicare pays for dental services in a limited number of circumstances, specifically when that service is an integral part of specific treatment of a person's primary medical condition. Examples include reconstruction of the jaw after a fracture or injury, tooth extractions done in preparation for radiation treatment for cancer involving the jaw, or oral exams prior to organ transplantation. Dental Services must be 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.

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, 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 $20 Copayment per visit**
- Physician Specialist Visits for Services covered under this "Dental Services" section: **a $20 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 $20 Copayment per procedure**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a $20 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 Services (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 Services (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 Services (refer to "Hospital Inpatient Services")
- 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 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 (or another location used as your home as defined by Medicare)
- The item is expected to last at least 3 years

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 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:

- Glucose monitors for diabetes testing and their supplies (such as 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):

- Glucose monitors for diabetes testing and their supplies (such as 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:

- 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 exclusions

- 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 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 $20 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 $20 Copayment per procedure**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a $20 Copayment per procedure**
- Outpatient imaging: **no charge**
- Outpatient laboratory: **no charge**
- Outpatient administered drugs: **no charge**

- Hospital inpatient Services (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")
- Diagnostic Services provided by Plan Providers who are not physicians, such as EKGs and EEGs (refer to "Outpatient Imaging, Laboratory, and Other Diagnostic and Treatment Services")

Fertility Services exclusions

- Reversal of surgical sterilization originally performed for family planning purposes
- 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)

Fitness benefit (One Pass®)

A fitness benefit is provided through the One Pass program to help members take control of their health and feel their best. The One Pass program includes:

- Gyms and Fitness Locations: You receive a membership with access to a wide variety of in-network gyms through the core and premium networks. Fitness locations include national, local, and community fitness centers and boutique studios. You can use any in-network location, and you may use multiple participating fitness locations during the same month
- Online Fitness: You have access to live, digital fitness classes and on-demand workouts through the One Pass member website or mobile app
- Fitness and Social Activities: You also have access to groups, clubs, and social events through the One Pass member website
- Home Fitness Kits: If you prefer to work out at home, you can select a home fitness kit for Strength, Yoga, or Dance
- Brain Health: Access to online brain health cognitive training programs

For more information about participating gyms and fitness locations, the program's benefits, or to set up your online account, visit **www.YourOnePass.com** or call **1-877-614-0618** (TTY users call **711**), Monday through Friday, 6 a.m. to 7 p.m.

One Pass® is a registered trademark of Optum, Inc. in the U.S. and other jurisdictions and is a voluntary program. The One Pass program and amenities vary by plan, area, and location. The information provided under this program is for general informational purposes only and is not intended to be nor should be construed as medical advice. One Pass is not responsible for the services or information provided by third parties. Individuals should consult an appropriate health care professional before beginning any exercise program and/or to determine what may be right for them.

Your Cost Share: You pay the following for covered fitness: **no charge**.

Fitness benefit exclusions

- Additional services (such as personal training, fee-based group fitness classes, expanded access hours, or additional classes outside of the standard membership offering)

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, contact your local Health Education Department, call Member Services 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 $20 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 $20 Copayment per visit**
- Physician Specialist Visits to diagnose and treat hearing problems: **a $20 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 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 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 specialized wound care supplies (refer to "Ostomy, Urological, and Specialized 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 exclusions

- 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. Note: Our plan covers hospice consultation services for a terminally ill person who hasn't elected the hospice benefit.

If you have Medicare Part A, you're eligible for the hospice benefit when your doctor and the hospice medical director have given you a terminal prognosis certifying that you're terminally ill and have six months or less to live if your illness runs its normal course. You can get care from any Medicare-certified hospice program. Our plan is obligated to help you find Medicare-certified hospice programs in our plan's Service Area, including programs we own, control, or have a financial interest in. 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

When you're admitted to a hospice, you have the right to stay in our plan; if you stay in our plan, you must continue to pay plan premiums.

For hospice services and services covered by Medicare Part A or B that are related to your terminal prognosis: Original Medicare (rather than our plan) will pay your hospice provider for your hospice services and any Part A and Part B services related to your terminal prognosis. While you're in the hospice program, your hospice provider will bill Original Medicare for the services Original Medicare pays for. You'll be billed Original Medicare cost sharing.

For services covered by Medicare Part A or B not related to your terminal prognosis: If you need nonemergency, non–urgently needed services covered under Medicare Part A or B that aren't related to your terminal prognosis, your cost for these services depends on whether you use a Plan Provider and follow plan rules (like if there's a requirement to get prior authorization):

- If you get the covered Services from a Plan Provider and follow plan rules for getting service, you pay only your Cost Share for in-network Services
- If you get the covered Services from a Non–Plan Provider, you pay the cost sharing under Original Medicare

For services covered by our plan but not covered by Medicare Part A or B: We will continue to cover Plan-covered Services that aren't covered under Part A or B whether or not they're related to your terminal prognosis. You pay your Cost Share for these Services.

For drugs that may be covered by our plan's Part D benefit: If these drugs are unrelated to your terminal hospice condition, you pay your Cost Share. If they're related to your terminal hospice condition, you pay Original Medicare cost-sharing. Drugs are never covered by both hospice and our plan at the same time. For more information, go to "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's not related to your terminal prognosis), contact us to arrange the services.

For more information about Original Medicare hospice coverage, visit **https://www.medicare.gov**, and view or download the publication "Medicare Hospice Benefits." Or call **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**.

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 (your Plan Pharmacy can tell you if a drug you take is one of these drugs)
- Durable medical equipment
- Respite care when necessary to relieve your caregivers. Respite care is occasional short-term inpatient Services 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 Services required at a level that cannot be provided at home

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

- Partial hospitalization
- Multidisciplinary treatment in an intensive outpatient or day-treatment 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 $20 Copayment per visit**
- Group mental health treatment: **a $10 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 and sleep studies (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 get coverage of Services to treat OUD through an Opioid Treatment Program (OTP) which includes the following Services:

- U.S. Food and Drug Administration (FDA) approved opioid agonist and antagonist medication-assisted treatment (MAT) medications and the dispensing and administration of 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 Specialized Wound Care Supplies

We cover ostomy, urological, and specialized wound care supplies if the following requirements are met:

- A Plan Physician has prescribed ostomy, urological, and specialized 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 specialized wound care supplies: **no charge**.

Ostomy, urological, and specialized wound care supplies exclusions

- 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, EEGs, and sleep studies): **no charge**
- Radiation therapy: **no charge**
- Ultraviolet light therapy 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 your Home Region 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")

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 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 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
- 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 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, 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 Pharmacy Directory, or our website at **kp.org/refill** can give you more information about obtaining refills through our mail-order service. 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 aren't able to use a Plan Pharmacy. Check first with Member Services to see if there's a Plan Pharmacy nearby.

We cover prescriptions filled at a Non–Plan Pharmacy only in these circumstances:

- 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 not covered under Medicare Part D; therefore, payments for these drugs don't 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 within the United States and its territories but outside your Home Region Service Area and you become ill or run out of your covered Part D prescription drugs, we will cover prescriptions that are filled at an out-of-network pharmacy in limited, nonroutine circumstances according to our Medicare Part D formulary guidelines
  - ♦ if you are unable to obtain a covered drug in a timely manner within your Home Region 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

If you must use a Non–Plan Pharmacy, you'll generally have to pay the full cost (rather than your normal Cost Share) at the time you fill your prescription. You can ask us to reimburse you for our share of the cost by submitting a request for reimbursement as described in the "Requests for Payment" section. You may be required to pay the difference between what you pay for the drug at the Non–Plan Pharmacy and the cost we would cover at a Plan Pharmacy.

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're enrolled in Medicare hospice and require certain drugs (e.g., anti-nausea, laxative, pain medication, or anti-anxiety drugs) that aren't covered by your hospice because it is unrelated to your terminal illness and related conditions, our plan must get notification from either the prescriber or your hospice provider that the drug is unrelated before our plan can cover the drug. To prevent delays in getting these drugs that should be covered by our plan, ask your hospice provider or prescriber to provide notification before your prescription is filled.

In the event you either revoke your hospice election or are discharged from hospice, our plan should cover 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.

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). Refer to our "Medicare Part D drug formulary (2026 Comprehensive Formulary)" in this "Outpatient Prescription Drugs, Supplies, and Supplements" section for more information about the Part D drug formulary.

Initial Coverage Stage

During the Initial Coverage Stage, we pay our share of the cost of your covered Part D drugs, and you pay your Cost Share. Your share of the cost will vary depending on the drug and where you fill your prescription. Sometimes the cost of the drug is lower than your Cost Share. In these cases, you pay the lower price for the drug instead of your Cost Share.

You stay in the Initial Coverage Stage until your total out-of-pocket costs reach **$2,100**. You then move to the Catastrophic Coverage Stage. The Part D EOB you get will help you keep track of how much you, our plan, and any third parties have spent on your behalf during the year.

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 in the Initial Coverage Stage:

- Generic drugs: **a $10 Copayment for up to a 100-day supply**
- Brand-name and specialty drugs: **a $10 Copayment for up to a 100-day supply**
- Injectable Part D vaccines: **no charge**
- Emergency contraceptive pills: **no charge**
- Insulin-administration devices (such as needles, syringes, alcohol swabs, and gauze): **a $10 Copayment for up to a 100-day supply**

Catastrophic Coverage Stage

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

Note: Each year, effective on January 1, the Centers for Medicare & Medicaid Services may change the coverage stage amounts that apply for the calendar year. We will notify you in advance of any change to your coverage.

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

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

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

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

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

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

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

- **Show your membership card every time you get a prescription filled.** This helps make sure we know about the prescriptions you fill and what you pay

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

These payments <u>are included</u> in your out-of-pocket costs. Your out-of-pocket costs **include** the payments listed below (as long as they are for covered Part D drugs, and you followed the rules for drug coverage explained in this section):

- The amount you pay for drugs when you're in the Initial Coverage Stage
- Any payments you made during this calendar year as a member of a different Medicare drug plan before you joined our plan
- Any payments for your drugs made by family or friends
- Any payments made for your drugs by Extra Help from Medicare, employer or union health plans, Indian Health Service, AIDS drug assistance programs, and most charities

These payments <u>aren't included</u> in your out-of-pocket costs. Your out-of-pocket costs **don't include** any of these types of payments:

- The amount you contribute, if any, toward your group's Premium
- Drugs you buy outside the United States and its territories
- Drugs that aren't covered by our plan
- Drugs you get at a Non–Plan Pharmacy that don't meet our plan's requirements for out-of-network coverage
- Non–Part D drugs, including prescription drugs and vaccines covered by Part A or Part B and other drugs excluded from coverage by Medicare
- Payments for your drugs made by certain insurance plans and government-funded health programs such as TRICARE and the Veterans Health Administration (VA)
- Payments for your drugs made by a third-party with a legal obligation to pay for prescription costs (for example, Workers' Compensation)
- Payments made by drug manufacturers under the Manufacturer Discount Program

Reminder: If any other organization like the ones listed above pays part or all your out-of-pocket costs for Part D drugs, you're required to tell our plan by calling Member Services.

Extra Help from Medicare

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

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

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

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

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

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

You or your appointed representative may need to provide the evidence to a 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 (CMS) updates its records to reflect your current status. Once CMS updates its records, you will no longer need to present the evidence to the Plan Pharmacy. Provide your evidence in one of the following ways so we can forward it to CMS for updating:

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

When we get the evidence showing the right Cost Share level, we'll update our system so you can pay the right amount when you get your next prescription. If you overpay your Cost Share, we'll pay you back, either by check or a future Cost Share credit. If our Plan Pharmacy didn't collect your Cost Share and you owe them a debt, 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. Call Member Services if you have questions.

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

Extra Help and coverage from an AIDS Drug Assistance Program (ADAP)

The AIDS Drug Assistance Program (ADAP) helps people living with HIV/AIDS access life-saving HIV medications. Medicare Part D drugs that are also on the ADAP formulary qualify for prescription cost-sharing help through the California AIDS Drug Assistance Program.

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

Medicare Prescription Payment Plan

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

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

If you disagree with the amount billed as part of this payment option, you can follow the steps described in

the "Coverage Decisions. Appeals, and Complaints" section to make a complaint or appeal.

Medicare Part D drug formulary (2026 Comprehensive Formulary)

Our plan has a Comprehensive Formulary (formulary). In this *EOC*, we call it the Drug List.

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

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

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

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

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

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

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

A generic drug is a prescription drug that has the same active ingredients as the brand-name drug. Biological products have alternatives called biosimilars. Generally, generics and biosimilars work just as well as the brand-name drug or original biological product and usually cost less. There are generic drug substitutes available for many brand-name drugs and biosimilar alternatives for some original biological products. Some biosimilars are interchangeable biosimilars and, depending on state law, may be substituted for the original biological product at the pharmacy without needing a new prescription, just like generic drugs can be substituted for brand-name drugs.

The references in the formulary to preferred generic, generic, brand-name, non-preferred, and specialty tier drugs do not apply to you. All the drugs in the formulary are covered the same under your plan without regard for whether they are generic, brand, non-preferred, or specialty tier drugs. Note that sometimes a drug may appear more than once on our 2026 Comprehensive Formulary. This is because different restrictions or Cost Share 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).

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

- Add or remove drugs from the Drug List
- Move a drug to a higher or lower cost-sharing tier
- Add or remove a restriction on coverage for a drug
- Replace a brand name drug with a generic version of the drug
- Replace an original biological product with an interchangeable biosimilar version of the biological product

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

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

Changes to drug coverage that affect you during this plan year:

- **Adding new drugs to the Drug List and immediately removing or making changes to a like drug on the Drug List**
  - when adding a new version of a drug to the Drug List, we may immediately remove a like drug from the Drug List, move the like drug to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions
  - we'll make these immediate changes only if we add a new generic version of a brand name or add certain new biosimilar versions of an original biological product that was already on the Drug List
  - we may make these changes immediately and tell you later, even if you take the drug that we remove or make changes to. If you take the like drug at the time we make the change, we'll tell you about any specific change we made
- **Adding drugs to the Drug List and removing or making changes to a like drug on the Drug List with advance notice**
  - when adding another version of a drug to the Drug List, we may remove a like drug from the Drug List, move it to a different cost-sharing tier, add new restrictions, or both. The new version of the drug will be on the same or a lower cost-sharing tier and with the same or fewer restrictions
  - we'll make these changes only if we add a new generic version of a brand name drug or add certain new biosimilar versions of an original biological product that was already on the Drug List
  - we'll tell you at least 30 days before we make the change, or tell you about the change and cover a 30-day fill of the version of the drug you're taking
- **Removing unsafe drugs and other drugs on the Drug List that are withdrawn from the market**
  - sometimes a drug can be deemed unsafe or taken off the market for another reason. If this happens, we may immediately remove the drug from the Drug List. If you take that drug, we'll tell you after we make the change
- **Making other changes to drugs on the Drug List**
  - we may make other changes once the year has started that affect drugs you are taking. For example, we based on FDA boxed warnings or new clinical guidelines recognized by Medicare
  - we'll tell you at least 30 days before we make these changes, or tell you about the change and cover an additional 30-day fill of the drug you're taking

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

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

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

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

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

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

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

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

- Possible medication errors
- Drugs that may not be necessary because you take another similar drug to treat the same condition
- Drugs that may not be safe or appropriate because of your age or gender

- Certain combinations of drugs that could harm you if taken at the same time
- Prescriptions for drugs that have ingredients you're allergic to
- Possible errors in the amount (dosage) of a drug you take
- Unsafe amounts of opioid pain medications

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

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

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

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

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

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

Some members who have certain chronic diseases and take medications that exceed a specific amount of drug costs or are in a DMP to help them use opioids safely, may be able to get services through an MTM program. If you qualify for the program, a pharmacist or other health professional will give you a comprehensive review of all your medications. During the review, you can talk about your medications, your costs, and any problems or questions you have about your prescription and over-the-counter medications. You'll get a written summary which has a recommended to-do list that includes steps you should take to get the best results from your medications. You'll also get a medication list that will include all the medications you're taking, how much you take, and when and why you take them. In addition, members in the MTM program will get information on the safe disposal of prescription medications that are controlled substances.

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

If we have a program that fits your needs, we'll automatically enroll you in the program and send you information. If you decide not to participate, notify us and we'll withdraw you. For questions about this program, call Member Services.

Medicare Part D exclusions. Some kinds of prescription drugs are excluded. If you get drugs that are excluded (except for drugs described under "Outpatient drugs, supplies, and supplements not covered by Medicare"), you must pay for them yourself. If you

appeal and the requested drug is found not to be excluded under Part D, we'll pay for or cover it. (For information about appealing a decision, go to the "Coverage Decisions, Appeals, and Complaints" section.) 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.

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

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

In addition, by law, the following categories of drugs aren't covered by Medicare drug plans:

- 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 requires associated tests or monitoring services be purchased only from the manufacturer as a condition of sale

If you get Extra Help to pay for your prescriptions, Extra Help won't pay for drugs that aren't normally covered. If you have drug coverage through Medicaid, your state Medicaid program may cover some prescription drugs not normally covered in a Medicare drug plan. Contact your state Medicaid program to determine what drug coverage may be available to you. (Find phone numbers and contact information for Medicaid in the "Phone Numbers and Resources" section.)

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 Plan Provider and filled at a Plan home-infusion pharmacy

Outpatient drugs covered by Medicare Part B

These drugs are covered under Part B of Original Medicare. Members of our plan get coverage for these drugs through our plan. Covered drugs include:

- Drugs that usually aren't self-administered by the patient and are injected or infused while you get physician, hospital outpatient, or ambulatory surgical center services
- Insulin furnished through an item of durable medical equipment (such as a Medically Necessary insulin pump)
- Other drugs you take using durable medical equipment (such as nebulizers) that were authorized by our plan
- The Alzheimer's drug, Leqembi® (generic name lecanemab), which is administered intravenously. In addition to medication costs, you may need additional scans and tests before and/or during treatment that could add to your overall costs. Talk to your doctor about what scans and tests you may need as part of your treatment
- Clotting factors you give yourself by injection if you have hemophilia
- Transplant/immunosuppressive drugs: Medicare covers transplant drug therapy if Medicare paid for your organ transplant. You must have Part A at the time of the covered transplant, and you must have Part B at the time you get immunosuppressive drugs. Medicare Part D drug coverage covers immunosuppressive drugs if Part B doesn't cover them
- Injectable osteoporosis drugs, if you're homebound, have a bone fracture that a doctor certifies was related to post-menopausal osteoporosis, and can't self-administer the drug
- Some antigens: Medicare covers antigens if a doctor prepares them and a properly instructed person (who

could be you, the patient) gives them under appropriate supervision

- Certain oral anti-cancer drugs: Medicare covers some oral cancer drugs you take by mouth if the same drug is available in injectable form or the drug is a prodrug (an oral form of a drug that, when ingested, breaks down into the same active ingredient found in the injectable drug) of the injectable drug. As new oral cancer drugs become available, Part B may cover them. If Part B doesn't cover them, Part D does
- Oral anti-nausea drugs: Medicare covers oral anti-nausea drugs you use as part of an anti-cancer chemotherapeutic regimen if they're administered before, at, or within 48 hours of chemotherapy or are used as a full therapeutic replacement for an intravenous anti-nausea drug
- Certain oral End-Stage Renal Disease (ESRD) drugs covered under Medicare Part B
- Intravenous Immune Globulin for the home treatment of primary immune deficiency diseases
- Calcimimetic and phosphate binder medications under the ESRD payment system, including the intravenous medication Parsabiv®, and the oral medication Sensipar®
- Certain drugs for home dialysis, including heparin, the antidote for heparin, when Medically Necessary, and topical anesthetics
- Erythropoiesis-stimulating agents: Medicare covers erythropoietin by injection if you have End-Stage Renal Disease (ESRD) or you need this drug to treat anemia related to certain other conditions (such as Procrit®, Retacrit®, Epoetin Alfa, Aranesp®, or Darbepoetin Alfa)
- Parenteral and enteral nutrition (intravenous and tube feeding)

We also cover some vaccines under Part B and most adult vaccines under our Part D drug benefit as described under "Medicare Part D drugs."

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 and specialty drugs: **a $10 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

We cover the following additional items not covered by Medicare Part B or D, in accord with our commercial drug formulary:

- 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 commercial drug formulary and prescribed by a Plan Physician
- Diaphragms, cervical caps, contraceptive rings, and contraceptive patches
- Disposable needles and syringes needed for injecting covered drugs and supplements
- 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 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*): **a $10 Copayment for up to a 100-day supply**
- Generic drugs prescribed for the treatment of sexual dysfunction disorders: **25 percent Coinsurance for up to a 100-day supply**
- Brand drugs prescribed for the treatment of sexual dysfunction disorders: **25 percent Coinsurance for up to a 100-day supply**
- Generic drugs prescribed for the treatment of infertility: **a $10 Copayment for up to a 100-day supply**
- Brand drugs prescribed for the treatment of infertility: **a $10 Copayment for up to a 100-day supply**
- 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**
- Elemental dietary enteral formula when used as a primary therapy for regional enteritis: **no charge for up to a 30-day supply**

- Ketone test strips and sugar or acetone test tablets or tapes for diabetes urine testing: **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 or Coinsurance, you will pay the lesser amount.

Commercial drug formulary. The commercial drug formulary includes a list of drugs that our Pharmacy and Therapeutics Committee has approved for our Members. Our Pharmacy and Therapeutics Committee, which is primarily composed of Plan Physicians and pharmacists, selects drugs for the drug formulary based on several factors, including safety and effectiveness as determined from a review of medical literature. The drug formulary is updated monthly based on new information or new drugs that become available. To find out which drugs are on the formulary for your plan, refer to the California Commercial HMO formulary on our website at **kp.org/formulary**. The formulary also discloses requirements or limitations that apply to specific drugs, such as whether there is a limit on the amount of the drug that can be dispensed and whether the drug must be obtained at certain specialty pharmacies. If you would like to request a copy of this drug formulary, call Member Services. Note: The presence of a drug on the drug formulary does not necessarily mean that it will be prescribed for a particular medical condition.

Our Commercial 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 "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.

Manufacturer coupon program. For outpatient prescription drugs or items that are covered under the "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**.

For the following Services, refer to these sections

- Diabetes blood-testing equipment and their supplies, and insulin pumps and their supplies (refer to "Durable Medical Equipment 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 for Home Use")
- Outpatient administered drugs (refer to "Outpatient Care")
- Vaccines covered by Medicare Part B (refer to "Preventive Services")

Outpatient prescription drugs, supplies, and supplements not covered by Medicare limitations

- The prescribing physician or dentist determines how much of a drug, supply, item, 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 for you. Upon payment of the Cost Share specified in the "Outpatient prescription drugs, supplies, and supplements," you will receive the supply prescribed up to the day supply limit specified

in this section or in the drug formulary for your plan (see "Commercial drug formulary" above). The maximum you may receive at one time of a covered item, 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

- 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
- The pharmacy may reduce the day supply dispensed at the Cost Share specified under "Outpatient prescription drugs, supplies, and supplements not covered by Medicare" for any drug 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)

Outpatient prescription drugs, supplies, and supplements not covered by Medicare exclusions

- Any requested packaging (such as dose packaging) other than the dispensing pharmacy's standard packaging
- Compounded products unless the drug is listed on one of our drug formularies 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 tobacco cessation drugs and contraceptive drugs
  - ♦ an entire class of prescription drugs when one drug within that class becomes available over-the-counter
- All drugs, supplies, and supplements related to covered assisted reproductive technology (ART) Services
- Drugs when prescribed solely for the purposes of losing weight, except when Medically Necessary for the treatment of morbid obesity. We may require Members who are prescribed drugs for morbid obesity to be enrolled in a covered comprehensive weight loss program, for a reasonable period of time prior to or concurrent with receiving the prescription drug

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 Member Services.

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: **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 screening tests: **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 Hepatitis B, flu/influenza, pneumococcal, and COVID-19 vaccines that are administered to you in a Plan Medical Office: **no charge**

- Lung cancer screening with low dose computed tomography (LDCT): **no charge**
- Medical nutrition therapy for kidney disease and diabetes: **no charge**
- Medicare diabetes prevention program (MDPP): **no charge**
- Obesity screening and therapy to promote sustained weight loss: **no charge**
- Pre-exposure prophylaxis (PrEP) for HIV prevention: **no charge**
- Prostate cancer screening exams, including digital rectal exams and Prostate Specific Antigen (PSA) tests: **no charge**
- Screening for Hepatitis C Virus infection: **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

Your Cost Share. You pay the following for other covered prosthetic and orthotic devices: **no charge**. For internally implanted prosthetic and orthotic devices, you pay the Cost Share for the procedure to implant the device. For example, see "Outpatient Care" in this "Benefits and Your Cost Share" section for the Cost Share that applies for outpatient surgery.

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 exclusions

- 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 Specialized 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 $20 Copayment per procedure**
- Any other outpatient surgery that does not require a licensed staff member to monitor your vital signs as described above: **a $20 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 Services (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 exclusions

- 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

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

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

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

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

- The facility providing the care must be certified by Medicare.
- Our plan only covers *non-religious* aspects of care.

If you get services from this institution provided to you in a facility, the following conditions apply:

- You must have a medical condition that would allow you to get covered services for inpatient hospital care or skilled nursing facility care
- *– and –* you must get approval in advance from our plan before you're admitted to the facility, or your stay won't be covered

Note: Covered Services are subject to the same limitations and Cost Share required for Services provided by Plan Providers as described in this "Benefits and Your Cost Share" section.

Services Associated with Clinical Trials

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

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

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

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

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

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

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

Get more information about joining a clinical research study in the Medicare publication Medicare and Clinical Research Studies, available at **www.Medicare.gov/sites/default/files/2019-09/02226-medicare-and-clinical-research-studies.pdf**. You can also call **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**.

Services associated with clinical trials exclusions

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

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

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 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
- Physical, occupational, and speech therapy in accord with Medicare guidelines
- Respiratory therapy

Non–Plan Skilled Nursing Facility care

Generally, you get Skilled Nursing Facility care from Plan Facilities. 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

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")

Substance Use Disorder Treatment

We cover Services specified in this "Substance Use Disorder Treatment" section only when the Services are for the preventive, 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 by a qualified clinician, including a licensed marriage and family therapist (LMFT)
- 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 $20 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 to diagnose, evaluate or treat symptoms of a stroke, regardless of your location
- Telehealth services for members with a substance use disorder or co-occurring mental health disorder, regardless of their location
- Telehealth services for diagnosis, evaluation, and treatment of mental health disorders if:
  - you have an in-person visit within 6 months prior to your first telehealth visit
  - you have an in-person visit every 12 months while getting these telehealth services
  - exceptions can be made to the above for certain circumstances
- Telehealth services for mental health visits provided by Rural Health Clinics and Federally Qualified Health Centers
- Virtual check-ins (for example, by phone or video chat) with your doctor for 5-10 minutes if:
  - you're not a new patient and
  - the check-in isn't related to an office visit in the past 7 days and
  - the check-in doesn't lead to an office visit within 24 hours or the soonest available appointment
- Evaluation of video and/or images you send to your doctor, and interpretation and follow-up by your doctor within 24 hours if:
  - you're not a new patient and
  - the evaluation isn't related to an office visit in the past 7 days and
  - the evaluation doesn't lead to an office visit within 24 hours or the soonest available appointment
- Consultation your doctor has with other doctors by phone, internet, or electronic health record

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 Member Services 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 Services" in this "Benefits and Your Cost Share" section for the Cost Share that applies for hospital inpatient Services.

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 $20 Copayment per visit**

- Physician Specialist Visits to diagnose and treat injuries or diseases of the eye: **a $20 Copayment per visit**
- Non-Physician Specialist Visits to diagnose and treat injuries or diseases of the eye: **a $20 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, 2024, 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, 2026. 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 don't 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'll provide an Allowance toward the purchase price of a replacement item of the same type (eyeglass lens, or contact lens, fitting, and dispensing) for the eye that had the .50 diopter change. The Allowance toward one of these replacement lenses is $30 for a single vision eyeglass lens or for a contact lens (including fitting and dispensing) and $45 for a multifocal or lenticular eyeglass lens.

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 exclusions

- 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 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 (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 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 doesn't 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, and services of massage therapists.

Oral nutrition and weight loss aids

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

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 don't require licenses or certificates by the state to provide health care services and where the Member's condition doesn't require that the services be provided by a licensed health care provider.

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 Member Services.

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 Emergency Department 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 Member Services 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:

The Rawlings Company
One Eden Parkway
P.O. Box 2000
LaGrange, KY 40031-2000
Fax: 1-502-753-7064
Email:
ManualFileCoordinator@rawlingscompany.com

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

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

asserted the claim against the third party. We may assign our rights to enforce our liens and other rights.

Surrogacy Arrangements

If you enter into a Surrogacy Arrangement and you or any other payee are entitled to receive monetary 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. 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:

The Rawlings Company
One Eden Parkway
P.O. Box 2000
LaGrange, KY 40031-2000
Fax: 1-502-753-7064

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 Member Services.

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

Asking Us to Pay Our Share of a Bill for Covered Medical Services or Drugs

Situations when you should ask us to pay our share for covered Services or drugs

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

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

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

When you got emergency, urgently needed medical care from a Non–Plan Provider. Outside the service area, you can get emergency or urgently needed services from any provider, whether or not the provider is a Plan Provider. In these cases:

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

When a Plan Provider sends you a bill you think you shouldn't pay. Plan Providers should always bill our plan directly and ask you only for your share of the cost. But sometimes they make mistakes and ask you to pay more than your share.

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

If you're retroactively enrolled in our plan. Sometimes a person's enrollment in our plan is retroactive. (This means that the first day of their enrollment has already passed. The enrollment date may even have occurred last year.) If you were retroactively enrolled in our plan and you paid out-of-pocket for any of your covered Services or drugs after your enrollment date, you can ask us to pay you back for our share of the costs. You need to submit paperwork, such as receipts and bills for us to handle the reimbursement.

When you use a Non–Plan Pharmacy to fill a prescription. If you go to a Non-Plan Pharmacy, the pharmacy may not be able to submit the claim directly to us. When that happens, you have to pay the full cost of your prescription.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. Remember that we only cover non-plan pharmacies in limited circumstances. Go to the "Outpatient Prescription Drugs, Supplies, and Supplements" section to learn about these circumstances. We may not pay you back the difference

between what you paid for the drug at the Non-Plan Pharmacy and the amount we'd pay at a Plan Pharmacy.

When you pay the full cost for a prescription because you don't have our plan membership card with you. If you don't have our plan membership card with you, you can ask the pharmacy to call our plan or look up our plan enrollment information. If the pharmacy can't get the enrollment information they need right away, you may need to pay the full cost of the prescription yourself.

Save your receipt and send a copy to us when you ask us to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription.

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

- For example, the drug may not be on our plan's Drug List, or it could have a requirement or restriction you didn't know about or don't think should apply to you. If you decide to get the drug immediately, you may need to pay the full cost for it
- Save your receipt and send a copy to us when you ask us to pay you back. In some situations, we may need to get more information from your doctor to pay you back for our share of the cost. We may not pay you back the full cost you paid if the cash price you paid is higher than our negotiated price for the prescription

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

How to Ask Us to Pay You Back or Pay a Bill You Got

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

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

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

  Kaiser Permanente
  Claims Department
  P.O. Box 7004
  Downey, CA 90242-7004

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

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

We'll Consider Your Request for Payment and Say *Yes* or *No*

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

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

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

If you think we made a mistake in turning down your request for payment or the amount we're paying, you can make an appeal. If you make an appeal, it means you're asking us to change the decision we made when we turned down your request for payment.

The appeals process is a formal process with detailed procedures and important deadlines. For the details on how to make this appeal, go to the "Coverage Decisions, Appeals, and Complaints" section.

Your Rights and Responsibilities

Our plan must honor your rights and cultural sensitivities

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

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

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

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

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

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

Debemos proporcionar la información de un modo adecuado para usted y que sea coherente con sus sensibilidades culturales (en idiomas distintos al inglés, en letra grande, en braille, en archivo de audio o en CD de datos)

Nuestro plan está obligado a garantizar que todos los servicios, tanto clínicos como no clínicos, se brinden de manera culturalmente competente y sean accesibles para todos los inscritos, incluidos aquellos con habilidades de lectura y dominio del inglés limitadas, discapacidad auditiva o a los miembros de diversos orígenes étnicos y culturales. Algunos ejemplos de cómo nuestro plan puede cumplir estos requisitos de accesibilidad incluyen, entre otros, proporcionar servicios de traducción, servicios de interpretación, de teletipo o TTY (teléfono de texto o teletipo).

Nuestro plan tiene servicios de interpretación disponibles sin costo para responder las preguntas de los miembros que no hablan inglés. Este documento está disponible en idiomas que no son inglés, incluso en español y, si lo necesita, en letra grande, braille, archivo de audio o CD de datos sin ningún costo. Tenemos la obligación de darle información acerca de los beneficios de nuestro plan en un formato que sea accesible y adecuado para usted. Para obtener información de una forma que se adapte a sus necesidades, llame a Servicio a los Miembros al **1-800-443-0815** (si es usuario de TTY, llame al **711**).

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

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

Si tiene algún problema para obtener información de nuestro plan en un formato que sea accesible y adecuado para usted, para ver a un especialista en salud de la mujer o para encontrar un especialista de la red, llame a Servicio a los Miembros para presentar una queja formal al **1-800-443-0815** (si es usuario de TTY, llame al **711**). También puede presentar una queja informal en Medicare llamando al **1-800-MEDICARE** (**1-800-633-4227**) o directamente con la Oficina de Derechos Civiles al **1-800-368-1019** o al TTY **1-800-537-7697**.

We must ensure you get timely access to covered Services and drugs

You have the right to choose a primary care provider (PCP) in our plan's network to provide and arrange for your covered services. You also have the right to go to a women's health specialist (such as a gynecologist, a mental health services provider, and an optometrist) without a referral, as well as other providers described in the "How to Obtain Services" section.

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

If you think you aren't getting your medical care or 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 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 this plan as well as your medical records and other medical and health information
- You have rights related to your information and controlling how your health information is used. We give you a written notice, called a Notice of Privacy Practices, that tells about these rights and explains how we protect the privacy of your health information

How do we protect the privacy of your health information?

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

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

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

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

If you have questions or concerns about the privacy of your personal health information, call Member Services.

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.

If you want any of the following kinds of information, call Member Services:

- **Information about our plan.** This includes, for example, information about our plan's financial condition
- **Information about our network providers and pharmacies**
  - you have the right to get information about the qualifications of the providers and pharmacies in our network and how we pay the providers in our network
- **Information about your coverage and the rules you must follow when using your coverage**
  - the "How to Obtain Services" and "Benefits and Your Cost Share" sections provide information regarding medical Services
  - the "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section provides information about drug coverage
- **Information about why something is not covered and what you can do about it**
  - the "Coverage Decisions, Appeals, and Complaints" section provides information on asking for a written explanation on why a medical service or drug isn't covered, or if your coverage is restricted
  - the "Coverage Decisions, Appeals, and Complaints" section also provides information on asking us to change a decision, also called an appeal

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

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

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

- **To know about all your choices.** You have the right to be told about all treatment options recommended for your condition, no matter what they cost or whether they're covered by our plan. It also includes being told about programs our plan offers to help members manage their medications and use drugs safely
- **To know about the risks.** You have the right to be told about any risks involved in your care. You must be told in advance if any proposed medical care or treatment is part of a research experiment. You always have the choice to refuse any experimental treatments
- **The right to say "no."** You have the right to refuse any recommended treatment. This includes the right to leave a hospital or other medical facility, even if your doctor advises you not to leave. You also have the right to stop taking your medication. If you refuse treatment or stop taking medication, you accept full responsibility for what happens to your body as a result

You have the right to give instructions about what's to be done if you can't make medical decisions for yourself

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

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

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

How to set up an advance directive to give instructions:

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

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

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

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

If your instructions aren't followed
If you sign an advance directive and you believe that a doctor or hospital didn't follow the instructions in it, you can file a complaint with the Quality Improvement Organization listed in the "Phone Numbers and Resources" section.

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

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

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

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

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

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

How to get more information about your rights

Get more information about your rights from these places:

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

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 Member Services with any suggestions.

Your responsibilities as a Member of our plan

Things you need to do as a Member of our plan are listed below. For questions, call Member Services.

- **Get familiar with your covered services and the rules you must follow to get these covered services**.

Use this *EOC* to learn what's covered and the rules you need to follow to get covered services

- ♦ the "How to Obtain Services" and "Benefits and Your Cost Share" sections give details about medical services
- ♦ the "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section give details about drug coverage

- **If you have any other health coverage or drug coverage in addition to our plan, you're required to tell us**.
  - ♦ the "Exclusion, Limitations, Coordination of Benefits, and Reductions" section tells you about coordinating these benefits
- **Tell your doctor and other health care providers that you're enrolled in our plan.** Show our plan membership card whenever you get medical care or drugs
- **Help your doctors and other providers help you by giving them information, asking questions, and following through on your care**
  - ♦ to help get the best care, tell your doctors and other health providers about your health problems. Follow the treatment plans and instructions you and your doctors agree on
  - ♦ make sure 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 the drugs you're taking, including over-the-counter drugs, vitamins, and supplements
  - ♦ if you have questions, be sure to ask and get an answer you can understand
- **Be considerate.** We expect our members to respect the rights of other patients. We also expect you to act in a way that helps the smooth running of your doctor's office, hospitals, and other offices
- **Pay what you owe.** As a plan member, you're responsible for these payments:
  - ♦ you must continue to pay a premium for your Medicare Part B to stay a Member of our plan
  - ♦ for most of your medical Services or drugs covered by our plan, you must pay your share of the cost when you get the Service or drug
  - ♦ if you're required to pay the extra amount for Part D because of your yearly income, you must continue to pay the extra amount directly to the government to stay a Member of our plan
- **If you move within your Home Region Service Area**, we need to know so we can keep your membership record up to date and know how to contact you
- **If you move outside our Service Area**, you can't stay a member of our plan
- If you move, tell Social Security (or the Railroad Retirement Board)

Coverage Decisions, Appeals, and Complaints

What to Do if You Have a Problem or Concern

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

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

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

The information in this "Coverage Decisions, Appeals, and Complaints" section will help you identify the right process to use and what to do.

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**). 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.

Legal terms

There are 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. To make

things easier, this section uses more familiar words in place of some legal terms.

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

Where To Get More Information and Personalized Help

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

State Health Insurance Assistance Program (SHIP)

Each state has a government program with trained counselors. The program is not connected with us or with any insurance company or health plan. The counselors at this program can help you understand which process you should use to handle a problem you're having. They can also answer questions, give you more information, and offer guidance on what to do.

The services of SHIP counselors are free. You can contact HICAP (California's SHIP) at **1-800-434-0222** (TTY **711**).

Medicare

You can also contact Medicare for help.

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

Which Process to Use for Your Problem

Is your problem or concern about your benefits or coverage?

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

- **Yes**. Go to "A Guide to Coverage Decisions and Appeals"
- **No**. Go to "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns"

A Guide to Coverage Decisions and Appeals

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

Asking for coverage decisions before you get services

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

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

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

Making an appeal

If we make a coverage decision, whether before or after you get a benefit, and you aren't satisfied, you can **appeal** the decision. An appeal is a formal way of asking

us to review and change a coverage decision we made. Under certain circumstances, you can ask for an expedited or **fast appeal** of a coverage decision. Your appeal is handled by different reviewers than those who made the original decision.

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

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

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

- You don't need to do anything to start a Level 2 appeal. Medicare rules require we automatically send your appeal for medical care to Level 2 if we don't fully agree with your Level 1 appeal
- Go to "The Level 2 appeal process" for more information about Level 2 appeals for medical care
- Part D appeals are discussed further in "Part D Drugs: How to Ask for a Coverage Decision or Make an Appeal"

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

Get help asking for a coverage decision or making an appeal

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

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

Rules and deadlines for different situations

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

- "Medical Care: How to Ask for a Coverage Decision or Make an Appeal"
- "Part D 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 You're Being Discharged Too Soon"
- "How to Ask Us to Keep Covering Certain Medical Services if You Think Your Coverage is Ending Too Soon" (applies only to these services: home health care, Skilled Nursing Facility care, and Comprehensive Outpatient Rehabilitation Facility (CORF) services)

If you're not sure which information applies to you, call Member Services. You can also get help or information from your SHIP.

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

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

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

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

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

Note: If the coverage that will be stopped is for hospital care, home health care, Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services, go to "How to Ask Us to Cover a Longer Inpatient Hospital Stay if You Think the Doctor Is Discharging You Too Soon" and "How to Ask Us to Keep Covering Certain Medical Services if You Think Your Coverage is Ending Too Soon". Special rules apply to these types of care.

How to ask for a coverage decision

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

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

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

- you may only ask for coverage for medical items and/or services (not requests for payment for items and/or services you already got)
- you can get a fast coverage decision only if using the standard deadlines could cause serious harm to your health or hurt your ability to regain function

If your doctor tells us that your health requires a fast coverage decision, we'll automatically agree to give you a fast coverage decision

If you ask for a fast coverage decision on your own, without your doctor's support, we'll decide whether your health requires that we give you a fast coverage decision. If we don't approve a fast coverage decision, we'll send you a letter that:

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

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

- Start by calling, writing, or faxing our plan to make your request for us to authorize or provide coverage for the medical care you want. You, your doctor, or your representative can do this. The "Phone Numbers and Resources" section has contact information

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

For standard coverage decisions, we use the standard deadlines.

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

- **however**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug
- if you believe we shouldn't take extra days, you can file a fast complaint. We'll give you an answer to your complaint as soon as we make the decision. (The process for making a complaint is different from the process for coverage decisions and appeals. Go to "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" for information on complaints.)

For fast coverage decisions, we use an expedited timeframe.

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

- **however**, if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug
- if you believe we shouldn't take extra days, you can file a fast complaint. Go to "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" for information on complaints.) We'll call you as soon as we make the decision
- if our answer is no to part or all of what you asked for, we'll send you a written statement that explains why we said no

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

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

How to make a Level 1 appeal

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

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

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

- If you're appealing a decision we made about coverage for care, you and/or your doctor need to decide if you need a fast appeal. If your doctor tells us that your health requires a fast appeal, we'll give you a fast appeal
- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in "Medical Care: How to Ask for a Coverage Decision or Make an Appeal"

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

- **If you're asking for a standard appeal, submit your standard appeal in writing**. The "Phone Numbers and Resources" section has contact information
- **If you're asking for a fast appeal, make your appeal in writing or call us**. The "Phone Numbers and Resources" section has contact information
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal
- **You can ask for a copy of the information regarding your medical decision. You and your doctor may add more information to support your appeal**. We're allowed to charge a fee for copying and sending this information to you

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

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to
  - ♦ if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time if your request is for a Part B drug
  - ♦ if we don't give you an answer within 72 hours (or by the end of the extended time period if we took extra days), we're required to automatically send your request on to Level 2 of the appeals process, where it will be reviewed by an independent review organization. "The Level 2 Appeal Process" explains the Level 2 appeal process
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage we agreed to within 72 hours after we get your appeal
- **If our answer is no to part or all of what you asked for**, we'll automatically forward your appeal to the independent review organization for a Level 2 appeal. The independent review organization will notify you in writing when it gets your appeal

Deadlines for a standard appeal

- For standard appeals, we must give you our answer **within 30 calendar days** after we get your appeal. If your request is for a Part B drug you didn't get yet, we'll give you our answer **within 7 calendar days** after we receive your appeal. We'll give you our decision sooner if your health condition requires us to
  - ♦ if you ask for more time, or if we need more information that may benefit you, **we can take up to 14 more calendar days** if your request is for a medical item or service. If we take extra days, we'll tell you in writing. We can't take extra time to make a decision if your request is for a Part B drug
  - ♦ if you believe we shouldn't take extra days, you can file a fast complaint. When you file a fast complaint, we'll give you an answer to your complaint within 24 hours. (Go to "How to Make a Complaint About Quality of Care, Waiting Times, Customer Service, or Other Concerns" in this section for information on complaints)
  - ♦ if we don't give you an answer by the deadline (or by the end of the extended time period), we'll send your request to a Level 2 appeal, where an independent review organization will review the appeal. Later in this section, we explain the Level 2 appeal process
- **If our answer is yes to part or all of what you asked for**, we must authorize or provide the coverage within 30 calendar days if your request is for a medical item or service, or **within 7 calendar days** if your request is for a Part B drug
- **If our plan says no to part or all of what your appeal**, we'll automatically send your appeal to the independent review organization for a Level 2 appeal

The Level 2 appeal process

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

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

Step 1: The independent review organization reviews your appeal

- We'll send the information about your appeal to this organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We're allowed to charge you a fee for copying and sending this information to you
- You have a right to give the independent review organization additional information to support your appeal
- Reviewers at the independent review organization will take a careful look at all the information about your appeal

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

- For the fast appeal, the independent review organization must give you an answer to your Level 2 appeal **within 72 hours** of when it gets your appeal
- If your request is for a medical item or service and the independent review organization needs to gather more

information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug

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

- For the standard appeal, if your request is for a medical item or service, the independent review organization must give you an answer to your Level 2 appeal **within 30 calendar days** of when it gets your appeal. If your request is for a Part B drug, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** of when it gets your appeal
- If your request is for a medical item or service and the independent review organization needs to gather more information that may benefit you, **it can take up to 14 more calendar days**. The independent review organization can't take extra time to make a decision if your request is for a Part B drug

Step 2: The independent review organization gives you its answer

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

- **If the independent review organization says yes to part or all of a request for a medical item or service**, we must authorize the medical care coverage **within 72 hours** or provide the service **within 14 calendar days** after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **72 hours** from the date we get the decision from the independent review organization
- **If the independent review organization says** yes **to part or all of a request for a Part B drug**, we must authorize or provide the Part B drug **within 72 hours** after we get the decision from the independent review organization for **standard requests**. For **expedited requests**, we have **24 hours** from the date we get the decision from the independent review organization
- **If this organization says no to part or all of your appeal**, it means it agrees with us that your request (or part of your request) for coverage for medical care shouldn't be approved. (This is called **upholding the decision** or **turning down your appeal**.) In this case, the independent review organization will send you a letter that:
  - ♦ explains the decision
  - ♦ lets you know about your right to a Level 3 appeal if the dollar value of the medical care coverage meets a certain minimum. The written notice you get from the independent review organization will tell you the dollar amount you must meet to continue the appeals process
  - ♦ tells you how to file a Level 3 appeal

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. "Taking Your Appeal to Level 3 and Beyond" explains the Levels 3, 4, and 5 appeals processes

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

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

Asking for reimbursement is asking for a coverage decision from us

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

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

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

To make this appeal, follow the process for appeals that we describe in "How to make a Level 1 Appeal." For appeals concerning reimbursement, note:

- We must give you our answer within 60 calendar days after we get your appeal. If you're asking us to pay you back for medical care you already got and paid for, you aren't allowed to ask for a fast appeal
- If the independent review organization decides we should pay, we must send you or the provider the payment within 30 calendar days. If the answer to your appeal is yes at any stage of the appeals process after Level 2, we must send the payment you asked for to you or the provider within 60 calendar days

Part D 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 include coverage for many prescription drugs. To be covered, the 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 Food and Drug Administration or supported by certain reference books.) For details about Part D drugs, rules, restrictions, and costs go to "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section. **This section is about your Part D drugs only.** To keep things simple, we generally say drug in the rest of this section, instead of repeating covered outpatient prescription drug or Part D drug every time. We also use the term Drug List instead of List of Covered Drugs or 2026 Comprehensive Formulary.

- If you don't know if a drug is covered or if you meet the rules, you can ask us. Some drugs require you to get approval from us before we'll cover it
- If your pharmacy tells you that your prescription can't be filled as written, the pharmacy will give you a written notice explaining how to contact us to ask for a coverage decision

Part D coverage decisions and appeals

An initial coverage decision about your Part D drugs is called a **coverage determination**.

A coverage decision is a decision we make about your benefits and coverage or about the amount we'll pay for your drugs. This section tells what you can do if you're in any of the following situations:

- Asking to cover a Part D drug that's not on our 2026 Comprehensive Formulary. **Ask for an exception**
- Asking to waive a restriction on our plan's coverage for a drug (such as limits on the amount of the drug you can get, prior authorization criteria, or the requirement to try another drug first). **Ask for an exception**
- Asking to pay a lower cost-sharing amount for a covered drug on a higher cost-sharing tier. **Ask for an exception**
- Asking to get pre-approval for a drug. **Ask for a coverage decision**
- Pay for a prescription drug you already bought. **Ask us to pay you back**

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

This section tells you both how to ask for coverage decisions and how to ask for an appeal.

Asking for an exception

- Asking for coverage of a drug that's not on the Drug List is a formulary exception
- Asking for removal of a restriction on coverage for a drug is a **formulary exception**
- Asking to pay a lower price for a covered non-preferred drug is a **tiering exception**

If a drug isn't covered in the way you'd like it to be covered, you can ask us to make an **exception**. An exception is a type of coverage decision.

For us to consider your exception request, your doctor or other prescriber will need to explain the medical reasons why you need the exception approved. Here are three examples of exceptions that you or your doctor or other prescriber can ask us to make:

- **Covering a Part D drug that's not on our Drug List.** If we agree to cover a drug not on the Drug List, you'll need to pay your Cost Share, which will vary depending on your plan. You can't ask for an exception to the Cost Share we require you to pay for the drug
- **Removing a restriction for a covered drug**. "Outpatient Prescription Drugs, Supplies, and Supplements" in the "Benefits and Your Cost Share" section describes the extra rules or restrictions that apply to certain drugs on our Drug List. If we agree to make an exception and waive a restriction for you, you can ask for an exception to the Cost Share we require you to pay for the drug

- **Changing coverage of a drug to a lower cost-sharing tier.** Every drug on our Drug List is in one of six cost-sharing tiers. In general, the lower the cost-sharing tier number, the less you pay as your share of the cost of the drug
  - ♦ if our Drug List contains alternative drug(s) for treating your medical condition that are in a lower cost-sharing tier than your drug, you can ask us to cover your drug at the cost-sharing amount that applies to the alternative drug(s)
  - ♦ if the drug you're taking is a biological product you can ask us to cover your drug at a lower cost-sharing amount. This would be the lowest tier that contains biological product alternatives for treating your condition
  - ♦ if the drug you're taking is a brand name drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains brand name alternatives for treating your condition
  - ♦ if the drug you're taking is a generic drug you can ask us to cover your drug at the cost-sharing amount that applies to the lowest tier that contains either brand or generic alternatives for treating your condition
  - ♦ you can't ask us to change the cost-sharing tier for any drug in Tier 5 (specialty-tier drugs)
  - ♦ if we approve your tiering exception request and there's more than one lower cost-sharing tier with alternative drugs you can't take, you usually pay the lowest amount

Important things to know about asking for exceptions

Your doctor must tell us the medical reasons

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

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

We can say yes or no to your request

- If we approve your request for an exception, our approval usually is valid until the end of our plan year. This is true as long as your doctor continues to prescribe the drug for you and that drug continues to be safe and effective for treating your condition
- If we say no to your request, you can ask for another review by making an appeal

How to ask for a coverage decision, including an exception

A fast coverage decision is called an **expedited coverage determination**.

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

Standard coverage decisions are made within **72 hours** after we get your doctor's statement. **Fast coverage decisions** are made within **24 hours** after we get your doctor's statement.

If your health requires it, ask us to give you a fast coverage decision. To get a fast coverage decision, you must meet 2 requirements:

- You must be asking for a drug you didn't get yet. (You can't ask for a fast coverage decision to be paid back for a drug you have already bought)
- Using the standard deadlines could cause serious harm to your health or hurt your ability to function
- **If your doctor or other prescriber tells us that your health requires a fast coverage decision**, we'll automatically give you a fast coverage decision
- **If you ask for a fast coverage decision on your own, without your doctor or prescriber's support, we'll decide whether your health requires that we give you a fast coverage decision.** If we don't approve a fast coverage decision, we'll send you a letter that:
  - ♦ explains that we'll use the standard deadlines
  - ♦ explains if your doctor or other prescriber asks for the fast coverage decision, we'll automatically give you a fast coverage decision
  - ♦ tells you how you can file a fast complaint about our decision to give you a standard coverage decision instead of the fast coverage decision you asked for. We'll answer your complaint within 24 hours of receipt

Step 2: Ask for a standard coverage decision or a fast coverage decision

Start by calling, writing, or faxing our plan to ask us to authorize or provide coverage for the medical care you

want. You can also access the coverage decision process through our website. We must accept any written request, including a request submitted on the CMS Model Coverage Determination Request Form, which is available on our website **kp.org**. The "Phone Numbers and Resources" section has contact information. To help us process your request, include your name, contact information, and information that shows which denied claim is being appealed.

You, or your doctor (or other prescriber), or your representative can do this. You can also have a lawyer act on your behalf. "How to Get Help When You are Asking for a Coverage Decision or Making an Appeal" tells how you can give written permission to someone else to act as your representative.

- If you're asking for an exception, provide the supporting statement which is the medical reasons for the exception. Your doctor or other prescriber can fax or mail the statement to us. Or your doctor or other prescriber can tell us on the phone and follow up by faxing or mailing a written statement if necessary

Step 3: We consider your request and give you our answer

Deadlines for a fast coverage decision

- We must generally give you our answer **within 24 hours** after we get your request
  - for exceptions, we'll give you our answer within 24 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to
  - if we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 24 hours after we get your request or doctor's statement supporting your request
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal

Deadlines for a standard coverage decision about a drug you didn't get yet

- We must generally give you our answer **within 72 hours** after we get your request
  - for exceptions, we'll give you our answer within 72 hours after we get your doctor's supporting statement. We'll give you our answer sooner if your health requires us to
  - if we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it'll be reviewed by an independent review organization
- **If our answer is yes to part or all of what you asked for**, we must **provide the coverage** we agreed to **within 72 hours** after we get your request or doctor's statement supporting your request
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal

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

- We must give you our answer **within 14 calendar days** after we get your request
  - if we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization
- **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within 14 calendar days after we get your request
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal

Step 4: If we say no to your coverage request, you can make an appeal

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

How to make a Level 1 appeal

An appeal to our plan about a Part D drug coverage decision is called a plan **redetermination**. A fast appeal is called an **expedited redetermination**.

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

A standard appeal is usually made within 7 calendar days. A fast appeal is generally made within 72 hours. If your health requires it, ask for a fast appeal

- If you're appealing a decision we made about a drug you didn't get yet, you and your doctor or other

prescriber will need to decide if you need a fast appeal

- The requirements for getting a fast appeal are the same as those for getting a fast coverage decision in "How to ask for a coverage decision, including a Part D exception"

Step 2: You, your representative, doctor, or other prescriber must contact us and make your Level 1 appeal. If your health requires a quick response, you must ask for a fast appeal

- **For standard appeals, submit a written request**. The "Phone Numbers and Resources" section has contact information
- **For fast appeals either submit your appeal in writing or call Member Services**. The "Phone Numbers and Resources" section has contact information
- **We must accept any written request**, including a request submitted on the CMS Model Redetermination Request Form, which is available on our website **kp.org**. Include your name, contact information, and information about your claim to help us process your request
- **You must make your appeal request within 65 calendar days** from the date on the written notice we sent to tell you our answer on the coverage decision. If you miss this deadline and have a good reason for missing it, explain the reason your appeal is late when you make your appeal. We may give you more time to make your appeal. Examples of good cause may include a serious illness that prevented you from contacting us or if we provided you with incorrect or incomplete information about the deadline for asking for an appeal
- **You can ask for a copy of the information in your appeal and add more information**. You and your doctor may add more information to support your appeal. We're allowed to charge a fee for copying and sending this information to you

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

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

Deadlines for a fast appeal

- For fast appeals, we must give you our answer **within 72 hours after we get your appeal**. We'll give you our answer sooner if your health requires us to
  - if we don't give you an answer within 72 hours, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. "How to make a Level 2 appeal" explains the Level 2 appeal process
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage we agreed to within 72 hours after we get your appeal
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision

Deadlines for a standard appeal for a drug you didn't get yet

- For standard appeals, we must give you our answer **within 7 calendar days** after we get your appeal. We'll give you our decision sooner if you didn't get the drug yet and your health condition requires us to do so
  - if we don't give you a decision within 7 calendar days, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization. "How to make a Level 2 appeal" explains the Level 2 appeal process
- **If our answer is yes to part or all of what you asked for**, we must provide the coverage as quickly as your health requires, but no later than **7 calendar days** after we get your appeal
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no and how you can appeal our decision

Deadlines for a standard appeal about payment for a drug you already bought

- We must give you our answer **within 14 calendar days** after we get your request
  - if we don't meet this deadline, we're required to send your request to Level 2 of the appeals process, where it will be reviewed by an independent review organization
- **If our answer is yes to part or all of what you asked for**, we're also required to make payment to you within 30 calendar days after we get your request
- **If our answer is no to part or all of what you asked for**, we'll send you a written statement that explains why we said no. We'll also tell you how you can appeal our decision

Step 4: If we say no to your appeal, you decide if you want to continue with the appeals process and make another appeal

- If you decide to make another appeal, it means your appeal is going on to Level 2 of the appeals process

How to make a Level 2 appeal

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

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

Step 1: You (or your representative or your doctor or other prescriber) must contact the independent review organization and ask for a review of your case

- If we say no to your Level 1 appeal, the written notice we send you will include **instructions on how to make a Level 2 appeal** with the independent review organization. These instructions will tell who can make this Level 2 appeal, what deadlines you must follow, and how to reach the independent review organization.
  - ♦ **you must make your appeal request within 65 calendar days** from the date on the written notice
- If we did not complete our review within the applicable timeframe or make an unfavorable decision regarding an **at-risk** determination under our drug management program, we'll automatically forward your request to the IRE
- We'll send the information about your appeal to the independent review organization. This information is called your **case file**. **You have the right to ask us for a copy of your case file**. We're allowed to charge you a fee for copying and sending this information to you
- You have a right to give the independent review organization additional information to support your appeal

Step 2: The independent review organization reviews your appeal

Reviewers at the independent review organization will take a careful look at all the information about your appeal.

Deadlines for fast appeal

- If your health requires it, ask the independent review organization for a fast appeal
- If the organization agrees to give you a fast appeal, the organization must give you an answer to your Level 2 appeal **within 72 hours** after it receives your appeal request

Deadlines for standard appeal

- For standard appeals, the independent review organization must give you an answer to your Level 2 appeal **within 7 calendar days** after it receives your appeal if it is for a drug you didn't get yet. If you're asking us to pay you back for a drug you already bought, the independent review organization must give you an answer to your Level 2 appeal **within 14 calendar days** after it gets your request

Step 3: The independent review organization gives you its answer

For fast appeals:

- **If the independent review organization says yes to part or all of what you asked for**, we must provide the drug coverage that was approved by the independent review organization **within 24 hours** after we get the decision from the independent review organization

For standard appeals:

- **If the independent review organization says yes to part or all of your request for coverage**, we must **provide the drug coverage** that was approved by the independent review organization **within 72 hours** after we get the decision from the independent review organization
- **If the independent review organization says yes to part or all of your request to pay you back** for a drug you already bought, we're required to **send payment to you** within 30 calendar days after we get the decision from the independent review organization

What if the independent review organization says *no* to your appeal?

If this organization says no to **part or all of** your appeal, it means they agree with our decision not to approve your request (or part of your request). (This is called **upholding the decision**. It's also called **turning down your appeal**.) In this case, the independent review organization will send you a letter that:

- Explains the decision

- Lets you know about your right to a Level 3 appeal if the dollar value of the drug coverage you're asking for meets a certain minimum. If the dollar value of the drug coverage you're asking for is too low, you can't make another appeal and the decision at Level 2 is final
- Tells you the dollar value that must be in dispute to continue with the appeals process

Step 4: If your case meets the requirements, you choose whether you want to take your appeal further

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal)
- If you want to go on to a Level 3 appeal the details on how to do this are in the written notice you get after your Level 2 appeal decision
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. "Taking Your Appeal to Level 3 and Beyond" tells 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 You're Being Discharged Too Soon

When you're admitted to a hospital, you have the right to get all covered hospital Services necessary to diagnose and treat your illness or injury.

During your covered hospital stay, your doctor and the hospital staff will work with you to prepare for the day you leave the hospital. They'll help arrange for care you may need after you leave.

- The day you leave the hospital is called your **discharge date**
- When your discharge date is decided, your doctor or the hospital staff will tell you
- If you think you're being asked to leave the hospital too soon, you can ask for a longer hospital stay and your request will be considered

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

Within 2 calendar days of being admitted to the hospital, you'll be given a written notice called *An Important Message from Medicare about Your Rights.* Everyone with Medicare gets a copy of this notice If you don't get the notice from someone at the hospital (for example, a caseworker or nurse), ask any hospital employee for it. If you need help, call Member Services or **1-800-MEDICARE** (**1-800-633-4227**) (TTY users call **1-877-486-2048**).

- **Read this notice carefully and ask questions if you don't understand it.** It tells you:
  - your right to get Medicare-covered services during and after your hospital stay, as ordered by your doctor. This includes the right to know what these services are, who will pay for them, and where you can get them
  - your right to be involved in any decisions about your hospital stay
  - where to report any concerns you have about the quality of your hospital care
  - your right to **request an immediate review** of the decision to discharge you if you think you're being discharged from the hospital too soon. This is a formal, legal way to ask for a delay in your discharge date so we'll cover your hospital care for a longer time
- **You'll be asked to sign the written notice to show that you got it and understand your rights**
  - you or someone who is acting on your behalf will be asked to sign the notice
  - signing the notice shows only that you got the information about your rights. The notice doesn't give your discharge date. Signing the notice **doesn't mean** you're agreeing on a discharge date
- **Keep your copy** of the notice so you have the information about making an appeal (or reporting a concern about quality of care) if you need it
  - if you sign the notice more than 2 calendar days before your discharge date, you'll get another copy before you're scheduled to be discharged
  - to look at a copy of this notice in advance, call Member Services or **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**. You can also get the notice online at **www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im**

How to make a Level 1 appeal to change your hospital discharge date

To ask us to cover your inpatient hospital services for a longer time, use the appeals process to make this request. Before you start, understand what you need to do and what the deadlines are.

- **Follow the process**
- **Meet the deadlines**
- **Ask for help if you need it.** If you have questions or need help, call Member Services. Or call your State Health Insurance Assistance Program (SHIP) for personalized help. California's SHIP is known as the

Health Insurance Counseling and Advocacy Program (**www.aging.ca.gov/HICAP/**). SHIP contact information is available in the "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.

The **Quality Improvement Organization** is a group of doctors and other health care professionals paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing hospital discharge dates for people with Medicare. These experts aren't part of our plan.

Step 1: Contact the Quality Improvement Organization for your state and ask for an immediate review of your hospital discharge. You must act quickly

How can you contact this organization?

- The written notice you got (*An Important Message from Medicare About Your Rights*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in the "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**
  - **if you meet this deadline**, you can stay in the hospital after your discharge date without paying for it while you wait to get the decision from the Quality Improvement Organization
  - **if you don't meet this deadline, contact us**. If you decide to stay in the hospital after your planned discharge date, you may have to pay the costs for hospital care you get after your planned discharge date

Once you ask for an immediate review of your hospital discharge, the Quality Improvement Organization will contact us. By noon of the day after we're contacted, we'll give you a **Detailed Notice of Discharge**. This notice gives your planned discharge date and explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date.

You can get a sample of the **Detailed Notice of Discharge** by calling Member Services or **1-800-MEDICARE** (**1-800-633-4227**). TTY users call **1-877-486-2048**. Or you can get a sample notice online at **www.CMS.gov/Medicare/forms-notices/beneficiary-notices-initiative/ffs-ma-im**.

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

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you (or your representative) why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want
- The reviewers will also look at your medical information, talk with your doctor, and review information that we and the hospital gave them
- By noon of the day after the reviewers told us of your appeal, you'll get a written notice from us that gives your planned discharge date. This notice also explains in detail the reasons why your doctor, the hospital, and we think it is right (medically appropriate) for you to be discharged on that date

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

What happens if the answer is yes?

- If the independent review organization says *yes*, **we must keep providing your covered inpatient hospital services for as long as these services are medically necessary**
- You'll have to keep paying your share of the costs (such as Cost Share, if applicable). In addition, there may be limitations on your covered hospital services

What happens if the answer is no?

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

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

- If the Quality Improvement Organization said *no* to your appeal, *and* you stay in the hospital after your planned discharge date, you can make another appeal. Making another appeal means you are going on to *Level 2* of the appeals process

How to make a Level 2 appeal to change your hospital discharge date

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at its decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your stay after your planned discharge date.

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

- You must ask for this review **within 60 calendar days** after the day the Quality Improvement Organization said no to your Level 1 appeal. You can ask for this review only if you stay in the hospital after the date your coverage for the care ended

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

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

Step 3: Within 14 calendar days of receipt of your request for a Level 2 appeal, the reviewers will decide on your appeal and tell you their decision

If the independent review organization says yes:

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

If the independent review organization says no:

- It means they agree with the decision they made on your Level 1 appeal. This is called upholding the decision
- The notice you get will tell you in writing what you can do if you want to continue with the review process

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

- There are 3 additional levels in the appeals process after Level 2 (for a total of 5 levels of appeal). If you want to go to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. The "Taking Your Appeal to Level 3 and Beyond" section tells 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

When you're getting covered **home health services, Skilled Nursing Facility care, or rehabilitation care (Comprehensive Outpatient Rehabilitation Facility)**, you have the right to keep getting your services for that type of care for as long as the care is needed to diagnose and treat your illness or injury.

When we decide it's time to stop covering any of these 3 types of care for you, we're required to tell you in advance. When your coverage for that care ends, *we'll stop paying our share of the cost for your care.*

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

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

The **Notice of Medicare Non-Coverage** tells how you can ask for a **fast-track appeal**. Asking for a fast-track appeal is a formal, legal way to ask for a change to our coverage decision about when to stop your care.

- **You get a notice in writing** at least 2 calendar days before our plan is going to stop covering your care. The notice tells you:
  - the date when we'll stop covering the care for you
  - how to ask for a fast-track appeal to ask us to keep covering your care for a longer period of time

- **You, or someone who is acting on your behalf, will be asked to sign the written notice to show that you got.** Signing the notice shows *only* that you have got the information about when your coverage will stop. **Signing it doesn't mean you agree** with our plan's decision to stop care

How to make a Level 1 appeal to have our plan cover your care for a longer time

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

- **Follow the process**
- **Meet the deadlines**
- **Ask for help if you need it**. If you have questions or need help, call Member Services. Or call your State Health Insurance Assistance Program (SHIP) for personalized help. California's SHIP is known as the Health Insurance Counseling and Advocacy Program (**www.aging.ca.gov/HICAP/**). SHIP contact information is available in the "Phone Numbers and Resources" section

During a Level 1 appeal, the Quality Improvement Organization reviews your appeal. It decides if the end date for your care is medically appropriate.

The **Quality Improvement Organization** is a group of doctors and other health care experts paid by the federal government to check on and help improve the quality of care for people with Medicare. This includes reviewing plan decisions about when it's time to stop covering certain kinds of medical care. These experts aren't part of our plan.

Step 1: Make your Level 1 appeal: contact the Quality Improvement Organization and ask for a fast-track appeal. You must act quickly

How can you contact this organization?

- The written notice you got (*Notice of Medicare Non-Coverage*) tells you how to reach this organization. Or find the name, address, and phone number of the Quality Improvement Organization for your state in the "Phone Numbers and Resources" section

Act quickly

- You must contact the Quality Improvement Organization to start your appeal **by noon of the day before the effective date** on the *Notice of Medicare Non-Coverage*.
- If you miss the deadline, and you want to file an appeal, you still have appeal rights. Contact the Quality Improvement Organization using the contact information on the *Notice of Medicare Non-Coverage*. The name, address, and phone number of the Quality Improvement Organization for your state may also be found in the "Phone Numbers and Resources" section

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

The **Detailed Explanation of Non-Coverage** gives details on reasons for ending coverage.

What happens during this review?

- Health professionals at the Quality Improvement Organization (the reviewers) will ask you or your representative why you believe coverage for the services should continue. You don't have to prepare anything in writing, but you can if you want
- The independent review organization will also look at your medical information, talk with your doctor, and review information our plan gives them
- By the end of the day the reviewers tell us of your appeal, you'll get the *Detailed Explanation of Non-Coverage* from us that explains in detail our reasons for ending our coverage for your services.

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

What happens if the reviewers say yes?

- If the reviewers say *yes* to your appeal, then **we must keep providing your covered services for as long as it's medically necessary**
- You'll have to keep paying your share of the costs (such as Cost Share, if applicable). There may be limitations on your covered services

What happens if the reviewers say no?

- If the reviewers say *no,* then **your coverage will end on the date we told you**
- If you decide to keep getting the home health care, or Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services after this date when your coverage ends, **you'll have to pay the full cost** of this care yourself

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

- If reviewers say *no* to your Level 1 appeal, and you choose to continue getting care after your coverage

for the care has ended, then you can make a Level 2 appeal

How to make a Level 2 appeal to have our plan cover your care for a longer time

During a Level 2 appeal, you ask the Quality Improvement Organization to take another look at the decision on your first appeal. If the Quality Improvement Organization turns down your Level 2 appeal, you may have to pay the full cost for your home health care, or Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services **after** the date when we said your coverage would end.

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

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

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

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

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

What happens if the independent review organization says yes?

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

What happens if the independent review organization says no?

- It means they agree with the decision made to your Level 1 appeal
- The notice you get will tell you in writing what you can do if you want to continue with the review process. It will give you details about how to go to the next level of appeal, which is handled by an Administrative Law Judge or attorney adjudicator

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

- There are 3 additional levels of appeal after Level 2, for a total of 5 levels of appeal. If you want to go on to a Level 3 appeal, the details on how to do this are in the written notice you get after your Level 2 appeal decision
- The Level 3 appeal is handled by an Administrative Law Judge or attorney adjudicator. "Taking Your Appeal to Level 3 and Beyond" in this "Coverage Decisions, Appeals, and Complaints" section tells more about Levels 3, 4, and 5 of the appeals process

Taking Your Appeal to Levels 3, 4, and 5

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

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the dollar value of the item or medical service you appealed meets certain minimum levels, you may be able to go on to additional levels of appeal. If the dollar value is less than the minimum level, you can't appeal any further. The written response you get to your Level 2 appeal will explain how to make a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer

- **If the Administrative Law Judge or attorney adjudicator says yes to your appeal, the appeals process *may or may not* be over**. Unlike a decision at a Level 2 appeal, we have the right to appeal a Level 3 decision that's favorable to you. If we decide to appeal, it will go to a Level 4 appeal
  - if we decide *not* to appeal, we must authorize or provide you with the medical care within 60 calendar days after we get the Administrative Law Judge's or attorney adjudicator's decision
  - if we decide to appeal the decision, we'll send you a copy of the Level 4 appeal request with any accompanying documents. We may wait for the Level 4 appeal decision before authorizing or providing the medical care in dispute

- **If the Administrative Law Judge or attorney adjudicator says no to your appeal, the appeals process *may or may not* be over**
  - ♦ if you decide to accept the decision that turns down your appeal, the appeals process is over
  - ♦ if you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal

Level 4 appeal

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

- **If the answer is yes, or if the Council denies our request to review a favorable Level 3 appeal decision, the appeals process *may or may not* be over**. Unlike a decision at Level 2, we have the right to appeal a Level 4 decision that is favorable to you. We'll decide whether to appeal this decision to Level 5
  - ♦ if we decide *not* to appeal the decision, we must authorize or provide you with the medical care within 60 calendar days after getting the Council's decision
  - ♦ if we decide to appeal the decision, we'll let you know in writing
- **If the answer is no or if the Council denies the review request, the appeals process *may or may not* be over**
  - ♦ if you decide to accept this decision that turns down your appeal, the appeals process is over
  - ♦ if you don't want to accept the decision, you may be able to continue to the next level of the review process. If the Council says no to your appeal, the notice you get will tell you whether the rules allow you to go to a Level 5 appeal and how to continue with a Level 5 appeal

Level 5 appeal

A judge at the **Federal District Court** will review your appeal

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court

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

This section may be right for you if you made a Level 1 appeal and a Level 2 appeal, and both of your appeals were turned down.

If the value of the Part D drug you appealed meets a certain dollar amount, you may be able to go to additional levels of appeal. If the dollar amount is less, you can't appeal any further. The written response you get to your Level 2 appeal will explain who to contact and what to do to ask for a Level 3 appeal.

For most situations that involve appeals, the last 3 levels of appeal work in much the same way as the first 2 levels. Here's who handles the review of your appeal at each of these levels.

Level 3 appeal

An **Administrative Law Judge** or an attorney adjudicator who works for the federal government will review your appeal and give you an answer

- **If the answer is yes, the appeals process is over**. We must **authorize or provide the drug coverage** that was approved by the Administrative Law Judge or attorney adjudicator **within 72 hours (24 hours for expedited appeals) or make payment no later than 30 calendar days** after we get the decision
- **If the answer is no, the appeals process *may or may not* be over**
  - ♦ If you decide to accept the decision that turns down your appeal, the appeals process is over
  - ♦ If you don't want to accept the decision, you can continue to the next level of the review process. The notice you get will tell you what to do for a Level 4 appeal

Level 4 appeal

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

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

Level 5 appeal

A judge at the **Federal District Court** will review your appeal

- A judge will review all the information and decide *yes* or *no* to your request. This is a final answer. There are no more appeal levels after the Federal District Court

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

What kinds of problems are handled by the complaint process?

The complaint process is *only* used for certain types of problems. This includes problems about quality of care, waiting times, and customer service. Here are examples of the kinds of problems handled by the complaint process:

- **Quality of your medical care**
  - ♦ are you unhappy with the quality of care you got (including care in the hospital)?
- **Respecting your privacy**
  - ♦ did someone not respect your right to privacy or share confidential information?
- **Disrespect, poor customer service, or other negative behaviors**
  - ♦ has someone been rude or disrespectful to you?
  - ♦ are you unhappy with our Member Services?
  - ♦ do you feel you're being encouraged to leave our plan?
- **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 or exam room, or getting a prescription
- **Cleanliness**
  - ♦ are you unhappy with the cleanliness or condition of a clinic, hospital, or doctor's office?
- **Information you get from our plan**
  - ♦ did we fail to give you a required notice?
  - ♦ is our written information hard to understand?
- **Timeliness (these types of complaints are all about the timeliness of our actions related to coverage decisions and appeals).** If you asked for a coverage decision or made an appeal, and you think we aren't responding quickly enough, you can make a complaint about our slowness. Here are examples:
  - ♦ you asked us for a fast coverage decision or a fast appeal, and we said no; you can make a complaint
  - ♦ you believe we aren't meeting the deadlines for coverage decisions or appeals; you can make a complaint
  - ♦ you believe we aren't meeting deadlines for covering or reimbursing you for certain medical services or drugs that were approved; you can make a complaint
  - ♦ you believe we failed to meet required deadlines for forwarding your case to the independent review organization; you can make a complaint

How to make a complaint

- A **complaint** is also called a **grievance**
- **Making a complaint** is called **filing a grievance**
- **Using the process for complaints** is called **using the process for filing a grievance**
- A **fast complaint** is called an **expedited grievance**

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

- **Calling Member Services is usually the first step**. If there's anything else you need to do, Member Services will let you know
- **If you don't want to call (or you called and weren't satisfied), you can put your complaint in writing and send it to us**. If you put your complaint in writing, we'll respond to your complaint in writing. We'll also respond in writing when you make a complaint by phone if you request a written response or your complaint is related to quality of care
- **If you have a complaint, we'll try to resolve your complaint over the phone**. If we 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're dissatisfied with the services you received. Go to the "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 for medical care or items, or if we extend the time we need to make a decision about a coverage decision or appeal for medical care or items. We must respond to your fast grievance **within 24 hours**

- The **deadline** for making a complaint is 60 calendar days from the time you had the problem you want to complain about

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

- **If possible, we'll answer you right away**. If you call us with a complaint, we may be able to give you an answer on the same phone call
- **Most complaints are answered within 30 calendar days**. If we need more information and the delay is in your best interest or if you ask for more time, **we can take up to 14 more calendar days** (44 calendar days total) to answer your complaint. If we decide to take extra days, we'll tell you in writing
- **If you're making a complaint because we denied your request for a fast coverage decision or a fast appeal, we'll automatically give you a fast complaint.** If you have a fast complaint, it means we'll give you **an answer within 24 hours**
- **If we don't agree** with some or all of your complaint or don't take responsibility for the problem you're complaining about, we'll include our reasons in our response to you

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

When your complaint is about *quality of care*, you have 2 extra options:

- **You can make your complaint directly to the Quality Improvement Organization**. The Quality Improvement Organization is a group of practicing doctors and other health care experts paid by the federal government to check and improve the care given to Medicare patients. The "Phone Numbers and Resources" section has contact information
- **Or you can make your complaint to both the Quality Improvement Organization and us at the same time**

You can also tell Medicare about your complaint

You can submit a complaint about our plan directly to Medicare. To submit a complaint to Medicare, go to **www.medicare.gov/my/Medicare-complaint**. You can also call **1-800-MEDICARE (1-800-633-4227)**. TTY/TDD users call **1-877-486-2048**.

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 Member Services.

Initiating arbitration

Claimants shall initiate arbitration by serving a Demand for Arbitration. The Demand for Arbitration shall include the basis of the claim against the Respondents; the amount of damages the Claimants seek in the arbitration; the names, addresses, and 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, Professional & Public Liability
> 393 E. Walnut St.
> Pasadena, CA 91188

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

Filing fee

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

Any Claimant who claims extreme hardship may request that the Office of the Independent Administrator waive the filing fee and the neutral arbitrator's fees and expenses. A Claimant who seeks such waivers shall complete the Fee Waiver Form and submit it to the Office of the Independent Administrator and simultaneously serve it upon the Respondents. The Fee

Waiver Form sets forth the criteria for waiving fees and is available by calling Member Services.

Number of arbitrators

The number of arbitrators may affect the Claimants' responsibility for paying the neutral arbitrator's fees and expenses (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, 2027, your last minute of coverage was at 11:59 p.m. on December 31, 2026). 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 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, 2027, your last minute of coverage was at 11:59 p.m. on December 31, 2026.

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're required to pay the extra Part D amount because of your income and you don't pay it, Medicare will disenroll you from our Senior Advantage Plan and you'll lose drug coverage.

Note: If you lose eligibility for Senior Advantage due to any of these circumstances, you may be eligible to transfer your membership to another Kaiser Permanente plan offered by your Group. 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**
- Sending written notice to the following address:
  Kaiser Permanente
  Medicare Unit
  P.O. Box 232400
  San Diego, CA 92193-2400

Other Medicare Health Plans. If you want to enroll in another Medicare Health Plan or a Medicare prescription drug plan, you should first confirm with the other plan and your Group that you're able to enroll. 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 won't need to send us a disenrollment request.

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

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

Note: If you disenroll from Medicare drug coverage and go without creditable prescription drug coverage for 63 or more days in a row, you may need to pay a Part D late enrollment penalty if you join a Medicare drug plan later.

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'll send you advance written notice and advise you of your health care options. Also, you may be eligible to transfer your membership to another Kaiser Permanente plan offered by your Group.

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 we do not receive 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'll terminate just the particular product by sending you written notice at least 90 days before the product terminates. If we discontinue offering all products in the group market, we may terminate your Group's *Agreement* by sending you written notice at least 180 days before the *Agreement* terminates.

Payments after Termination

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

- Refund any amounts we owe 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 Member Services 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, 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 birthing person 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 birthing person's or newborn's attending provider, after consulting with the birthing person, from discharging the birthing person or their 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 Member Services 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 Member Services 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. The Subscriber is also responsible for notifying Group of any change in contact information.

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 Member Services. 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.

Phone Numbers and Resources

Kaiser Permanente Senior Advantage contacts

For help with claims, billing, or member card questions, call or write to our plan's Member Services. We'll 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 ask for a coverage decision or appeal, or make a complaint about your medical care

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

You can make a complaint about us or one of our network providers, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes.

For more information on how to ask for coverage decisions or appeals, or make a complaint about your medical care, go to the "Coverage Decisions, Appeals, and Complaints" section.

Coverage Decisions, Appeals, or Complaints for Medical Care – 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., seven days a week.

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

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 ask for a coverage decision about your Part D drugs

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

Coverage Decisions for Part D drugs – Contact Information

Call **1-888-791-7213**

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 2975
Mission, KS 66201

Website kp.org

How to ask for an appeal about your Part D drugs

An appeal is a formal way of asking us to review and change a coverage decision. For more information on how to ask for appeals about your Part D drugs, go to the "Coverage Decisions, Appeals, and Complaints" section.

Appeals for Part D 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, 8:30 a.m. to 5 p.m.

Fax **1-866-206-2974**

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

Website kp.org

How to make a complaint about your Part D drugs

You can make a complaint about us or one of our network pharmacies, including a complaint about the quality of your care. This type of complaint doesn't involve coverage or payment disputes. For more information on how to make a complaint about your Part D drugs, go to the "Coverage Decisions, Appeals, and Complaints" section.

Complaints about Part D drugs – Contact Information

Call **1-800-443-0815**

Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.

If your complaint qualifies for a fast decision, call the Part D Unit at **1-866-206-2973**, 8:30 a.m. to 5 p.m.,
seven days a week. Go to 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
Medicare Part D Unit
P.O. Box 1809
Pleasanton, CA 94566

Medicare Website To submit a complaint about our plan directly to Medicare, go to **https://www.Medicare.gov/MedicareComplaintForm/home.aspx**.

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

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

If you send us a payment request and we deny any part of your request, you can appeal our decision. Go to 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're requesting payment of a Part D drug that was prescribed by a Plan Provider and obtained from a Plan Pharmacy, call our Part D unit at **1-866-206-2973**, 8:30 a.m. to 5 p.m., seven days a week.

TTY **711**

Calls to this number are free. Seven days a week, 8 a.m. to 8 p.m.

Write **For medical care:**

Kaiser Permanente
Claims Department
P.O. Box 7004
Downey, CA 90242-7004

For Part D drugs:

If you're 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
Medicare Part D Unit
P.O. Box 1809
Pleasanton, CA 94566

Website **kp.org**

Get help from Medicare

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

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

Medicare – Contact Information

Call **1-800-MEDICARE (1-800-633-4227)**

Calls to this number are free. 24 hours a day, 7 days a week.

TTY **1-877-486-2048**

This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number are free.

Chat Live Chat Live at **www.Medicare.gov/talk-to-someone**.

Write Medicare
P.O. Box 1270
Lawrence, KS 66044

Website **https://www.Medicare.gov**

- Get information about the Medicare health and drug plans in your area, including what they cost and what services they provide
- Find Medicare-participating doctors or other health care providers and suppliers
- Find out what Medicare covers, including preventive services (like screenings, shots or vaccines, and yearly "Wellness" visits)
- Get Medicare appeals information and forms
- Get information about the quality of care provided by plans, nursing homes, hospitals, doctors, home health agencies, dialysis facilities, hospice centers, inpatient rehabilitation facilities, and long-term care hospitals
- Look up helpful websites and phone numbers

You can also visit **https://www.Medicare.gov** to tell Medicare about any complaints you have about our plan.

To submit a complaint to Medicare, go to **https://www.Medicare.gov/my/medicare-complaint**. Medicare takes your complaints seriously and will use this information to help improve the quality of the Medicare program.

State Health Insurance Assistance Program (SHIP)

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

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

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

Health Insurance Counseling and Advocacy Program (California's SHIP) – Contact Information

Call **1-800-434-0222**

TTY **711**

Write Your HICAP office for your county.

Website **www.aging.ca.gov/HICAP/**

Quality Improvement Organization (QIO)

A designated Quality Improvement Organization (QIO) serves people with Medicare in each state. For California, the Quality Improvement Organization is called Commence Health. Commence Health has a group of doctors and other health care professionals paid by Medicare to check on and help improve the quality of care for people with Medicare. Commence Health is an independent organization. It's not connected with our plan.

Contact Commence Health in any of these situations:

- You have a complaint about the quality of care you got. Examples of quality-of-care concerns include getting the wrong medication, unnecessary tests or procedures, or a misdiagnosis
- You think coverage for your hospital stay is ending too soon
- You think coverage for your home health care, Skilled Nursing Facility care, or Comprehensive Outpatient Rehabilitation Facility (CORF) services is ending too soon

Commence Health (California's Quality Improvement Organization) – Contact Information

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

Calls to this number are free. Monday through Friday, 9 a.m. to 5 p.m. Weekends and holidays, 10 a.m. to 4 p.m.

TTY **711**

Write Commence Health
BFCC– QIO Program
P.O. Box 2687
Virigina Beach, VA 23450

Website **https://www.livantaqio.cms.gov/en**

Social Security

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

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

Social Security – Contact Information

Call **1-800-772-1213**

Calls to this number are free. Available 8 a.m. to 7 p.m., Monday through Friday.

Use Social Security's automated telephone services to get recorded information and conduct some business 24 hours a day.

TTY **1-800-325-0778**

This number requires special telephone equipment and is only for people who have difficulties with hearing or speaking. Calls to this number are free. Available 8 a.m. to 7 p.m., Monday through Friday.

Website **www.SSA.gov**

Medicaid

Medicaid is a joint federal and state government program that helps with medical costs for certain people with limited incomes and resources. Some people with Medicare are also eligible for Medicaid. Medicaid offers programs to help people with Medicare pay their Medicare costs, such as their Medicare premiums. These **Medicare Savings Programs** include:

- **Qualified Medicare Beneficiary (QMB):** Helps pay Medicare Part A and Part B premiums, and other Cost 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 Medicare Savings Programs, contact Medi-Cal.

Medi-Cal (California's Medicaid program) – Contact Information

Call **1-800-430-4263**

Calls to this number are free. Monday through Friday, 8 a.m. to 6 p.m.

TTY **1-800-430-7077**

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

Write CA Department of Health Care Services
Health Care Options
P.O. Box 989009
West Sacramento, CA 95798-9850

Website **www.healthcareoptions.dhcs.ca.gov/**

Railroad Retirement Board (RRB)

The Railroad Retirement Board is an independent federal agency that administers comprehensive benefit programs for the nation's railroad workers and their families. If you get Medicare through the Railroad Retirement Board, let them know if you move or change your mailing address. For questions about your benefits from the Railroad Retirement Board, contact the agency.

Railroad Retirement Board (RRB) – Contact Information

Call **1-877-772-5772**

Calls to this number are free.

Press "0," to speak with an RRB representative from 9 a.m. to 3:30 p.m., Monday, Tuesday, Thursday, and Friday, and from 9 a.m. to 12 p.m. on Wednesday.

Press "1," to access the automated RRB HelpLine and get recorded information 24 hours a day, including weekends and holidays.

TTY **1-312-751-4701**

This number requires special telephone equipment and is only for people who have difficulties hearing or speaking. Calls to this number aren't free.

Website **https://RRB.gov/**

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.

Important Notices

Notice of Language Assistance

English: ATTENTION. Timely language assistance is available at no cost to you. You can ask for interpreter services, including sign language interpreters. You can ask for materials translated into your language or alternative formats, such as braille, audio, or large print. You can also request auxiliary aids and devices at our facilities. Call our Member Services department for help. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week
- All others: **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week

Arabic: انتباه المساعدة اللغوية متوفرة في الوقت المناسب بدون تكلفة عليك. يمكنك طلب خدمات الترجمة، بما في ذلك مترجمي لغة الإشارة. يمكنك طلب وثائق مترجمة بلغتك أو بصيغ بديلة مثل طريقة برايل للمكفوفين أو ملف صوتي أو الطباعة بأحرف كبيرة. يمكنك أيضًا طلب وسائل مساعدة وأجهزة مساعدة في مرافقنا. اتصل مع قسم خدمات الأعضا (Member Services) لدينا للحصول على المساعدة. قسم خدمات الأعضاء مغلق أيام العطلات الرئيسية.

- Medicare، بما في ذلك D-SNP على: **1-800-443-0815** (TTY **711**)، 8 صباحاً إلى 8 مساءً، 7 أيام في الأسبوع
- Medi-Cal: على **1-855-839-7613** (TTY **711**)، 24 ساعة في اليوم، 7 أيام في الأسبوع
- الآخرين جميعاً: **1-800-464-4000** (TTY **711**)، 24 ساعة في اليوم، 7 أيام في الأسبوع

Armenian: ՈՒՇԱԴՐՈՒԹՅՈՒՆ: Ժամանակին տրամադրվող լեզվական աջակցությունը հասանելի է ձեզ անվճար: Դուք կարող եք խնդրել բանավոր թարգմանության ծառայություններ, այդ թվում՝ ժեստերի լեզվի թարգմանիչներ: Դուք կարող եք խնդրել ձեր լեզվով թարգմանված նյութեր կամ այլընտրանքային ձևաչափեր, ինչպիսիք են՝ բրայլը, ձայնագրությունը կամ խոշոր տառատեսակը: Դուք կարող եք նաև դիմել օժանդակ աջակցության և սարքերի համար, որոնք առկա են մեր հաստատություններում: Օգնության համար զանգահարեք մեր Անդամների սպասարկման բաժին: Անդամների սպասարկման բաժինը (Member Services) փակ է հիմնական տոն օրերին:

- Medicare, ներառյալ D-SNP՝ **1-800-443-0815** (TTY **711**), 8 a.m.-ից 8 p.m.-ը, շաբաթը 7 օր
- Medi-Cal՝ **1-855-839-7613** (TTY **711**), օրը 24 ժամ, շաբաթը 7 օր
- Մյուս բոլորը՝ **1-800-464-4000** (TTY **711**), օրը 24 ժամ, շաբաթը 7 օր

Chinese：请注意。我们免费为您提供及时语言协助。您可以要求我们提供口译服务，包括手语翻译员。您可以要求将资料翻译成您所使用的语言或其他格式，如盲文版、音频版或大字版。您还可以要求在我们的设施使用语言辅助工具和设备。请致电会员服务部(Member Services)以获取帮助。会员服务部于重要节假日休息。

- 联邦医疗保险计划 (Medicare)，包括 D-SNP：**1-800-443-0815** (TTY **711**)，每周 7 天，上午 8:00 至晚上 8:00
- 加州医疗保健辅助计划：**1-855-839-7613** (TTY **711**)，每周 7 天，每天 24 小时
- 所有其他计划：**1-800-757-7585** (TTY **711**)，每周 7 天，每天 24 小时

Farsi: توجه. امکان بهره‌مندی به‌موقع و مقتضی از مساعدت زبانی به طور رایگان برای شما وجود دارد. می‌توانید خدمات ترجمه شفاهی را درخواست کنید، از جمله مترجمان زبان اشاره. همچنین می‌توانید مطالب ترجمه‌شده به زبان خودتان یا در قالب‌های جایگزین را درخواست کنید، از جمله خط بریل، فایل صوتی، یا چاپ با حروف درشت. همچنین می‌توانید امکانات و دستگاه‌های کمکی را از مراکز ما درخواست کنید. برای دریافت کمک، با بخش خدمات اعضای ما (Member Services) تماس بگیرید. بخش خدمات اعضا در تعطیلات رسمی تعطیل می‌باشد.

- Medicare، شامل D-SNP: با شماره **1-800-443-0815** (TTY **711**) از 8 صبح تا 8 عصر، در 7 روز هفته تماس بگیرید
- Medi-Cal: با شماره **1-855-839-7613** (TTY **711**)، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید
- همه موارد دیگر: با شماره **1-800-464-4000** (TTY **711**)، در 24 ساعت شبانه‌روز، 7 روز هفته تماس بگیرید

Hindi: ध्यान दें। समय पर भाषा सहायता आपके लिए बिना किसी शुल्क के उपलब्ध है। आप दुभाषिया सेवाओं के लिए अनुरोध कर सकते हैं, जिसमें साइन लैंगुवेज के दुभाषिये भी शामिल हैं। आप सामग्रियों को अपनी भाषा या वैकल्पिक प्रारूप, जैसे कि ब्रेल, ऑडियो, या बड़े प्रिंट में अनुवाद करवाने के लिए भी कह सकते हैं। आप हमारे सुविधा-केंद्रों पर सहायक साधनों और उपकरणों का भी अनुरोध कर सकते हैं। सहायता के लिए हमारे सदस्य सेवा (Member Services) विभाग को कॉल करें। सदस्य सेवा विभाग मुख्य छुट्टियों वाले दिन बंद रहता है।

- Medicare, जिसमें D-SNP शामिल है: **1-800-443-0815** (TTY **711**), सुबह 8 बजे से रात 8 बजे तक, सप्ताह के 7 दिन
- Medi-Cal: **1-855-839-7613** (TTY **711**), दिन के चौबीस घंटे, सप्ताह के 7 दिन
- बाकी सभी: **1-800-464-4000** (TTY **711**), दिन के चौबीस घंटे, सप्ताह के 7 दिन

Hmong: CEEB TOOM. Sij hawm muaj kev pab txhais lus pub dawb rau koj. Koj muaj peev xwm thov kom pab txhais lus, suav nrog kws txhais lus piav tes. Koj muaj peev xwm thov kom muab cov ntaub ntawv no txhais ua koj yam lus los sis ua lwm hom, xws li hom ntawv rau neeg dig muag xuas, tso ua suab lus, los sis luam tawm kom koj. Koj kuj tuaj yeem thov kom muab tej khoom pab dawb thiab tej khoom siv txhawb tau rau

ntawm peb cov chaw kuaj mob. Hu mus thov kev pab rau ntawm peb Lub Chaw Pab Cuam Tswv Cuab. Lub Chaw Pab Cuam (Member Services) Tswv Cuab raug kaw rau cov hnub so tseem ceeb.

- Medicare, suav nrog D-SNP: **1-800-443-0815** (TTY **711**), 8 teev sawv ntxov txog 8 teev tsaus ntuj, 7 hnub hauv ib lub vij
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 teev hauv ib hnub, 7 hnub hauv ib lub vij
- Tag nrho lwm yam: **1-800-464-4000** (TTY **711**), 24 teev hauv ib hnub, 7 hnub hauv ib lub vij

Japanese：注意。タイムリーな言語サポートを無料でご利用いただけます。あなたは手話通訳を含む通訳サービスを依頼できます。点字、大型活字、または録音音声など、あなたの言語に翻訳された資料や別のフォーマットの資料を求めることができます。当社の施設では補助器具や機器の要請も承っております。支援が必要な方は、加入者サービス部門 (Member Services) にお電話ください。加入者向けサービスは、主要な休日には営業しておりません。

- D-SNP を含む Medicare: **1-800-443-0815** (TTY **711**)、午前 8 時から午後 8 時まで、年中無休
- Medi-Cal: **1-855-839-7613** (TTY **711**)、24 時間、年中無休
- その他全て: **1-800-464-4000** (TTY **711**)、24 時間、年中無休

Khmer (Cambodian): យកចិត្តទុកដាក់។
ជំនួយភាសាទាន់ពេលវេលាអាចរកបានដោយមិនគិតថ្លៃសម្រាប់អ្នក។
អ្នកអាចស្នើសុំសេវាអ្នកបកប្រែ រួមទាំងអ្នកបកប្រែភាសាសញ្ញាផងដែរ។
អ្នកអាចស្នើសុំឯកសារដែលត្រូវបានបកប្រែជាភាសារបស់អ្នក
ឬទម្រង់ផ្សេងទៀតដូចជាអក្សរស្ដាប សំឡេង ឬអក្សរធំៗ។ អ្នកក៏អាចស្នើសុំជំនួយបន្ថែម និងឧបករណ៍ជំនួយនៅតាមកន្លែងរបស់យើងផងដែរ។
សូមទូរសព្ទទៅផ្នែកសេវាសមាជិករបស់យើងសម្រាប់ជំនួយ។
សេវាកម្មសមាជិកត្រូវបានបិទនៅថ្ងៃឈប់សម្រាកសំខាន់ៗ (Member Services)។

- Medicare រួមទាំង D-SNP: **1-800-443-0815** (TTY **711**) ពីម៉ោង 8 ព្រឹក ដល់ 8 យប់ 7 ថ្ងៃក្នុងមួយសប្ដាហ៍
- Medi-Cal: **1-855-839-7613** (TTY **711**) 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្ដាហ៍
- ផ្សេងៗទៀតទាំងអស់៖ **1-800-464-4000** (TTY **711**) 24 ម៉ោងក្នុងមួយថ្ងៃ 7 ថ្ងៃក្នុងមួយសប្ដាហ៍

Korean: 참고. 무료로 시기적절한 언어 지원을 제공합니다. 수화 통역사를 포함한 통역 서비스를 요청할 수 있습니다. 한국어로 번역된 자료 또는 점자, 오디오 또는 큰 글씨와 같은 대체 형식의 자료를 요청할 수 있습니다. 저희 시설에서 보조 기구와 장치를 요청할 수도 있습니다. 가입자 서비스 (Member Services) 부서에 전화하여 도움을 요청하십시오. 주요 공휴일에는 가입자 서비스를 운영하지 않습니다.

- Medicare(D-SNP 포함): 주 7 일 오전 8 시~오후 8 시에 **1-800-443-0815** (TTY **711**)번으로 문의
- Medi-Cal: **1-855-839-7613** (TTY **711**), 주 7 일, 하루 24 시간
- 기타 모두: **1-800-464-4000** (TTY **711**), 주 7 일, 하루 24 시간

Laotian: ຂໍ້ຄວນເອົາໃຈໃສ່. ມີການຊ່ວຍເຫຼືອດ້ານພາສາຢ່າງທັນເວລາໃຫ້ທ່ານໂດຍບໍ່ເສຍຄ່າ. ທ່ານສາມາດຂໍບໍລິການລ່າມແປພາສາ, ລວມທັງລ່າມແປພາສາມື.
ທ່ານສາມາດຂໍເອກະສານທີ່ແປເປັນພາສາຂອງທ່ານ ຫຼື ຮູບແບບອື່ນ ເຊັ່ນ: ອັກສອນນູນ, ສຽງ ຫຼື ຕົວພິມໃຫຍ່. ນອກຈາກນີ້ ທ່ານຍັງສາມາດຮ້ອງຂໍເຄື່ອງຊ່ວຍເຫຼືອ ແລະ ອຸປະກອນເສີມໄດ້ທີ່ສະຖານທີ່ຍ່ານພະຍາບານຂອງພວກເຮົາ. ໂທຫາພະແນກການບໍລິການສະມາຊິກ (Member Services) ຂອງພວກເຮົາສຳລັບການຊ່ວຍເຫຼືອ. ການບໍລິການສະມາຊິກຈະປິດໃນວັນພັກສຳຄັນ.

- Medicare, ລວມທັງ D-SNP: **1-800-443-0815** (TTY **711**), 8 ໂມງເຊົ້າ ຫາ 8 ໂມງແລງ, 7 ມື້ຕໍ່ອາທິດ
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ
- ທັງໝົດອື່ນໆ: **1-800-464-4000** (TTY **711**), 24 ຊົ່ວໂມງຕໍ່ມື້, 7 ມື້ຕໍ່ອາທິດ

Mien: MBUOX JANGX-FIM WAAC. Ninh mbuo duqv liepc ziangx tengx faan waac bun meih muangx hingh mv zuqc hoic meih ndortv nyaanh cingv oc. Meih corc haiv tov taux ninh mbuo tengx lorz faan waac bun meih, caux longc buoz wuv faan waac bun muangx. Meih aengx haih tov taux ninh mbuo dorh nyungc horngh jaa dorngx faan benx meih nyei waac a'fai fiev bieqc da'nyeic diuc daan, fiev benx domh nzangc-pokc bun hluo, bungx waac-qiez bun uangx, a'fai aamx bieqc domh zeiv-linh. Meih corc haih tov longc benx wuotc ginc jaa-dorngx tengx aengx caux jaa-sic nzie bun yiem njiec zorc goux baengc zingh gorn zangc. Mborqv finx lorz taux yie mbuo dinc zangc domh gorn ziux goux baengc mienh nyei dorngx liouh tov heuc ninh mbuo tengx nzie weih. Goux baengc mienh nyei dorngx duqv guon mv zoux gong yiem gingc nyei hnoi-nyieqc oc (Member Services).

- Medicare, caux D-SNP: **1-800-443-0815** (TTY **711**), yiem 8 dimv lungh ndorm taux 8 dimv lungh muonx, yietc norm leiz baaix zoux gong 7 hnoi
- Medi-Cal: **1-855-839-7613** (TTY **711**), yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi
- Yietc zungv da'nyeic diuc jauv-louc: **1-800-464-4000** (TTY **711**), yietc hnoi goux junh 24 norm ziangh hoc, yietc norm leiz baaix zoux gong 7 hnoi

Navajo: YÁ'ÁDÍÍŁTĮĮH. T'áá Bíní'dée'go Bizaad Bee Na'anish Bééhózin, Doo BéeNOLso Bee Na'al'a' Da. Tł'éé'góó tł'ízí'ígíí éí tséé' naalkáah sidá'ígíí bikáa' dah sidaaígíí, t'á'ii bik'eh dah na'ałkaígíí. T'á'ii éí tł'éé'góó tł'ízí'ígíí bik'eh dah deidiyós, t'á'ii éí bi'éé' bik'eh dah na'ałkaígíí bik'eh dah deidiyós. T'á'ii bik'eh dah na'ałkaígíí bikáa' dah na'ałkaígíí t'áá ałtso bik'eh dah deidiyós. Bi'éé' naalkáah sidá'ígíí bik'eh ha'a'aah. T'á'ii bik'eh dah na'ałkaígíí éí bik'eh dah naazhjaa'ígíí bik'eh dah na'ałkaígíí (Member Services).

- Medicare, 'ałdó' bii' hóló D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. góó 8 p.m., 7 jį t'ááłá'í damóo
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 tł'ohch'oolí t'ááłá'í jį, 7 jį t'ááłá'í damóo
- T'áá ał'ąą: **1-800-464-4000** (TTY **711**), 24 tł'ohch'oolí t'ááłá'í jį, 7 jį t'ááłá'í damóo

Punjabi: ਧਿਆਨ ਦਿਓ। ਸਮੇਂ ਸਿਰ ਦਿੱਤੀ ਜਾਣ ਵਾਲੀ ਭਾਸ਼ਾ ਸਹਾਇਤਾ ਤੁਹਾਡੇ ਲਈ ਬਿਨਾਂ ਕਿਸੇ ਲਾਗਤ ਦੇ ਉਪਲਬਧ ਹੈ। ਤੁਸੀਂ ਦੁਭਾਸ਼ਿਏ ਦੀਆਂ ਸੇਵਾਵਾਂ ਦਿੱਤੇ ਜਾਣ ਲਈ ਕਹਿ ਸਕਦੇ ਹੋ, ਜਿਸ ਵਿੱਚ ਸਾਈਨ ਲੈਂਗੁਵੇਜ਼ ਦੇ ਦੁਭਾਸ਼ਿਏ ਵੀ ਸ਼ਾਮਲ ਹਨ। ਤੁਸੀਂ ਸਮੱਗਰੀਆਂ ਨੂੰ ਆਪਣੀ ਭਾਸ਼ਾ ਵਿੱਚ, ਜਾਂ ਕਿਸੇ ਵੈਕਲਪਿਕ ਫਾਰਮੈਟ, ਜਿਵੇਂ ਕਿ ਬ੍ਰੇਲ, ਆਡੀਓ, ਜਾਂ ਵੱਡੇ ਪ੍ਰਿੰਟ ਵਿੱਚ ਅਨੁਵਾਦਿਤ ਕਰਨ ਲਈ ਵੀ ਕਹਿ ਸਕਦੇ ਹੋ। ਤੁਸੀਂ ਸਾਡੀਆਂ ਸਹੂਲਤਾਂ 'ਤੇ ਸਹਾਇਕ

ਏਡਜ਼ ਅਤੇ ਉਪਕਰਨਾਂ ਲਈ ਵੀ ਬੇਨਤੀ ਕਰ ਸਕਦੇ ਹੋ। ਮਦਦ ਲਈ ਸਾਡੇ ਮੈਂਬਰਾਂ ਸੇਵਾਵਾਂ (Member Services) ਦੇ ਵਿਭਾਗ ਨੂੰ ਕਾੱਲ ਕਰੋ। ਮੈਂਬਰਾਂ ਸੇਵਾਵਾਂ ਦਾ ਵਿਭਾਗ ਮੁੱਖ ਛੁਟੀਆਂ ਵਾਲੇ ਦਿਨ ਬੰਦ ਰਹਿੰਦਾ ਹੈ।

- Medicare, ਬਜਸ ਬਵੱ D-SNP ਵੀ ਸ਼ਾਮਲ ਹੈ: **1-800-443-0815** (TTY **711**), ਸਵੇਰੇ 8 ਵਜੇ ਤੋਂ ਸ਼ਾਮ 8 ਵਜੇ ਤੱਕ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- Medi-Cal: **1-855-839-7613** (TTY **711**), ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ
- ਬਾਕੀ ਸਾਰੇ: **1-800-464-4000** (TTY **711**), ਦਿਨ ਦੇ 24 ਘੰਟੇ, ਹਫ਼ਤੇ ਦੇ 7 ਦਿਨ

Russian: ВНИМАНИЕ! Для Вас доступны бесплатные услуги перевода. Вы можете запросить услуги устного перевода, в том числе услуги переводчика языка жестов. Вы также можете запросить материалы, переведенные на ваш язык или в альтернативных форматах, например шрифтом Брайля, крупным шрифтом или в аудиоформате. Вы также можете запросить дополнительные приспособления и вспомогательные устройства в наших учреждениях. Если Вам нужна помощь, позвоните в отдел обслуживания участников. Отдел обслуживания участников (Member Services) не работает в дни государственных праздников.

- Medicare, включая D-SNP: **1-800-443-0815** (линия TTY **711**), ежедневно с 8:00 до 20:00.
- Medi-Cal: **1-855-839-7613** (линия TTY **711**), круглосуточно, ежедневно.
- Любые другие поставщики услуг: **1-800-464-4000** (линия TTY **711**), круглосуточно, ежедневно.

Spanish: ATENCIÓN. Se ofrece ayuda oportuna en otros idiomas sin ningún costo para usted. Puede solicitar servicios de interpretación, incluyendo intérpretes de lengua de señas. Puede solicitar materiales traducidos a su idioma o en formatos alternativos, como braille, audio o letra grande. También puede solicitar ayuda adicional y dispositivos auxiliares en nuestros centros de atención. Llame al Departamento de Servicio a los Miembros (Member Services) para pedir ayuda. Servicio a los Miembros está cerrado los días festivos principales.

- Medicare, incluyendo D-SNP: **1-800-443-0815** (TTY **711**), los 7 días de la semana, de 8 a. m. a 8 p. m., los 7 días de la semana
- Medi-Cal: **1-855-839-7613** (TTY **711**), las 24 horas del día, los 7 días de la semana.
- Todos los demás: **1-800-788-0616** (TTY **711**), las 24 horas del día, los 7 días de la semana.

Tagalog: ATENSYON. Ang napapanahong tulong sa wika ay makukuha nang walang bayad para sa iyo. Maaari kang humiling ng mga serbisyo ng interpreter, kasama ang mga interpreter sa sign language. Maaari kang humiling ng mga babasahin na nakasalin-wika sa iyong wika o sa mga alternatibong format, na tulad ng braille, audio, o malalaking titik. Puwede ka ring humiling ng mga karagdagang tulong at device sa aming mga pasilidad. Tawagan ang aming departamento ng Mga Serbisyo sa Miyembro (Member Services) para sa tulong. Ang Mga Serbisyo sa Miyembro ay sarado sa mga pangunahing holiday.

- Medicare, kasama ang D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. hanggang 8 p.m., 7 araw sa isang linggo

- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo
- Ang lahat ng iba: **1-800-464-4000** (TTY **711**), 24 oras sa isang araw, 7 araw sa isang linggo

Thai: ส่งถึง มีบริการความช่วยเหลือด้านภาษาอย่างทันท่วงทีให้ท่านโดยไม่มีค่าใช้จ่าย ท่านสามารถขอรับบริการล่าม รวมถึงล่ามภาษามือได้ ท่านสามารถขอให้แปลเอกสารเป็นภาษาของท่าน หรือในรูปแบบอื่นๆ เช่นอักษรเบรลล์ ไฟล์เสียง หรือตัวอักษรขนาดใหญ่ ท่านสามารถขอรับอุปกรณ์ช่วยเหลือและอุปกรณ์เสริมได้ ณ สถานที่ให้บริการของเรา โทรติดต่อฝ่ายบริการสมาชิกของเรา (Member Services) เพื่อขอความช่วยเหลือได้ ฝ่ายบริการสมาชิกจะปิดทำการในวันหยุดราชการต่างๆ

- Medicare รวมถึง D-SNP: **1-800-443-0815** (TTY **711**) 8.00 น. ถึง 20.00 น.หรือ 7 วันต่อสัปดาห์
- Medi-Cal: **1-855-839-7613** (TTY **711**) ตลอด 24 ชั่วโมง หรือ 7 วันต่อสัปดาห์
- อื่นๆ ทั้งหมด: **1-800-464-4000** (TTY **711**) ตลอด 24 ชั่วโมง หรือ 7 วันต่อสัปดาห์

Ukrainian: УВАГА! Своєчасні послуги перекладача надаються безкоштовно. Ви можете залишити запит на послуги усного перекладу, зокрема мовою жестів. Ви можете зробити запит на отримання матеріалів, перекладених вашою мовою, або в альтернативних форматах, як-от надрукованим шрифтом Брайля чи великим шрифтом, а також у звуковому форматі. Крім того, ви можете зробити запит на отримання допоміжних засобів і пристроїв у закладах нашої мережі компаній. Якщо вам потрібна допомога, зателефонуйте у відділ обслуговування клієнтів (Member Services). Відділ обслуговування клієнтів зачинений у державні свята.

- Medicare, зокрема D-SNP: **1-800-443-0815** (TTY **711**), із 8:00 до 20:00, без вихідних.
- Medi-Cal: **1-855-839-7613** (TTY **711**), цілодобово, без вихідних.
- Усі інші надавачі послуг: **1-800-464-4000** (TTY **711**), цілодобово, без вихідних.

Vietnamese: LƯU Ý. Chúng tôi cung cấp dịch vụ hỗ trợ ngôn ngữ kịp thời, miễn phí cho quý vị. Quý vị có thể yêu cầu dịch vụ thông dịch, bao gồm cả thông dịch viên ngôn ngữ ký hiệu. Quý vị có thể yêu cầu tài liệu được dịch sang ngôn ngữ của quý vị hay định dạng thay thế, chẳng hạn như chữ nổi braille, băng đĩa thu âm hay bản in khổ chữ lớn. Quý vị cũng có thể yêu cầu các phương tiện và thiết bị phụ trợ tại các cơ sở của chúng tôi. Gọi cho ban Dịch Vụ Hội Viên (Member Services) của chúng tôi để được trợ giúp. Ban Dịch Vụ Hội Viên không làm việc vào những ngày lễ lớn.

- Medicare, bao gồm cả D-SNP: **1-800-443-0815** (TTY **711**), 8 giờ sáng đến 8 giờ tối, 7 ngày trong tuần
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần
- Mọi chương trình khác: **1-800-464-4000** (TTY **711**), 24 giờ trong ngày, 7 ngày trong tuần.

Nondiscrimination Notice

In this document, "we", "us", or "our" means Kaiser Permanente (Kaiser Foundation Health Plan, Inc, Kaiser Foundation Hospitals, The Permanente Medical Group, Inc., and the Southern California Medical Group). This notice is available on our website at **kp.org**.

Discrimination is against the law. We follow state and federal civil rights laws.

We do not discriminate, exclude people, or treat them differently because of age, race, ethnic group identification, color, national origin, cultural background, ancestry, religion, sex, gender, gender identity, gender expression, sexual orientation, marital status, physical or mental disability, medical condition, source of payment, genetic information, citizenship, primary language, or immigration status.

Kaiser Permanente provides the following services in a timely manner:

- No-cost aids and services to people with disabilities to help them communicate better with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (braille, large print, audio, accessible electronic formats, and other formats)
- No-cost language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, call our Member Services department at the numbers below. The call is free. Member services is closed on major holidays.

- Medicare, including D-SNP: **1-800-443-0815** (TTY **711**), 8 a.m. to 8 p.m., 7 days a week.
- Medi-Cal: **1-855-839-7613** (TTY **711**), 24 hours a day, 7 days a week.
- All others: **1-800-464-4000** (TTY **711**), 24 hours a day, 7 days a week.

Upon request, this document can be made available to you in braille, large print, audio, or electronic formats. To obtain a copy in one of these alternative formats, or another format, call our Member Services department and ask for the format you need.

How to file a grievance with Kaiser Permanente

You can file a discrimination grievance with us if you believe we have failed to provide these services or unlawfully discriminated in another way. You can file a grievance by phone, by mail, in person, or online. Please refer to your *Evidence of Coverage or Certificate of Insurance* for details. You can call Member Services for more information on the options that apply to you, or for help filing a grievance. You may file a discrimination grievance in the following ways:

- **By phone:** Call our Member Services department. Phone numbers are listed above.
- **By mail:** Download a form at **kp.org** or call Member Services and ask them to send you a form that you can send back.
- **In person:** Fill out a Complaint or Benefit Claim/Request form at a member services office located at a Plan Facility (go to your provider directory at **kp.org/facilities** for addresses)

- **Online:** Use the online form on our website at **kp.org**

You may also contact the Kaiser Permanente Civil Rights Coordinator directly at the addresses below:

Attn: Kaiser Permanente Civil Rights Coordinator
Member Relations Grievance Operations
P.O. Box 939001
San Diego CA 92193

How to file a grievance with the California Department of Health Care Services Office for Civil Rights *(For Medi-Cal Beneficiaries Only)*

You can also file a civil rights complaint with the California Department of Health Care Services Office for Civil Rights in writing, by phone or by email:

- **By phone:** Call DHCS Office of Civil Rights at **916-440-7370** (TTY **711**)
- **By mail:** Fill out a complaint form or send a letter to:

  Office of Civil Rights
  Department of Health Care Services
  P.O. Box 997413, MS 0009
  Sacramento, CA 95899-7413

  California Department of Health Care Services Office for Civil Rights Complaint forms are available at: http://www.dhcs.ca.gov/Pages/Language_Access.aspx

- **Online:** Send an email to CivilRights@dhcs.ca.gov

How to file a grievance with the U.S. Department of Health and Human Services Office for Civil Rights

You can file a discrimination complaint with the U.S. Department of Health and Human Services Office for Civil Rights. You can file your complaint in writing, by phone, or online:

- **By phone:** Call **1-800-368-1019** (TTY **711** or **1-800-537-7697**)
- **By mail:** Fill out a complaint form or send a letter to:

  U.S. Department of Health and Human Services
  200 Independence Avenue, SW
  Room 509F, HHH Building
  Washington, D.C. 20201

  U.S. Department of Health and Human Services Office for Civil Rights Complaint forms are available at: https://www.hhs.gov/ocr/office/file/index.html

- **Online:** Visit the **Office for Civil Rights Complaint Portal at: https://ocrportal.hhs.gov/ocr/smartscreen/main.jsf**